



STATE OF ALASKA
Department of Health and Social Services
Finance and Management Services
Grants and Contracts Support Team
350 Main Street, Suite 6
Juneau, Alaska 99801

Request For Proposals

RFP 2007-0600-6640

Date of Issue: November 03, 2006

Alaska MMIS Project

Purpose of RFP:

This RFP is issued by the Alaska Department of Health and Social Services to solicit proposals for Contractor services to potentially fulfill one or more of the following options: (1) takeover current fiscal agent operations defined in 1987 Alaska MMIS RFP and amendments; (2) design, develop, implement, and operate a new DW/DSS, Point of Sale System, and MMIS for the Department and (3) provide other fiscal agent services defined in Section 5 of this document.

Offerors Are Not Required To Return This Form.

Important Notice: If you received this solicitation from the State of Alaska's "Online Public Notice" web site, you must register with the Procurement Officer listed in this document to receive subsequent amendments. Failure to contact the Procurement Officer may result in the rejection of your offer.

**Staci Augustus
Procurement Officer
Department of Health & Social Services**

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1 INTRODUCTION AND INSTRUCTIONS

1.1 RFP Contact Information - Return Mailing Address, Contact Person, Telephone, Fax Numbers and Deadline for Receipt of Proposals

Offerors must submit one clearly marked original copy of their technical proposal, in writing, to the Procurement Officer in a sealed envelope. In addition, the Offeror must submit one clearly marked original copy of their cost proposal, in writing, to the Procurement Officer in a sealed envelope. The technical proposal must be sealed separately from the cost proposal, and each must be clearly identified on the outside of the package.

In addition, Offerors must submit fifteen (15) bound hard copies of the technical proposal. Also, Offerors must provide a compact disk (CD) in a separate sealed envelope, clearly marked "Electronic Copy," which contains the technical proposal in MS Word (version 2002 or 2003) and the cost proposal in MS Word or MS Excel (version 2002 or 2003).

Proposals are to be mailed or delivered to the following address:

STATE OF ALASKA
Department of Health and Social Services
Finance and Management Services
Grants and Contracts Support Team
Attention: **Staci Augustus**
Request For Proposal (RFP) Number: 2007-0600-6640
Project Name: Alaska MMIS System

If using U.S. Mail, the following mailing address applies:

P.O. Box 110650
Juneau, Alaska 99811-0650

If a delivery service is used, the following address applies:

Alaska Office Building
350 Main Street, Room 6
Juneau, Alaska 99801

Proposals must be received no later than 10:00 A.M., Alaska Time on January 29, 2007. Faxed, oral, or email proposals are not acceptable. An Offeror's failure to submit a proposal prior to the deadline will cause the proposal to be disqualified. Late proposals or amendments will not be opened or accepted for evaluation.

PROCUREMENT OFFICER: Staci Augustus
PHONE # 907-465-3005, FAX # 907-463-3153
E-MAIL ADDRESS: *Staci_Augustus@health.State.ak.us*

1.2 Contract Term and Work Schedule

The contract term and work schedule is dependent upon which phases the State chooses to execute. To be responsive, Offerors must submit technical and cost proposals for all four project phases. The State intends to award all phases to the Offeror with the winning proposal and reserves the right to execute Phase 1, Operational Takeover at its discretion.

Set out herein is the State of Alaska's best estimate of the schedule that will be followed. If a component of this schedule, such as the opening date, is delayed, the rest of the schedule will be shifted by the same number of days. The resulting contract may include up to four (4) phases, covering approximately ten (10) years. Section 3.1 lists the four phases and briefly describes each phase. Section 5, Scope of Work, describes each phase in detail. The following four potential project phases are as follows:

- Phase I. Operational Takeover is scheduled for six (6) months and two years of operations;
- Phase II. DDI is scheduled for two (2) years;
- Phase III. Operations is scheduled for five (5) years, with three (3) each 1-year renewal periods;
- Phase IV. Turnover is expected to last six (6) months.

The tentative solicitation schedule is as follows:

Timetable	Date
Issue RFP	11/03/06
Pre-Proposal Conference	12/06/06
Date for Submission of Questions	12/17/07
Proposal Submission Deadline, 10:00 AM	1/29/07
Evaluation Begins	2/5/07
Vendor Demonstrations Start	3/27/07
Negotiations Begin	4/19/07
State Issues Notice of Intent to Award a Contract	5/18/07
Ten Day Protest Ends	5/28/07
Contract Issuance	6/15/07
Contract Start Date	7/1/07
The following four potential project phase periods are based upon the contract start date.	
I Operational Takeover	6 months
II DDI	2 years
III Operations	5 years + 3ea. 1-year renewals
IV Turnover, runs concurrent with end of Phase III	6 months
Contract End Date	6/30/2017

1.3 Purpose of the RFP

This RFP is issued by the Alaska Department of Health and Social Services (DHSS) to solicit proposals for Contractor services to fulfill one or more of the following options: (1) design, develop, implement, and operate a new DW/DSS, Point of Sale, and MMIS for the Department and provide other fiscal agent services defined in Section 5 of this document; and (2) at the discretion of the State to takeover current fiscal agent operations defined in 1987 Alaska MMIS RFP and amendments. The new Alaska MMIS must be based on the transfer and modification of current MMIS technologies or similar claims processing and reporting system components that will meet all Federal MMIS certification requirements and address other Alaska-specific requirements. A detailed description of the Statement of Work and System Requirements is presented in Section 5.

1.4 Location of Work

The State expects that the Contractor and State staff will be co-located to the fullest extent possible for the DDI portion of the contract, transitioning to the Contractor's operations location during the implementation phase of the new system. Location(s) where the system DDI work is to be performed will include on-site staffing in Anchorage, Alaska as well as other system development support completed and managed at the central offices or other locations that are approved by the State. All services provided under the resulting contract by the Contractor and all sub-Contractors shall be performed in the United States.

The State requires that the DDI Manager, all Contractor key staff, and eventually the Operations Managers, described in Section 3.11, be located in Anchorage when they perform work related to the contract. Within the technical proposal, Offerors must describe the deployment of staff for the Takeover, DDI, and Operations phases. Section 3.11 presents onsite requirements for key staff. Proposals must describe how the Offeror will ensure that other lead Business Analysts will be on-site while critical requirements analysis, design, and acceptance testing tasks are executed.

The State will furnish office space, and meeting rooms for up to twenty (20) contractor staff in Anchorage that are co-located with State DDI staff. The Contractor will be responsible for providing computer equipment, printers, and specialized office equipment for Contractor DDI staff.

The Contractor must include all travel costs in their cost proposal, including but not limited to, transportation, lodging, equipment, and per diem costs sufficient to pay for all staff to complete all deliverables outlined in this RFP.

1.5 Assistance to Offerors With a Disability

Offerors with a disability may receive accommodation regarding the means of communicating this RFP or participating in the procurement process. For more information, contact the

Procurement Officer no later than ten days prior to the deadline for receipt of proposals.

1.6 Required Review

Offerors should carefully review this solicitation for defects and questionable or objectionable material. Comments concerning defects and objectionable material must be made in writing and received by the Procurement Officer at least ten days before the proposal opening. This will allow issuance of any necessary amendments. It will also help prevent the opening of a defective solicitation and exposure of Offerors' proposals upon which award could not be made. Protests based on any omission or error, or on the content of the solicitation, will be disallowed if these faults have not been brought to the attention of the Procurement Officer, in writing, at least ten days before the time set for opening.

1.7 Questions Received Prior to Opening of Proposals

All questions must be in writing and directed to the issuing office, addressed to the Procurement Officer. The interested party must confirm telephone conversations in writing.

Two types of questions generally arise. One may be answered by directing the questioner to a specific section of the RFP. These questions may be answered over the telephone. Other questions may be more complex and may require a written amendment to the RFP. The Procurement Officer will make that decision.

1.8 Amendments

If an amendment is issued, it will be provided to all who were mailed a copy of the RFP and to those who have registered with the Procurement Officer as having downloaded the RFP from the State of Alaska Online Public Notice web site.

1.9 Alternate Proposals

Offerors may only submit one proposal for evaluation.

In accordance with 2 AAC 12.830, alternate proposals (proposals that offer something different than what is asked for) will be rejected.

1.10 Right of Rejection

Offerors must comply with all of the terms of the RFP; the State Procurement Code (AS 36.30); and all applicable local, State, and federal laws, codes, and regulations. The Procurement Officer may reject any proposal that does not comply with all of the material and substantial terms, conditions, and performance requirements of the RFP.

Offerors may not qualify the proposal nor restrict the rights of the State. If an Offeror does so, the Procurement Officer may determine the proposal to be a non-responsive counter-offer and the proposal may be rejected.

Minor informalities that:

- Do not affect responsiveness;
- Are merely a matter of form or format;
- Do not change the relative standing or otherwise prejudice other offers;
- Do not change the meaning or scope of the RFP;
- Are trivial, negligible, or immaterial in nature;
- Do not reflect a material change in the work; or
- Do not constitute a substantial reservation against a requirement or provision;

may be waived by the Procurement Officer.

The State reserves the right to refrain from making an award if it determines that to be in its best interest.

A proposal from a debarred or suspended Offeror shall be rejected.

1.11 State Not Responsible for Preparation Costs

The State will not pay any cost associated with the preparation, submittal, demonstration, or evaluation of any proposal.

1.12 Disclosure of Proposal Contents

All proposals and other material submitted become the property of the State of Alaska and may be returned only at the State's option. AS 40.25.110 requires public records to be open to reasonable inspection. All proposal information, including detailed price and cost information, will be held in confidence during the evaluation process and prior to the time a Notice of Intent to Award is issued. Thereafter, technical proposals will become public information, unless otherwise stated.

Trade secrets and other proprietary data contained in Offeror proposals may be held confidential if the Offeror requests, in writing, that the Procurement Officer does so, and if the Procurement Officer agrees, in writing, to do so. However, the entire Offeror technical proposal is not considered to be proprietary information. Also, with regard to cost proposals, only Offeror cost proposal totals for each phase of the project will be released as public information. Other information within the cost proposal will be considered proprietary.

Material considered confidential by the Offeror must be clearly identified, and the Offeror must include a brief statement that sets out the reasons for confidentiality.

1.13 Sub-Contractors

Sub-Contractors may be used to perform work under this contract. If a proposal with Sub-Contractors is submitted, the Offeror must submit a statement with their proposal indicating that the Offeror will perform at least 45% of the amount of work for the entire project. This percentage is measured in terms of the total price of the contract.

If a proposal with Sub-Contractors is selected, the Offeror must provide with their proposal the information outlined in Section 6.2.5.1 for each subcontractor, in addition to the following information:

- (1) Complete name of the Sub-Contractor;
- (2) Complete address of the Sub-Contractor;
- (3) Type of work the Sub-Contractor will be performing;
- (4) Percentage of work the Sub-Contractor will be providing;
- (5) Evidence, as set out in the relevant section of this RFP, that the Sub-Contractor holds a valid Alaska business license; and
- (6) A written Statement, signed by each proposed Sub-Contractor, that clearly verifies that the Sub-Contractor is committed to render the services required by the contract.

An Offeror's failure to provide this information with their proposal may cause the State to consider their proposal non-responsive and reject it. The substitution of one Sub-Contractor for another may be made only at the discretion and prior written approval of the Procurement Officer.

1.14 Joint Ventures

Joint ventures are acceptable. If submitting a proposal as a joint venture, the Offeror must submit a copy of the joint venture agreement that identifies the principles involved and their rights and responsibilities regarding performance and payment.

1.15 Offeror's Certification

By signature on the transmittal letter, Offerors certify that they comply with all of the conditions outlined below (1) through (8) of this section and will provide the necessary statements outlined in Section 6.2.1.1:

- (1) The laws of the State of Alaska;
- (2) The applicable portion of the Federal Civil Rights Act of 1964;
- (3) The Equal Employment Opportunity Act and the regulations issued thereunder by the federal government;

- (4) The Americans with Disabilities Act of 1990 and the regulations issued thereunder by the federal government;
- (5) All terms and conditions set out in this RFP;
- (6) A condition that the proposal submitted was independently arrived at, without collusion, under penalty of perjury;
- (7) That the offers will remain open and valid for at least 180 days;
- (8) That programs, services, and activities provided to the general public under the resulting contract conform with the Americans with Disabilities Act of 1990, and the regulations issued thereunder by the federal government.

If any Offeror fails to comply with (1) through (8) of this paragraph, the State reserves the right to disregard the proposal, terminate the contract, or consider the Contractor in default. This certification also applies to Sub-Contractor transmittal letters.

By signature on their transmittal letter, the Offeror also certifies that:

- (1) All services provided under this contract by the Contractor and all Sub-Contractors shall be performed in the United States;
- (2) The Offeror and/or all Sub-Contractors are not established and headquartered, or incorporated and headquartered, in a country recognized as Tier 3 in the most recent United States Department of State's Trafficking in Persons Report; or
- (3) If the Offeror and/or Sub-Contractors are established and headquartered, or incorporated and headquartered, in a country recognized as Tier 3 in the most recent United States Department of State's Trafficking in Persons Report, a certified copy of the bidder's policy against human trafficking must be submitted to the State of Alaska prior to contract award.

Failure to comply with (1) and/or either(2) or (3) of this requirement will cause the State to reject the proposal as non-responsive, or cancel the contract. The most recent United States Department of State's Trafficking in Persons Report can be found at the following website: <http://www.State.gov/g/tip/>.

1.16 Conflict of Interest

Each proposal shall include a Statement indicating whether or not the firm or any individuals working on the contract has a possible conflict of interest (e.g., employed by the State of Alaska) and, if so, the nature of that conflict. The Commissioner, Department of Health and Social Services, reserves the right to cancel the award if any interest disclosed from any source could either give the appearance of a conflict or cause speculation as to the objectivity of the program to be developed by the Offeror. The Commissioner's determination regarding any questions of conflict of interest shall be final.

1.17 Right to Inspect Place of Business

At reasonable times, the State may inspect those areas of the Contractor's place of business that are related to the performance of a contract. If the State makes such an inspection, the Contractor must provide reasonable assistance.

1.18 Solicitation Advertising

Public notice has been provided in accordance with 2 AAC 12.220.

1.19 News Releases

News releases related to this RFP will not be made without prior approval of the Project Director.

1.20 Assignment

Per 2 AAC 12.480, the Contractor may not transfer or assign any portion of the contract without prior written approval from the Procurement Officer.

1.21 Disputes

Any dispute arising out of this agreement will be resolved under the laws of the State of Alaska. Any appeal of an administrative order or any original action to enforce any provision of this agreement or to obtain relief from or remedy in connection with this agreement may be brought only in the Superior Court for the State of Alaska.

1.22 Severability

If any provision of the contract or agreement is declared by a court to be illegal or in conflict with any law, the validity of the remaining terms and provisions will not be affected; and, the rights and obligations of the parties will be construed and enforced as if the contract did not contain the particular provision held to be invalid.

1.23 Federal Requirements

The Offeror must identify all known federal requirements that apply to the proposal, the evaluation, or the contract.

1.24 Budget

The budget for the DDI phase of the project is \$30,000,000.00. This budget is contingent upon State legislative appropriation and Federal approval. The State reserves the right to not award a contract if Federal approval does not include enhanced FFP.

2 STANDARD PROPOSAL INFORMATION

2.1 Authorized Signature

All proposals must be signed by an individual authorized to bind the Offeror to the provisions of the RFP. Proposals must remain open and valid for at least one hundred and eighty (180) days from the opening date.

2.2 Pre-Proposal Conference

A pre-proposal conference will be held at 10:00 AM, Alaska Time, on December 06, 2006 at 3601 C Street, Suite 890, Anchorage, Alaska 99503. The conference will take place in conference room 890 on the 8th floor of the Frontier Building in Anchorage, Alaska. The call-in number and teleconference code will be available to prospective Offerors that register with the Procurement Officer.

The purpose of the conference will be to discuss the work to be performed with the prospective Offerors and allow them to ask questions concerning the RFP. Questions and answers will be transcribed and sent to prospective Offerors as soon as possible after the meeting.

Offerors with a disability needing accommodation should contact the Procurement Officer prior to the date set for the pre-proposal conference so that reasonable accommodation can be made.

A library of reference materials regarding current DHSS programs, MMIS system documentation, and other materials will be available to registered Offerors at a State website. A list of documents contained in the library can be found in Attachment E.

2.3 Site Inspection

The State may conduct on-site visits to evaluate the Offeror's capacity to perform the contract. An Offeror must agree, at risk of being found non-responsive and having its proposal rejected, to provide the State reasonable access to relevant portions of its work sites. At the State's expense, individuals designated by the Procurement Officer will make site inspections.

2.4 Amendments to Proposals

Amendments to or withdrawals of proposals will only be allowed if acceptable requests are received prior to the deadline that is set for receipt of proposals. No amendments or withdrawals will be accepted after the deadline unless they are in response to the State's request in accordance with 2 AAC 12.290.

2.5 Supplemental Terms and Conditions

Proposals must comply with Section **1.10, Right of Rejection**. However, if the State fails to identify or detect supplemental terms or conditions that conflict with those contained in this

RFP, or that diminish the State's rights under any contract resulting from the RFP, the term(s) or condition(s) will be considered null and void. After award of contract:

- (1) If conflict arises between a supplemental term or condition included in the proposal and a term or condition of the RFP, the term or condition of the RFP will prevail; and
- (2) If the State's rights would be diminished as a result of application of a supplemental term or condition included in the proposal, the supplemental term or condition will be considered null and void.

2.6 Clarification of Offers

In order to determine if a proposal is reasonably susceptible for award, communications by the Procurement Officer or the Proposal Evaluation Committee (PEC) are permitted with an Offeror to clarify uncertainties or eliminate confusion concerning the contents of a proposal. Clarifications may not result in a material or substantive change to the proposal. The evaluation by the Procurement Officer or the Proposal Evaluation Committee may be adjusted as a result of a clarification under this section.

2.7 Minimum Requirements

In order for a proposal to be considered responsive, the proposal must meet the following minimum corporate, Offeror, system requirements, and performance bond letter requirements. An Offeror's failure to demonstrate these minimum requirements within the proposal will cause their proposal to be considered non-responsive and their proposal will be rejected.

2.7.1 Corporate Experience Requirements

The need for breadth and depth of knowledge of all aspects of Medicaid program administration can not be overstated. To be responsive, Offeror's proposals must demonstrate at least the following minimum stated corporate experience:

- (1) Five (5) years of DDI or MMIS and/or an equivalent public or private sector automated claims processing and information retrieval systems; and
- (2) Two (2) years of DDI and maintenance of a DW/DSS with equivalent capacity; and
- (3) Two (2) years of operations of an MMIS and/or equivalent public or private sector claims processing system; and
- (4) Two (2) years of fiscal agent services and/or equivalent public or private sector operations.

If a Sub-Contractor is proposed, the Sub-Contractor's experience may be substituted for the corporate experience if the Sub-Contractor is employed to provide services in the same area for which the experience was substituted.

The prior experience requirement must be with a system comparable in size to the current Alaska system. A private sector claims processing system which processes less than 75% of the yearly volume of claims processed by the Alaska MMIS is not considered an equivalent claims

processing system for demonstrating medical care programs and/or private sector claims processing corporate experience.

2.7.2 Offeror's Experience Requirements

To be responsive, Offerors must retain the following key staff positions and must demonstrate at least the following minimum stated experience for each key staff member:

Key Staff Position	Stated Experience Requirement
Project Manager/Account Manager	- a minimum of five (5) years experience in managing or in a key management position for an MMIS or other large-scale medical claims processing system; and - previous experience with an MMIS, or with major components of an operational MMIS.
Systems Development Manager	- a minimum of three (3) years of experience in the design, implementation, and implementation of a large-scale automated application similar to the proposed MMIS; and - previous experience with the MMIS or components of the MMIS proposed.
Training Manager	- a minimum of three (3) years experience managing provider training functions in Medicaid or other major public or private healthcare program; and - E-learning experience.
Quality Assurance Manager	- a minimum of five (5) years experience in the quality assurance function associated with implementation of a large-scale automated application similar to the proposed MMIS.
Data Conversion Manager	- a minimum of five (5) years experience in the conversion of large-scale data systems, with at least one year in a management capacity; and - previous experience with the MMIS or components of the MMIS proposed.
Testing Manager	- a minimum five (5) years experience planning and conducting system, systems integration, and user acceptance testing in an MMIS or major health plan claims processing environment.
Interface Manager	- a minimum of three (3) years experience in systems integration, messaging components, and interface development.
Operations / Claims Processing Manager	- a minimum of three (3) years experience in managing or in a key management position for an MMIS or other large-scale medical claims processing system; and - previous experience with an MMIS, or with major components of an operational MMIS.
Operational Takeover Manager (Operational Takeover Implementation Component)	- a minimum of three (3) years experience in managing or in a key management position for an MMIS or other large-scale medical claims processing system; and - previous experience with an MMIS, or with major components of an operational MMIS.

2.7.3 Other Minimum Requirements

To be responsive, Offerors must obtain a letter of commitment for a performance bond from a bonding company and submit it with their proposal.

2.8 Evaluation of Proposals

The Procurement Officer, or an evaluation committee made up of at least three State employees or public officials, will evaluate proposals. The evaluation will be based solely on the evaluation factors set out in Section 7 of this RFP.

After receipt of proposals, if there is a need for any substantial clarification or material change in the RFP, an amendment will be issued. The amendment will incorporate the clarification or change and establish a new date and time for new or amended proposals. Evaluations may be adjusted as a result of receiving new or amended proposals.

2.9 Vendor Tax ID

A valid Vendor Tax ID must be submitted to the issuing office with the proposal or within five days of the State's request.

2.10 Alaska Business License and Other Required Licenses

At the time the proposals are opened, all Offerors must hold a valid Alaska business license and any necessary applicable professional licenses required by Alaska Statute. Offerors should contact the Department of Commerce, Community, and Economic Development, Division of Occupational Licensing, P.O. Box 110806, Juneau, Alaska 99811-0806, for information on these licenses. Offerors must submit evidence of a valid Alaska business license with the proposal. An Offeror's failure to submit this evidence with the proposal will cause their proposal to be determined non-responsive. Acceptable evidence that the Offeror possesses a valid Alaska business license may consist of any one of the following:

- (1) Copy of an Alaska business license with the correct SIC code;
- (2) Certification in the proposal that the Offeror has a valid Alaska business license and has included the license number in the proposal;
- (3) A canceled check for the Alaska business license fee;
- (4) A copy of the Alaska business license application with a receipt stamp from the State's occupational licensing office; or
- (5) A sworn and notarized affidavit that the Offeror has applied and paid for the Alaska business license.

2.11 Application of Preferences

Certain preferences apply to all contracts for professional services, regardless of their dollar value. The Alaskan Bidder and Offeror preferences are the two most common preferences involved in the RFP process. Additional preferences that may apply to this procurement are

listed below. Guides that contain excerpts from the relevant statutes and codes, explain when the preferences apply, and provide examples of how to calculate the preferences are available at the Department of Administration, Division of General Services' web site:

<http://www.State.ak.us/local/akpages/ADMIN/dgs/policy.htm>

Employment Program Preference - AS 36.30.170(c)

Alaskans with Disability Preference - AS 36.30.170 (e)

Employers of People with Disabilities Preference - AS 36.30.170 (f)

The Division of Vocational Rehabilitation in the Department of Labor and Workforce Development keeps a list of qualified employment programs; a list of individuals who qualify as persons with a disability; and a list of persons who qualify as employers with 50 percent or more of their employees being disabled. A person must be on this list at the time the bid is opened in order to qualify for a preference under this section.

As evidence of an individual's or a business's right to a certain preference, the Division of Vocational Rehabilitation will issue a certification letter. To take advantage of the Employment Program Preference, Alaskans with Disability Preference or Employers of People with Disabilities Preference described above, an individual or business must be on the appropriate Division of Vocational Rehabilitation list at the time the proposal is opened and must provide the Procurement Officer a copy of their certification letter. Offerors must attach a copy of their certification letter to the proposal. The Offeror's failure to provide the certification letter mentioned above with the proposal will cause the State to disallow the preference.

2.11.1 5 Percent Alaskan Bidder Preference

2 AAC 12.260 & AS 36.30.170

An Alaskan Bidder Preference of five percent will be applied prior to evaluation. The preference will be given to an Offeror who:

- (1) Holds a current Alaska business license;
- (2) Submits a proposal for goods or services under the name on the Alaska business license;
- (3) Has maintained a place of business within the State staffed by the Offeror, or an employee of the Offeror, for a period of six months immediately preceding the date of the proposal;
- (4) Is incorporated or qualified to do business under the laws of the State, is a sole proprietorship and the proprietor is a resident of the State, is a limited liability company organized under AS 10.50 and all members are residents of the State, or is a partnership under AS 32.05 or AS 32.11 and all partners are residents of the State; and
- (5) If a joint venture, is composed entirely of entities that qualify under (1)-(4) of this subsection.

Alaskan Bidder Preference Affidavit

In order to receive the Alaskan Bidder Preference, proposals must include a Statement certifying that the Offeror is eligible to receive the Alaskan Bidder Preference.

2.11.2 Formula Used to Convert Cost to Points AS 36.30.250 & 2 AAC 12.260

The distribution of points based on cost will be determined as set out in 2 AAC 12.260 (d). The lowest cost proposal will receive the maximum number of points allocated to cost. The point allocations for cost on the other proposals will be determined through the method set out below.

EXAMPLE

Formula Used to Convert Cost to Points

[STEP 1]

List all proposal prices, adjusted where appropriate by the application of all applicable preferences.

Offeror #1	-	Non-Alaskan Offeror	\$40,000
Offeror #2	-	Alaskan Offeror	\$42,750
Offeror #3	-	Alaskan Offeror	\$47,500

[STEP 2]

Convert cost to points using this formula.

$$\frac{[(\text{Price of Lowest Cost Proposal}) \times (\text{Maximum Points for Cost})]}{(\text{Cost of Each Higher Priced Proposal})} = \text{POINTS}$$

Assume the RFP allotted 30% (3,000 points) of the total of 10,000 points for cost.

Offeror #1 receives 3,000 points.

The reason they receive 3,000 points is because the lowest cost proposal, in this case \$40,000, receives the maximum number of points allocated to cost, 3,000 points.

Offeror #2 receives 2,807 points.

$$\begin{array}{rclclcl} \$40,000 & \times & 3000 & = & 120,000,000 & \div & \$42,750 & = & 2,807 \\ \text{Lowest} & & \text{Max} & & & & \text{Offeror \#2} & & \text{Points} \\ \text{Cost} & & \text{Points} & & & & \text{Adjusted By} & & \\ & & & & & & \text{The Application Of} & & \\ & & & & & & \text{All Applicable} & & \\ & & & & & & \text{Preferences} & & \end{array}$$

Offeror #3 receives 2,526 points.

$$\begin{array}{rclclcl} \$40,000 & \times & 3000 & = & 120,000,000 & \div & \$47,500 & = & 2,526 \\ \text{Lowest} & & \text{Max} & & & & \text{Offeror \#3} & & \text{Points} \\ \text{Cost} & & \text{Points} & & & & \text{Adjusted By} & & \end{array}$$

The Application Of
All Applicable
Preferences

2.11.3 Alaskan Offeror's Preference AS 36.30.250 & 2 AAC 12.260

2 AAC 12.260(e) provides Alaskan Offerors a 10 percent overall evaluation point preference. Alaskan Bidders, as defined in AS 36.30.170(b), are eligible for the preference. This preference will be added to the overall evaluation score of each Alaskan Offeror. Each Alaskan Offeror will receive 10 percent of the total available points added to their evaluation score as a preference.

EXAMPLE

Alaskan Offeror's Preference

[STEP 1]

Determine the number of points available to Alaskan Offerors under the preference.

Total number of points available – 10,000 Points

$$\begin{array}{rcccl} \mathbf{10,000} & \times & \mathbf{10\%} & = & \mathbf{1,000} \\ \text{Total Points} & & \text{Alaskan Offerors} & & \text{Number of Points} \\ \text{Available} & & \text{Percentage Preference} & & \text{Given to Alaskan Offerors} \\ & & & & \text{Under the Preference} \end{array}$$

[STEP 2]

Add the preference points to the Alaskan offers. There are three Offerors: Offeror #1, Offeror #2, and Offeror #3. Offeror #2 and Offeror #3 are eligible for the Alaskan Offeror's Preference. For the purpose of this example, presume that all of the proposals have been completely evaluated based on the evaluation criteria in the RFP. Their scores at this point are:

Offeror #1 – 8,900 points
Offeror #2 – 8,000 points
Offeror #3 – 8,800 points

Offeror #2 and Offeror #3 each receive 1,000 additional points. The final scores for all of the offers are:

*Offeror #1 – **8,900 points***
*Offeror #2 – **9,000 points***
*Offeror #3 – **9,800 points***

2.11.4 15% Employment Program Preference AS 36.30.250. & AS 36.30.170

If an offeror qualifies for the Alaskan Bidder Preference, is offering services through a qualified employment program, and offers a proposal that is not more than fifteen percent (15%) higher than the lowest proposal after the 5% Alaskan Bidder Preference is applied, the Procurement Officer will award the maximum number of points allocated for cost to that offeror.

EXAMPLE

15% Employment Program Preference

[STEP 1]

List the raw proposal prices and identify those eligible for preference.

Offeror #1	-	Non-Alaskan Offeror No Employment Program	\$40,000
Offeror #2	-	Alaskan Offeror No Employment Program	\$45,000
Offeror #3	-	Alaskan Offeror With Employment Program	\$50,000

[STEP 2]

Calculate the amount of the five percent (5%) Alaskan Bidder Preference by multiplying the Alaskan proposals by 0.05 and deducting that amount from the price(s).

Offeror #2	-	$\$45,000 \times 0.05 = \$2,250$	$\$45,000 - \$2,250 = \$42,750$
Offeror #3	-	$\$50,000 \times 0.05 = \$2,500$	$\$50,000 - \$2,500 = \$47,500$

[STEP 3]

List all proposal prices, adjusted where appropriate, by the application of the Alaskan Bidder Preference.

Offeror #1	-	Non-Alaskan Offeror No Employment Program	\$40,000
Offeror #2	-	Alaskan Offeror No Employment Program	\$42,750
Offeror #3	-	Alaskan Offeror With Employment Program	\$47,500

[STEP 4]

Calculate the amount of the fifteen percent (15%) Employment Program Preference by multiplying the lowest priced proposal by 0.15.

Offeror #1	-	$\$40,000 \times 0.15 = \$6,000$

[STEP 5]

List all proposal prices, adjusted, where appropriate, by the application of the Alaskan Bidder Preference, and, where appropriate, deduct the employment program preference.

Offeror #1	-	Non-Alaskan Offeror No Employment Program	\$40,000
Offeror #2	-	Alaskan Offeror No Employment Program	\$42,750
Offeror #3	-	Alaskan Offeror With Employment Program	\$47,500 – \$6,000 = \$41,500

In this example the resulting lowest bidder is Offeror #1.

2.11.5 10% Alaskans with Disabilities Preference AS 36.30.250. & AS 36.30.170

If an Offeror

- Qualifies for the 5% Alaskan Bidder Preference,
- Is a sole proprietorship owned by a person with a disability, a partnership and each of the partners is a person with a disability, or a corporation that is wholly owned by individuals and each of the owners is a person with a disability, and
- Offers a proposal that is not more than ten percent higher than the lowest proposal

EXAMPLE

10% Alaskans with Disabilities Preference

[STEP 1]

List the raw proposal prices and identify those eligible for preference.

Offeror #1	-	Non-Alaskan Offeror Not Disabled	\$40,000
Offeror #2	-	Alaskan Offeror Not Disabled	\$45,000
Offeror #3	-	Alaskan Offeror Disabled Alaskan	\$50,000

[STEP 2]

Calculate the amount of the 5% Alaskan Bidder Preference by multiplying the Alaskan proposals by 0.05 and deducting that amount from the price(s).

Offeror #2	-	$\$45,000 \times 0.05 = \$2,250$	$\$45,000 - \$2,250 = \$42,750$

Offeror #3	-	$\$50,000 \times 0.05 = \$2,500$	$\$50,000 - \$2,500 = \$47,500$

[STEP 3]

List all proposal prices, adjusted where appropriate, by the application of the Alaskan Bidder Preference.

Offeror #1	-	Non-Alaskan Offeror Not Disabled	\$40,000
Offeror #2	-	Alaskan Offeror Not Disabled	\$42,750
Offeror #3	-	Alaskan Offeror Disabled Alaskan	\$47,500

[STEP 4]

Calculate the amount of the ten percent (10%) Alaskans with Disabilities Preference by multiplying the lowest priced proposal by 0.10.

Offeror #1	-	$\$40,000 \times 0.10 = \$4,000$

[STEP 5]

List all proposal prices, adjusted, where appropriate, by the application of the Alaska Bidder Preference, and, where appropriate, deduct the Alaskans with Disabilities Preference.

Offeror #1	-	Non-Alaskan Offeror Not Disabled	\$40,000
Offeror #2	-	Alaskan Offeror Not Disabled	\$42,750
Offeror #3	-	Alaskan Offeror Disabled Alaskan	$\$47,500 - \$4,000 = \$43,500$

2.11.6 10% Employers of People with Disabilities Preference AS 36.30.250. & AS 36.30.170

If an Offeror qualifies for the 5% Alaskan Bidder Preference and has not qualified for the Alaskans with Disabilities Preference, employs a staff that is made up of fifty percent or more people with disabilities, and offers a proposal that is not more than ten percent higher than the lowest proposal, the Procurement Officer will award the maximum number of points allocated for cost to that offeror.

EXAMPLE

10% Employers of People with Disabilities Preference

[STEP 1]

List the raw proposal prices and identify those eligible for preference.

Offeror #1	-	Non-Alaskan Offeror	\$40,000
Offeror #2	-	Alaskan Offeror Not Employer of Disabled	\$45,000
Offeror #3	-	Alaskan Offeror Employer of Disabled	\$50,000

[STEP 2]

Calculate the amount of the 5% Alaska Bidder Preference by multiplying the Alaskan proposals by 0.05 and deducting that amount from the price(s).

Offeror #2	-	$\$45,000 \times 0.05 = \$2,250$	$\$45,000 - \$2,250 = 42,750$
Offeror #3	-	$\$50,000 \times 0.05 = \$2,500$	$\$50,000 - \$2,500 = \$47,500$

[STEP 3]

List all proposal prices, adjusted where appropriate by the application of the 5% Alaskan Bidder Preference.

Offeror #1	-	Non-Alaskan Offeror	\$40,000
Offeror #2	-	Alaskan Offeror Not Employer of Disabled	\$42,750
Offeror #3	-	Alaskan Offeror Employer of Disabled	\$47,500

[STEP 4]

Calculate the amount of the 10% Employers of People with Disabilities Preference by multiplying the lowest priced proposal by 0.10.

Offeror #1	-	$\$40,000 \times .10 = \$4,000$

[STEP 5]

List all proposal prices adjusted, where appropriate, by the application of the 5% Alaskan Bidder Preference and, where appropriate, deduct the Employers of People with Disabilities Preference.

Offeror #1	-	Non-Alaskan Offeror	\$40,000
Offeror #2	-	Alaskan Offeror Not Employer of Disabled	\$42,750

Offeror #3	-	Alaskan Offeror Employer of Disabled	\$47,500 – \$4,000 = \$43,500

2.12 Contract Negotiation

2 AAC 12.315 CONTRACT NEGOTIATIONS. After final evaluation, the State may negotiate with the Offeror of the highest-ranked proposal. Negotiations, if held, shall be within the scope of the Request for Proposals and limited to those items that would not have an effect on the ranking of proposals. If the highest-ranked Offeror fails to provide necessary information for negotiations in a timely manner or fails to negotiate in good faith, the State may terminate negotiations and negotiate with the Offeror of the next highest-ranked proposal. If contract negotiations are commenced, they may be held telephonically or in the DHSS Frontier Building conference room on the 8th floor in Anchorage, Alaska. If the contract negotiations take place in Anchorage, Alaska, the Offeror will be responsible for their travel and per diem expenses.

2.13 Failure to Negotiate

If the selected Offeror

- Fails to provide the information required to begin negotiations in a timely manner; or
- Fails to negotiate in good faith; or
- Indicates they cannot perform the contract within the budgeted funds available for the project; or
- If the Offeror and the State, after a good faith effort, simply cannot come to terms,

the State may terminate negotiations with the Offeror initially selected and commence negotiations with the next highest ranked Offeror.

2.14 Notice of Intent to Award (NOIA) — Offeror Notification of Selection

After the completion of contract negotiation, the Procurement Officer will issue a written Notice of Intent to Award (NOIA) and send copies to all Offerors. The NOIA will set out the names of all Offerors and identify the proposal selected for award.

2.15 Protest

AS 36.30.560 provides that an interested party may protest the content of the RFP.

An interested party is defined in 2 AAC 12.990(a)(7) as "an actual or prospective bidder or Offeror whose economic interest might be affected substantially and directly by the issuance of a contract solicitation, the award of a contract, or the failure to award a contract."

If an interested party wishes to protest the content of a solicitation, the protest must be received, in writing, by the Procurement Officer at least ten days prior to the deadline for receipt of proposals.

AS 36.30.560 also provides that an interested party may protest the award of a contract or the proposed award of a contract.

If an Offeror wishes to protest the award of a contract or the proposed award of a contract, the protest must be received, in writing by the Procurement Officer within ten days after the date the Notice of Intent to Award the contract is issued.

A protester must have submitted a proposal in order to have sufficient standing to protest the proposed award of a contract. Protests must include the following information:

- (1) The name, address, and telephone number of the protester;
- (2) The signature of the protester or the protester's representative;
- (3) Identification of the contracting agency and the solicitation or contract at issue;
- (4) A detailed Statement of the legal and factual grounds of the protest including copies of relevant documents; and
- (5) The form of relief requested.

Protests filed by telex or telegram are not acceptable because they do not contain a signature. Fax copies containing a signature are acceptable.

The Procurement Officer will issue a written response to the protest. The response will set out the Procurement Officer's decision and contain the basis of the decision within the statutory time limit in AS 36.30.580. A copy of the decision will be furnished to the protester by certified mail, fax or another method that provides evidence of receipt.

All Offerors will be notified of any protest. The review of protests, decisions of the Procurement Officer, appeals, and hearings will be conducted in accordance with the State Procurement Code (AS 36.30), Article 8 "Legal and Contractual Remedies."

2.16 Discussions with Offerors

The State may conduct discussions with Offerors in accordance with AS 36.30.240 and 2 AAC 12.290. The purpose of these discussions will be to ensure full understanding of the requirements of the RFP and proposal. Discussions will be limited to specific sections of the RFP or proposal identified by the Procurement Officer. Discussions will only be held with Offerors who have submitted a proposal deemed reasonably susceptible for award by the Procurement Officer. Discussions, if held, will be after initial evaluation of proposals by the PEC. If modifications are made as a result of these discussions, they will be put in writing. Following discussions, the Procurement Officer may set a time for best and final proposal submissions from those Offerors with whom discussions were held. Proposals may be reevaluated after receipt of best and final proposal submissions.

If an Offeror does not submit a best and final proposal or a notice of withdrawal, the Offeror's immediate previous proposal is considered the Offeror's best and final proposal.

Offerors with a disability needing accommodation should contact the Procurement Officer prior to the date set for discussions so that reasonable accommodation can be made. Any oral modification of a proposal must be reduced to writing by the Offeror.

3 STANDARD CONTRACT INFORMATION

3.1 Contract Type

This contract is a fixed price contract, with incentive and penalty payments.

The Offeror will identify fixed prices for the deliverables and services described in Section 5, Statement of Work. The fixed prices will apply to the Phases I, II, III, and IV described below. No separate payment will be made for Phase IV – Turnover except as specified in Section 3.9.4. – Turnover Phase.

(1) Phase I – Operational Takeover (Scheduled for Six Months with Two Years Operations)

Proposal prices for this phase must include all costs related to the takeover and operations/maintenance of the current fiscal agent operations. It also covers software license fees for any proprietary software packages offered by the vendor. Included in the routine operation cost is the Central Processing Unit (CPU) time reserved for State testing or enhancements.

(2) Phase II – DDI (Two Years)

Proposal prices for this phase must include all costs related to modification of the successful Offeror's system to meet Alaska program requirements and install the system. The State will furnish office space for up to twenty (20) Contractor DDI staff.

(3) Phase III – Operations

Proposal prices for this phase must include all costs related to routine operation of the Alaska system, including all Contractor responsibilities specified in Sections 5.6 and 5.7 and Contractor overhead. It also covers software license fees for any proprietary software packages offered by the vendor. Included in the routine operation cost are all costs related to testing of enhancements.

(4) Phase IV – Turnover

At contract termination, the costs for turnover, to either the Department or designee, include all plans, training, and other activities as specified in Section 5.9, which are to be included in the monthly operations costs in Phase III. No additional monies will be paid for this phase.

3.2 Contract Approval

This RFP does not, by itself, obligate the State. The State's obligation will commence when the contract is approved by the Commissioner of the DHSS or the Commissioner's designee. Upon written notice to the Contractor, the State may set a different starting date for the contract. The State will not be responsible for any work done by the Contractor, even work done in good faith, if it occurs prior to the contract start date set by the State.

3.3 Standard Contract Provisions

The Contractor will be required to sign and submit the attached State's Standard Agreement Form for Professional Services Contracts (form 02-093/Appendix A). The Contractor must comply with the contract provisions set out in this attachment. No alteration of these provisions will be permitted without prior written approval from the Department of Law. Objections to any of the provisions in Attachment A, all Appendices, must be set out in the Offeror's proposal.

3.4 Proposal as a Part of the Contract

Part or all of this RFP and the successful proposal may be incorporated into the contract.

3.5 Additional Terms and Conditions

The State reserves the right to add terms and conditions during contract negotiations. These terms and conditions will be within the scope of the RFP and will not affect the proposal evaluations.

3.6 Insurance Requirements

During the term of this Agreement the Contractor and each Contractor Agent shall maintain and keep in force, at its own expense, the following minimum insurance coverage and minimum limits:

Workers' Compensation Insurance: The Contractor and each Contractor Agent shall provide and maintain coverage as required by AS 23.30.045, and where applicable, any other statutory obligations including but not limited to Federal Longshore and Harbor Workers' Compensation Act (USL&H) and Jones Act requirements. The policy must waive subrogation against the State.

Commercial General Liability Insurance: covering all business premises and operations used by the Contractor and the Contractor Agents in the performance of Services under this Agreement with minimum coverage limits of \$1,000,000 combined single limit per occurrence.

Commercial Automobile Liability Insurance: covering all vehicles used by the Contractor and the Contractor Agents in the performance of Services under this Agreement with minimum coverage limits of \$300,000 combined single limit per occurrence.

The successful Offeror must secure the above insurance coverage required by the State. The coverage must be satisfactory to the Department of Administration, Division of Risk Management. An Offeror's failure to provide evidence of such insurance coverage is a material breach and grounds for withdrawal of the award or termination of the contract.

Offerors must review Attachment A, Appendix B for details on required coverage. No alteration

of these requirements will be permitted without prior written approval from the Department of Administration, Division of Risk Management. Objections to any of the requirements in Attachment A, Appendix B must be set out in the Offeror's proposal.

3.7 Performance Bond

To be responsive, Offerors must obtain a letter of commitment for a performance bond, from a bonding company, that equals 20% of the dollar amount of the DDI phase, as described in the Offeror's cost proposal. This letter of commitment must be submitted with their Offeror's proposal.

Within 20 days of notice of intent to award the contract, the successful Offeror shall deliver to the Project Director (a) a performance bond on terms acceptable to the State covering the Contractor's obligations under the Takeover Phase, (b) a separate performance bond on terms acceptable to the State covering the Contractor's obligations under the DDI Phase, and (c) a separate performance bond on terms acceptable to the State covering the Contractor's obligations under the Operations Phase and Turnover Phase, as set forth in this Section.

Each performance bond specified above shall be issued to the State as security for the due performance and observance by the Contractor of all of the terms and conditions of this Agreement. If the Contractor shall fail to perform and observe any of this Agreement, then the State shall be entitled to demand payment of the entire guaranteed amount under the then-applicable Performance Bond. In the event the amounts payable to the Contractor are increased from time to time pursuant to the Change Control Procedure, the State shall be entitled to require that the applicable Performance Bond be increased accordingly. If any part of the Performance Bond shall be enforced by the State, the Contractor shall on demand by the Project Director forthwith furnish a further Performance Bond for the amount so forfeited.

The Contractor shall, within seven (7) days of the Effective Date, obtain a Performance Bond in the face amount equal to thirty percent (30%) of the aggregate amounts payable in the Takeover Phase (including planning, implementation and operation components) to guarantee the Contractor's completion of its obligations in the Takeover Phase. The Contractor shall maintain such Performance Bond at all times during the Takeover Phase.

The Contractor shall, prior to requesting approval from the Project Director to begin work on the DDI Phase, obtain a Performance Bond in an amount equal to fifty percent (50%) of the aggregate amounts payable in the DDI Phase to guarantee the Contractor's completion of its obligations in the DDI Phase. The Contractor shall maintain such Performance Bond at all times during the DDI Phase.

The Contractor shall, prior to requesting approval from the Project Director for the start of operations of the new Alaska MMIS, obtain a Performance Bond in an amount equal to fifty percent (50%) of the aggregate amounts payable in the second year of the Operations Phase (inclusive of all operations line items) to guarantee the Contractor's completion of its obligations in the Operations Phase and Turnover Phase. The Contractor shall maintain such Performance

Bond at all times during the Operations Phase and Turnover Phase period and until such time as the final payment due to the Contractor under this Agreement has been made by the State Contracting Agency.

The Contractor shall ensure that (a) if a Performance Bond expires in accordance with its terms it is immediately replaced with the next Performance Bond specified herein so that there is no gap in the Performance Bonds specified herein, and (b) there is at all times during the term of this Agreement a Performance Bond in place and available for call by the State Contracting Agency. The Contractor's failure to provide a Performance Bond having terms acceptable to the State Contracting Agency within the required times specified in this Section shall be deemed a material breach of this Agreement by the Contractor. The State Contracting Agency may, in addition to its other remedies, withhold any payments otherwise due to the Contractor under this Agreement until the Contractor has complied with the requirements of this Section.

3.8 Contract Funding

Approval or continuation of a contract resulting from this RFP is contingent upon State legislative appropriation and federal approval.

3.9 Contract Payment

No payment will be made until the contract is approved by the Commissioner of DHSS or the Commissioner's designee. Under no conditions will the State be liable for the payment of any interest charges associated with the cost of the contract.

The State 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.

Each billing must consist of an invoice and progress report. No payment will be made until the progress report and invoice has been approved by the Project Director.

Allowed payments for each phase are described below. All payments are subject to the agreement terms and conditions.

3.9.1 Operational Takeover Phase I

The State will pay the Contractor for work accomplished and approved at key milestones in the Operational Takeover Phase, as defined below, at the amounts identified in the Contractor's final cost proposal. The requirements for each milestone will be negotiated between the Contractor and the State. The Operational Takeover Phase is divided into two components: (1) Operational Takeover Implementation Component; and (2) Operational Takeover Maintenance Component.

3.9.1.1 Operational Takeover Milestones

Milestone Operational Takeover 1	Five percent (5%) of the Phase I price upon the State's acceptance and approval of the initial Operational Takeover work plan.	5%
Milestone Operational Takeover 2	Twenty percent (20%) of the Phase I price upon State's acceptance and the approval of the Requirements Analysis Document.	20%
Milestone Operational Takeover 3	Ten percent (10%) of the Phase I price upon State's acceptance and the approval of the System Takeover and Testing Document.	10%
Milestone Operational Takeover 4	Ten percent (10%) of the Phase I price upon the State's acceptance and the approval of the Takeover DSS Implementation Extract Document.	10%
Milestone Operational Takeover 5	Fifteen (15%) of the Phase I price upon the State's acceptance and the approval successful testing of all MMIS and POS operations.	15%
Milestone Operational Takeover 6	Thirty percent (30%) of the Phase I price upon the State's acceptance and the approval of the Operational Takeover Implementation.	30%
Milestone Operational Takeover 7	Ten percent (10%) of the Phase I price upon the State's acceptance and approval of Post Implementation Evaluation Remediation.	10%

3.9.1.2 Operational Maintenance Payments

Upon implementation of the Operational Takeover MMIS, the Contractor will be paid for work in equal monthly installments of the annual fixed operations fees, as identified on Pricing Schedule A (the Pricing Schedule in Attachment H must include two years of operations and an optional third year) in the successful Offeror's final cost proposal, for all operations components, for each year of the contract. Such reimbursement shall represent payment for all responsibilities and activities defined in this contract for the Operational Takeover Maintenance Component, with the exception of postage.

Postage costs will be separately reimbursed at direct cost and will be subject to separate reporting procedures.

3.9.2 DDI Phase II

The State will pay the Contractor for work accomplished and approved at key milestones in the DDI Phase, as defined below, at the amounts identified in the successful Offeror's final cost proposal for the DDI Phase. Deliverables are specified in the RFP, and requirements for each milestone will be negotiated between the Contractor and the State.

Milestone DDI 1	Payment upon completion and the State's acceptance and approval of the project initiation activities.	5%
Milestone DDI 2	Payment upon completion and the State's acceptance and approval of the Requirements Verification Activities.	20%
Milestone DDI 3	Payment upon completion and the State's acceptance and approval of the System Design Activities.	10%

Milestone DDI 4	Payment upon completion and the State's acceptance and approval of the Conversion Activities.	10%
Milestone DDI 5	Payment upon completion and the State's acceptance and approval of the MMIS development.	10%
Milestone DDI 6	Payment upon completion and the State's acceptance and approval of Testing activities (excluding Acceptance testing).	10%
Milestone DDI 7	Payment upon completion and the State's acceptance and approval of the Acceptance Test activities.	10%
Milestone DDI 8	Payment upon completion and the State's acceptance and approval of the MMIS Implementation.	25%

3.9.3 Operations Phase III

After successful design, development, and implementation of the MMIS; the Contractor will be paid for work accomplished and approved in equal monthly installments of the annual fixed operations fees, as identified on the Pricing Schedule A of the successful Offeror's final cost proposal. Approved payments will be made by the State for completion and acceptance of work related to all operations (Phase III) activities defined in Section 5 of the RFP, with the exception of postage. Postage costs will be reimbursed separately at direct cost and will be subject to separate reporting procedures.

3.9.3.1 Escalation Factor

Fixed operating fees for operations work accomplished in Phase III must include anticipated inflation, projected by the Offeror for system operations in later years.

3.9.4 Turnover Phase IV

There will be no separate payment for the turnover phase. The payment for this phase is included in the fixed monthly fee for the Operations Phase. The State will pay the Contractor the Operations Withheld amount upon State's acceptance and approval of the Turnover Plan and all Turnover activities.

3.9.4.1 No Additional Payments

No payment beyond that described in Section 3.9.1 through 3.9.3 will be made to the Contractor for services required pursuant to this contract without a formal contract amendment.

3.10 Data Compliance Warranty

The Contractor warrants, for the term of this contract, that all delivered computer programs, documentation, reports, procedures, and other deliverables and items or services used in providing the services described within this RFP and within any amendments will comply with the specifications as stated in the contract, its attachments and the approved system design documents. The Contractor's liability with respect to this warranty will be limited to correction of errors, omissions, and design deficiencies throughout the system and replacement of incorrect

or defective documentation within three (3) weeks of notification by the contract manager of such deficiencies; or using all due diligence, such longer period as may be approved by the contract manager, such approval not to be unreasonably withheld or denied. If the Contractor fails to repair an identified error, deficiency, or defect within such period, or fails to proceed with due diligence to effect such repair, the contract manager may, at his/her option, act to repair such deficiency, and the Contractor will be required to reimburse the State for all reasonable costs incurred in effecting such repair.

System modifications and other changes made during the contract period shall also be covered by this warranty.

3.11 Contract Personnel

Any change of the project team members named in the proposal must be approved, in advance and in writing, by the Project Director. Personnel changes that are not approved by the State may be grounds for the State to terminate the contract.

3.11.1 General Requirements for Key Personnel

General requirements for key personnel, as listed in Section 3.11.3 are as follows:

- (1) The Project Manager/Account Manager for the Takeover and DDI Phases must be employed by the Offeror (or Sub-Contractor) when the proposal is submitted. These personnel must be located full-time in Anchorage during Takeover (Phase I) and DDI (Phase II). The Operations Account Manager must also be located in Anchorage full-time.
- (2) All key DDI (Phase II) personnel must be employed by or committed to join the Offeror's (or Sub-Contractor's) organization by the contract start date. All DDI key personnel must be on-site in Anchorage full-time. All Contractor business, functional, and technical analyst staff must be present on-site in Anchorage during requirements analysis, design, and user acceptance testing.
- (3) The Contractor must indicate a commitment to overlap all key personnel identified as key operations personnel and include a proposed overlap time. The State estimates that a minimum three-month overlap for all staff identified as key operations personnel, if different from the comparable position in the DDI phase, would be necessary. For example, if the Systems Operation Manager is not the same person as the Systems Development Manager, the Contractor must assure a three-month overlap on their respective tenure on the project.
- (4) All other requirements as specified in this RFP and Contract.

3.11.2 Change to Contractor's Key Staff

The Contractor may not replace or alter the number and distribution of key personnel as proposed without the prior written approval of the Procurement Officer, which shall not be unreasonably withheld. Replacement staff must have comparable training, experience, and

ability to the person originally offered for the position. If the Project Director gives written approval of the termination, transfer, or reassignment of key personnel, such personnel will remain assigned to the performance of duties under this contract until replacement personnel approved by the Procurement Officer are in place performing the key personnel functions. The State reserves the right to waive this requirement at its discretion.

3.11.3 Key Personnel by Project Phase

The following contractor's key personnel and required experience are listed below for each phase of the Alaska MMIS project:

Phase I - Turnover

Operational Takeover Manager (operational takeover implementation component)	a minimum of three (3) years experience in managing or in a key management position for an MMIS or other large-scale medical claims processing system; and previous experience with an MMIS, or with major components of an operational MMIS.
Operational Takeover Manager (operational takeover <u>maintenance</u> component)	a minimum of three (3) years of experience in managing a large scale claims processing component of an MMIS, or other large scale healthcare payment system; and previous experience with the MMIS or components of the MMIS proposed.

Phase II – DDI

Project Manager / Account Manager	a minimum of five (5) years experience in managing or in a key management position for an MMIS or other large-scale medical claims processing system; and previous experience with an MMIS or with major components of an operational MMIS.
Systems Development Manager	a minimum of three (3) years of experience in the design, implementation, and implementation of a large-scale automated application similar to the proposed MMIS; and previous experience with the MMIS or components of the MMIS proposed.
Operations / Claims Processing Manager	a minimum of three (3) years of experience in managing a large-scale claims processing component of a MMIS or other large-scale healthcare payment system; and previous experience with the MMIS or component of the MMIS proposed.
Training Manager	a minimum of three (3) years experience managing provider training functions in Medicaid or other major public or private healthcare program; and E-learning experience.
Quality Assurance Manager	a minimum of five (5) years experience in the quality assurance function associated with implementation of a large-scale automated application similar to the proposed MMIS
Data Conversion Manager	a minimum of five (5) years experience in the conversion of large-scale data systems, with at least one year in a management capacity; and previous experience with the MMIS or components of the MMIS

	proposed.
Testing Manager	a minimum five (5) years experience planning and conducting system, systems integration, and user acceptance testing in an MMIS or major health plan claims processing environment.
Interface Manager	a minimum of three (3) years experience in systems integration, messaging components, and interface development.

Phase III - Operations

Project Manager / Account Manager	a minimum of five (5) years experience in managing or in a key management position for an MMIS or other large-scale medical claims processing system; and previous experience with an MMIS or with major components of an operational MMIS.
Systems Operations Manager	a minimum of three (3) years of experience in the design, implementation, and operation of a large-scale automated application similar to the proposed MMIS; and previous experience with the MMIS or components of the MMIS proposed.
Operations / Claims Processing Manager	a minimum of three (3) years of experience in managing a large-scale claims processing component of a MMIS or other large-scale healthcare payment system; and previous experience with the MMIS or component of the MMIS proposed.
Training Manager	a minimum of three (3) years experience managing provider training functions in Medicaid or other major public or private healthcare program; and E-learning experience.
Quality Assurance Manager	a minimum of five (5) years experience in the quality assurance function associated with implementation of a large-scale automated application similar to the proposed MMIS.

3.12 Service and Performance Levels

Service levels and performance by the successful Offeror shall meet or exceed the service levels set forth in this RFP. Unless otherwise stated, it is understood that the Offeror will measure and report monthly service levels to the State.

The State has identified service levels and performance standards for all major contract activities. These standards set the performance expectations for the successful Offeror and are designed to facilitate State oversight of Contractor performance. The process and procedures that will be used to establish performance credits and monitor performance are described in Section 5.7.1.

The State requires a balanced approach to contract management, including incentives for exceptional performance and penalties intended to ensure responsible Contractor performance. The State has identified specific opportunities for incentive payments. The Contractor will be eligible to receive incentive payments as described in Section 5.7.1.

3.12.1 Federal Match

Section 1903(a)(b)(d) of Title XIX of the Social Security Act provides seventy-five percent (75%) Federal Financial Participation (FFP) for operation of mechanized claims payment and information retrieval systems approved by the United States Department of Health & Human Services (DHHS). Up to ninety percent (90%) FFP is available for MMIS-related development costs receiving prior approval by DHHS. The new Alaska MMIS must, throughout all phases of the contract period, meet requirements for the maximum allowable Federal Financial Participation and meet all certification and re-certification requirements established by DHHS.

Should the Contractor's system fail to meet Federal requirements, the Contractor will be liable for the difference between the maximum allowable enhanced FFP and that received by the State, including any losses due to loss of certification, failure to obtain approval retroactive to the operational start date, or delays in readiness to support certification.

3.12.2 System Availability and Response Time

The Contractor will be required to meet performance standards in 5.7.1 for user access to MMIS and POS applications, the DSS, and network availability and responsiveness.

3.12.3 User Access

The MMIS, including the POS, automated eligibility verification system, and the DSS, must be available for users ninety-eight percent (98%) of the hours between 7:00 AM and 6:00 PM (Alaska Time), Monday through Friday, and ninety-five percent (95%) of the remaining hours. Contractor may schedule maintenance during the off hours, from 7:00 PM to 6:00 AM (Alaska Time) without having the down time counted in the calculation of the ninety-five (95%) performance standard. An application is considered unavailable when a user does not get the complete, correct full-screen response to an input transaction after depressing the "enter" or another specified function key. The State will notify the Contractor when they have determined the system is unavailable.

The Contractor will report to the Division of Health Care Services (DHCS) IT Manager selected service level indicators from the MMIS applications to indicate availability of the selected application, plus an exception log identifying those applications that were not available during the reporting period. The Contractor will also include the calculation of user access availability in the report. The frequency, content, and methodology for the reports must be approved by the DHCS IT Manager.

The Contractor will be required to connect to the State WAN at the designated point of presence in Anchorage.

3.12.4 Network Performance

The Contractor will be required to meet the performance standards for network availability and performance as described in the chart below. For the purposes of the RFP and the resulting contract, the following definitions apply:

- (1) **Response Time** – means the overall processing delay, made up of individual latencies. For example the response time for querying an Oracle database server is made up of LAN and WAN latency, latency of the server hardware (CPU, disk, memory, etc.), and latency of the Oracle database query.
- (2) **Latency** – means the time necessary for an individual component to respond. Thus, the amount of time needed to get a block of data from a disk drive might be termed the disk latency.
- (3) **Round Trip Time RTT** – measure of how long it takes for the server to complete a request. The reference is in terms of the end-user's perspective, in the end-user PC, across an entire LAN/WAN segments (watching network traffic of multiple users).
- (4) **Packet** – is a bundle of data transmitted over a network.
- (5) **Demarcation** – means the point, jack, or cross connect pane at which ownership or responsibility for controlling and maintaining the packet passes from one party to another.
- (6) **Network Availability** – means percent of time access lines in service are available during a calendar month. This measurement is based on the total service outage time experienced by all access lines in a month, divided by the total amount of time available in a month for all access lines.
- (7) **Access line availability** – means percent of time a specific access line is available during a calendar month.

The proposed system must meet the following response time standards:

Term	Measurement	Performance Standard
<u>Latency</u>	Measured at Source Demarcation to Destination Demarcation	Not more than x ms round trip ≤ 150ms one-way delay end-end, with some provision for satellite ≤ 260ms one-way end-end to prevent double hops
<u>Packet Loss</u>	Measured at Source Demarcation to Destination Demarcation	Not more than .x% of all packets – Target < .25% of all packets ≤ 0.5%
<u>Jitter</u>	Measured at Source Demarcation to Destination Demarcation	x ms Target < 10 ms Up to 50ms, ≤ 35ms
<u>Access Line Availability</u>	Failure is the loss of service on a specific access line. SOA will provide Vendor with a site-by-site profile (i.e., Gold, Bronze)	x% Target – y% 98.9% from 7:00 AM to 5:00 PM on business days 95.9% for the remainder of hours

<u>Network Availability</u>	Measurement is based on the total service outage time experienced by all access lines in a month, divided by the total amount of time available in a month for all access lines	MASL: x% Target – y% (z min/mo.) 98.9% from 7:00 AM to 5:00 PM on business days 95.9% for the remainder of hours

The State may assess penalties in the amount of two thousand dollars (\$2,000) per month when the ninety-eight (98%) criterion is not met and one thousand dollars (\$1,000) per month when the ninety-five (95%) criterion is not met. The State may assess damages of five hundred dollars (\$500) per day for failure to meet the designated performance standard for any of the five indicators identified in the chart (Latency, Packet Loss, Jitter, Access Line Availability, and Network Availability) for three (3) consecutive twenty-four (24) hour periods.

3.12.5 Timeliness of Check-Write File and Provider Payments

Contractor must provide the required electronic interface with the Alaska State Accounting System (AKSAS) for each payment cycle. The interface consists of a minimum of three (3) files: the Journal Transaction, Warrant Registry, and Electronic Funds Transfer (EFT) files. The files must be in a format including data definitions and terminology approved by AKSAS. Contractor must meet the following schedule for production of the accounting files and processing of provider payments:

- (1) The Journal Transaction, Warrant Registry, and EFT files must be provided to AKSAS by 7:00 AM (Alaska Time) of the day following the payment run and not rejected due to errors caused by the Contractor.
- (2) Paper checks and remittance advices must be mailed to providers within forty-eight (48) hours of receipt of authorization from the State Treasurer.

The State may assess penalties in the amount of \$500 for each full day that the Contractor fails to meet either of the above standards.

3.13 Contract Changes - Unanticipated Amendments

During the course of this contract, the Contractor may be required to perform additional work. That work will be within the general scope of the initial contract. When additional work is required, the Project Director will provide the Contractor a written description of the additional work and request the Contractor to submit a firm time schedule for accomplishing the additional work and a firm price for the additional work. Cost and pricing data must be provided to justify the cost of such amendments per AS 36.30.400.

The Contractor will not commence additional work until the Procurement Officer has secured any required State approvals necessary for the amendment and issued a written contract amendment, approved by the Commissioner of the DHSS or designee.

3.13.1 Change Management

During the course of this contract, the software, systems, hardware, and equipment will undergo changes in order to meet the requirements of the RFP and the business needs of the State. Change management provisions are identified below and in the Attachment A, Appendix A. The Contractor will not commence work until the Procurement Officer has secured the State approvals necessary.

Changes that occur as a result of system maintenance and modification shall be classified into one of four categories: (1) DDI Change, (2) System Maintenance; (3) Enhancement Modifications; (4) Additions. Mechanisms are included within the Standard Agreement to accommodate DDI Change, System Maintenance, and Enhancements. Additions require a written, executed Amendment to the Agreement. Requirements for each category of change are further described in 5.7.3 and Attachment A (Appendix C).

For unanticipated changes, not already included in the relevant project phase, the State, at its sole option, may purchase additional services for the MMIS system and for fiscal agent service activities at hourly rates identified in the Offeror's proposal.

Offerors will provide, in the Pricing Schedule C of their cost proposal, the hourly rates for additional full-time equivalent (FTE) professional categories listed below:

- (1) System Manager
- (2) Technical Consultant
- (3) Programming Supervisor
- (4) Senior Programmer Analyst
- (5) Systems Analyst
- (6) Programmer Analyst
- (7) Programmer
- (8) Documentation Specialist
- (9) Training Specialist

The hourly rates identified by Offerors will include the full cost, including overhead, for the support of the FTE.

3.14 Inspection & Modification - Reimbursement for Unacceptable Deliverables

The Contractor is responsible for the completion of all work set out in the contract. All work is subject to inspection, evaluation, and approval by the Project Director. The State may employ all reasonable means to ensure that the work is progressing and being performed in compliance with the contract. Should the Project Director determine that corrections or modifications are necessary in order to accomplish the State's intent, the Project Director may direct the Contractor to make such changes. The Contractor will not unreasonably withhold such changes.

Substantial failure of the Contractor to perform the contract may cause the State to terminate the

contract. In this event, the State may require the Contractor to reimburse monies paid (based on the identified portion of unacceptable work received) and may seek associated damages.

3.15 Termination for Default

If the Project Director determines that the Contractor has refused to perform the work or has failed to perform the work with such diligence as to ensure its timely and accurate completion, the State may, by providing written notice to the Contractor, terminate the Contractor's right to proceed with part or all of the remaining work.

This clause does not restrict the State's termination rights under the contract provisions of Appendix A, attached.

3.16 Contract Invalidation

If any provision of this contract is found to be invalid, such invalidation will not be construed to invalidate the entire contract.

3.17 Informal Debriefing

When the contract is completed, an informal debriefing may be performed at the discretion of the Project Director. If performed, the scope of the debriefing will be limited to the work performed by the Contractor.

4 BACKGROUND INFORMATION

4.1 Alaska Medical Assistance Programs

The Alaska Medicaid program was implemented in July 1972 to provide medical assistance to persons eligible under Title XIX of the Social Security Act. In addition, the State provides limited medical services under the Chronic and Acute Medical Assistance (CAMA) program. Approximately 130,000 unduplicated individuals were eligible for the two programs during fiscal year 2005. Payments to medical providers for services provided under Medicaid and CAMA were \$982,000,000 in state fiscal year 2005. The Medicaid Fiscal Agent processed 370,000 claim lines each month for services provided to Medicaid and CAMA recipients in the last fiscal year. (See chart on following page for summary of program statistics)

Alaska's remoteness and large geographic area, combined with the small recipient base, provide unique challenges for program administration and fiscal agent operations. Program administration staff for the Division of Health Care Services is split between Juneau, the Capitol, and Anchorage, the fiscal agent operations site. Although the majority of program recipients are clustered around Anchorage, Fairbanks, and the towns in southeast Alaska, program recipients are scattered throughout the interior and northern coastal area. Some of these recipients are Alaska Natives who receive medical care through the Alaska Native Regional Corporations under Section 638 agreements with the Indian Health Service (IHS). Alaska's Medicaid program affects the service delivery of every division within the Department of Health and Social Services, as well as six other departments within the state government.

4.2 MMIS Status

Since 1979, Alaska has moved from a manual intensive, State-operated system, to a semi-mechanized State/contractor operation, to the current fully mechanized fiscal agent-operated claims processing and information retrieval system. Following a competitive procurement in 1987, First Health Services Corporation (FHSC) was selected to provide the MMIS and fiscal agent services for the State.

The current claims processing system, Alaska Medical Payment System (AMPS) operated by FHSC, represents major enhancements to the core system installed in 1987. The Alaska MMIS includes the FHSC POS system for pharmacy and provides interfaces to two State-operated DSS models. Despite these enhancements, the processing system remains a legacy system with largely batch operations running on a mainframe processor.

The system is a federally-certified MMIS, eligible for enhanced FFP matching rate of 75% for operations costs.

Program Caseload, Provider Participation, Claims Volume, and Expenditures for Fiscal Years 2000 - 2005

	% Change (FY99 to FY00)	FY 00	% Change (FY00 to FY01)	FY 01	% Change (FY01 to FY02)	FY 02	% Change (FY02 to FY03)	FY 03	% Change (FY03 to FY04)	FY 04	% Change (FY04 to FY05)	FY 05
Eligibles	17.54%	111,083	6.28%	118,062	4.28%	123,110	4.02%	128,055	2.23%	130,909	1.20%	132,476
Recipients	15.45%	92,103	8.73%	100,144	8.20%	108,357	7.08%	116,030	2.37%	118,782	2.79%	122,097
Pct. of Eligibles	na	82.91%	na	84.82%	na	88.02%	na	90.61%	na	90.74%	na	92.17%
Participating												
Cost Per Recipient	-0.80%	\$4,708.18	11.49%	\$5,249.33	16.47%	\$6,113.69	13.84%	\$6,959.55	7.89%	\$7,508.95	7.21%	\$8,050.08
Cost per Eligible	1.90%	\$4,080.76	9.11%	\$4,452.65	20.85%	\$5,381.05	17.19%	\$6,306.01	8.05%	\$6,813.35	8.89%	\$7,419.39
Providers	6.81%	4,045	8.75%	4,399	8.46%	4,771	14.25%	5,451	0.06%	5,454	4.71%	5,711
Participating												
Payment / Provider	10.58%	\$110,511	8.14%	\$119,502	16.19%	\$138,852	6.69%	\$148,141	10.39%	\$163,537	-38.89%	\$99,934
Total Reimb. for Claims Paid	12.47%	\$425,662,900	19.03%	\$525,689,000	26.02%	\$662,460,628	21.90%	\$807,516,085	10.45%	\$891,928,182	10.20%	\$982,890,670
Claim Lines Processed*	20.30%	3,720,254	18.50%	4,409,121	19.31%	5,260,453	14.58%	6,027,490	11.00%	6,690,344	18.13%	7,903,526
Paid Claim Lines	21.80%	3,037,059	19.30%	3,621,965	16.03%	4,202,677	13.66%	4,776,730	6.91%	5,106,692	20.43%	6,150,027
% Claim Lines Paid	1.20%	81.60%	0.70%	82.20%	-2.81%	79.89%		79.25%		76.33%		77.81%
Payment / Paid Claim	-3.00%	\$147.19	-1.39%	\$145.14	8.61%	\$157.63	7.24%	\$169.05	3.32%	\$174.66	-8.50%	\$159.82
Paid Claims / Recipient	2.60%	32	10.00%	35.2	10.23%	38.8	6.19%	41.2	4.37%	43	17.21%	50.4
Paid Claims / Provider	14.10%	750.8	9.66%	823.36	6.99%	881	-0.52%	876	6.85%	936	15.01%	1,077
Recipients per provider	8.09%	23	-0.02%	23	-0.24%	23	-6.28%	21	2.32%	22	-1.83%	21

4.3 Administration and Organization

DHSS is the federally-defined Medicaid Single State Agency (SSA) for Alaska. The Commissioner of DHSS is the Director of the SSA. The DHSS organizational chart can be found in Attachment D. The Department is organized into four functional units. Three of these units are each headed by a Deputy Commissioner. The Finance and Management Services unit is headed by the Assistant Commissioner, who is the Executive Sponsor for this project.

One Deputy Commissioner oversees seven Divisions and related Boards and Commissions: Division of Health Care Services, Division of Public Assistance (DPA), Division of Juvenile Justice (DJJ), Division of Behavioral Health (DBH), Division of Senior and Disabilities Services (DSDS), Alaska Pioneer Homes, and Division of Public Health (DPH), all of which have involvement in the administration of Alaska medical assistance programs. A second Deputy Commissioner is responsible for the Office of Children's Services (OCS). A third Deputy Commissioner is responsible for the offices of Program Review and Rate Review.

The Department administers the Medicaid program primarily through four Divisions: Health Care Services, Behavioral Health Services, Senior and Disabilities Services, and Office of Children's Services. Prior to SFY 2004, the Division of Medical Assistance provided all Medicaid services and administrative functions.

Medicaid Benefit Programs by Division

Behavioral Health	Mental health, substance abuse, residential psychiatric treatment centers, and inpatient psychiatric facilities
Children's Services	Behavioral rehabilitation
Health Care Services	Hospitals, physician services, pharmacy, transportation, dental, vision, physical/occupational/speech therapy, chiropractic, medical equipment, home health, hospice, laboratory, X-ray, state-only medical assistance, premium assistance, third party recoveries, supplemental hospital payments, and Medicaid administrative management
Senior and Disabilities Services	Nursing homes, personal care, and four home and community based waiver programs

DHSS medical programs include Title XIX Medicaid; Title XXI S-Children's Health Insurance Program (SCHIP) which is now referred to as Denali KidCare (DKC); the Permanent Fund Dividend Hold Harmless (PFDHH) Program; and the Alaska Longevity

Bonus Hold Harmless (ALBHH) Program. DHSS also a state-funded medical assistance program called the Chronic and Acute Medical Assistance Program (CAMA.).

The following sections describe the governmental organizations and their agents within the State of Alaska that are involved in the administration of the Alaska medical assistance programs or that interface with these programs. These departments include:

- Department of Health and Social Services <http://www.hss.state.ak.us>
- Department of Administration (DOA) <http://www.state.ak.us/admin>
- Department of Commerce, Community and Economic Development (DCCED) <http://www.dced.state.ak.us/>
- Department of Law (DOL) <http://www.law.state.ak.us>
- Department of Revenue (DOR) <http://www.revenue.state.ak.us>
- Department of Labor and Work Force Development (DOL/WD) <http://www.labor.state.ak.us/home.htm>
- Department of Education and Early Development (DE&ED) <http://www.eed.state.ak.us>

4.3.1 DHSS

<http://www.hss.state.ak.us>

The following divisions within DHSS are involved in the administration of health care programs for the State:

- Division of Health Care Services (DHCS)
- Division of Public Assistance (DPA)
- Division of Behavioral Health (DBH)
- Office of Children's Services (OCS)
- Division of Juvenile Justice (DJJ)
- Division of Public Health (DPH)
- Office of Finance and Management Services (FMS)
- Division of Senior and Disabilities Services (DSDS)
- Medicaid Program Contractors
- Division of Alaska Pioneer Homes

4.3.1.1 Division of Health Care Services

<http://www.hss.state.ak.us/dhcs/>

<http://www.hss.state.ak.us/dhcs/>

DHCS administers the Medicaid core services including hospitals, physician services, pharmacy, dental services, and transportation. Other Medicaid core services managed by the division include physical, occupational, and speech therapy; laboratory; radiology; durable medical equipment; hospice; and, home health care. On a department-wide basis, DHCS administers the following:

- State Children's Health Insurance Program (SCHIP)
- Medicaid Management Information System (MMIS)
- Claims payments and accounting

- Third-party liability collections and recoveries
- Federal reporting
- Medicaid financing
- Chronic and Acute Medical Assistance Program

The Division is primarily located in Anchorage and is organized as follows.

- Director's Office of Division of Health Care Services
- Pharmacy and Ancillary Services Unit
- Facility Relations Unit
- Practitioner Relations Unit
- Program Integrity Unit
- Accounting and Recovery Unit
- Recipient Services Unit

4.3.1.1.1 Director's Office of Division of Health Care Services

The Director's office is responsible for the overall administration of Division of Health Care Services. The Director manages the activities of Division of Health Care Services personnel, provides budgetary and program information to the legislature and other State agencies, and coordinates Federal relations. This office is also responsible for several professional service contracts that provide fiscal agent services, quality assurance and medical review, case management, and audit services.

4.3.1.1.2 Pharmacy and Ancillary Services Unit

This unit provides management including researching, analyzing, and implementing changes in service coverage for the following Medicaid Provider service programs: Pharmacy, Durable Medical Equipment, Hospice, Home Health, Private Duty Nursing, Hearing and Audiology, Orthotics and Prosthetics, Home Infusion Therapy, and Respiratory Therapy. The unit provides policy development, planning, regulations, oversight, and management for these services. Other programs administered in this unit include Drug Utilization Review, Preferred Drug List, Pharmacy and Therapeutics Committee, and the Behavioral Pharmacy Management Service.

4.3.1.1.3 Facility Relations Unit (FRU)

The FRU performs policy and program management for Medical Assistance services performed at institutional facilities including hospitals and ambulatory surgical centers and services performed by end-stage renal disease dialysis centers, federally qualified health centers, and rural health clinics. It is the responsibility of the FRU to ensure that the applicable federal and state regulations are applied to the provision and reimbursement of these services; evaluate program policy, procedures and operations to assure effective and efficient compliance; and develop and implement new or revised programs or initiatives for these service categories. In addition to the provision of contract monitoring and oversight of the full spectrum of fiscal agent services for all these provider types, the FRU is responsible for oversight and monitoring of the quality improvement organization (QIO) contracted to perform both utilization management

through the prior authorization of inpatient stays and case management services for clients with complex medical conditions.

4.3.1.1.4 Practitioner Relations Unit (PRU)

The PRU is responsible for assuring that program policies are consistent with current medical standards of practice and that the relationships with consumers and medical providers are maintained at the highest possible level. The PRU has developed and maintained relationships with various professional organizations and seeks their professional input into policies and programs. The PRU assists in answering difficult clinical questions which arise from medical providers, recipients, and the fiscal agent. The PRU is responsible for reviewing and determining coverage of services to assure that they are in compliance with both State and Federal regulations and statutes.

4.3.1.1.5 Program Integrity (PI) Unit

The PI Unit is responsible for complaint investigations, reviews, and audits. Program integrity processes and activities are designed to provide for efficient, economical, and effective administration of the Medicaid Program. The PI Unit assures that processes are in place to identify inappropriate activity, investigate, and refer to the Medicaid Fraud Control Unit suspected cases of fraud and abuse. Complaints may involve either recipient conduct or a provider's Medicaid billing practices. The Unit periodically analyzes and profiles providers to identify providers who may need investigation.

4.3.1.1.6 Accounting and Recovery Section

The Accounting and Recovery Section is currently comprised of one manager and two sub-sections: an Accounting and Collections Unit and a Third Party Liability and Recovery (TPL) Unit. The TPL Unit consists of one supervisor, three technical support staff, and one clerical support staff. The Accounting and Collections Unit consists of one professional accountant and two technical support staff. The Accounting and Recovery section provides services to support other Medicaid Divisions, as well as the Division of Health Care Services.

The primary responsibilities of the TPL Unit include working pending claims related to TPL, collection of third party payments, working pay-and-chase claims, administration of the Medicare buy-in and Drug Rebate programs, and oversight of the post payment review and cost avoidance contractor, Public Consulting Group. The TPL Unit administers the disabled working program and the estate recovery program, and it works with the Department of Law on subrogation cases. TPL recoveries are made on behalf of the Division of Health Care Services (DHCS), Division of Senior and Disabilities Services (DSDS), and the Division of Behavioral Health (DBH).

The primary responsibilities of the Accounting Unit include oversight and management of the accounting interface between the MMIS and the State Accounting System and ensuring weekly check writes are approved, reconciled, and issued. Internal accounting functions are provided for the DHCS, DSDS, and DBH.

4.3.1.1.7 Recipient Services Unit (RSU)

The RSU is responsible for assisting Medicaid recipients and health care providers in appropriately accessing benefits and resolving grievances. RSU monitors recipient travel under the State Travel Office; manages the statewide Early Prevention, Screening, Diagnosis, and Treatment program; coordinates Fair Hearing requests; represents the agency at Fair Hearing; and monitors the Fiscal Agent's performance related to prior authorization, the Recipient Helpline, provider enrollment, and the Care Management Program. Recipient Services intercedes in recipient and provider disputes regarding eligibility and claims processing.

4.3.1.2 DHCS Medicaid Program Contractors

DHSS contracts with several outside entities to support administration of the Medicaid program. These contractors interact with DHCS and other DHSS Divisions, Medicaid providers and recipients, and other government agencies in carrying out their responsibilities. These professional service contracts include:

- Medicaid Fiscal Agent
- Prior Authorization (PA) Agent(s)
- Third Party Liability (TPL) Contractor
- Technical Assistance Contractor (TAC)

4.3.1.2.1 Medicaid Fiscal Agent

First Health Services Corporation (FHSC) of Glen Allen, Virginia provides Fiscal Agent services for the Alaska Medicaid program. This responsibility includes claims payment for Medicaid, Denali KidCare and CAMA programs, as well as authorization for non-emergency transportation, dental, home health, Durable Medical Equipment (DME) and medical supplies, some vision, Magnetic Resonance Imaging (MRI), outpatient surgeries, and some prescription drugs. FHSC also administers the drug rebate program.

4.3.1.2.2 PA Agent(s)

DHCS currently contracts with two entities to perform other prior authorizations. Qualis, of Seattle Washington, is responsible for authorizing acute inpatient admissions and performing continued stay review activities. Health Care Management is responsible for inpatient mental health authorizations (acute and residential). These contracts may be reissued this year.

4.3.1.2.3 TPL Contractor

Public Consulting Group (PCG) of Boston, Massachusetts contracts with DHCS to pursue third party collections. PCG reviews trauma suspect cases and represents the State in the resultant subrogation. PCG also performs data matches with major insurance carriers to identify possible insurance coverage and pursue subsequent recoveries. This contractor also performs a Medicare recovery process for claims paid on behalf of recipients who are subsequently determined to have Medicare coverage.

4.3.1.2.4 Technical Assistance Contractor

FOX Systems, Inc. of Scottsdale, Arizona, currently provides technical assistance to DHSS in the analysis of requirements for a new MMIS, preparation of the RFP for fiscal agent services, and evaluation of vendor responses to the RFP.

4.3.1.3 Division of Public Assistance (DPA)

<http://www.hss.state.ak.us/dpa/>

DPA administers programs that provide temporary economic support to needy families and individuals; financial assistance to the elderly, blind, and disabled; benefits to supplement nutrition; medical benefits; and supportive services that enable and encourage welfare recipients to pursue economic independence and self-sufficiency.

The Division provides services to help Alaskans remain safe and healthy by:

- (1) Providing temporary financial assistance to low-income Alaskan families with children working towards self-sufficiency to help them meet their basic needs.
- (2) Providing employment assistance to low-income Alaskan families with children to help them become more self-sufficient and increase stability through employment.
- (3) Providing financial assistance to low-income aged, blind, or disabled Alaskans to help them meet their basic needs.
- (4) Providing food assistance to low-income Alaskans to decrease their incidence of food insecurity.
- (5) Providing home heating assistance to low-income Alaskans to reduce their disproportionate burden of home heating costs.
- (6) Providing child care subsidies to families who need child care to work or participate in approved training activities.
- (7) Licensing child care providers to increase the safety and quality of child care in Alaska.
- (8) Making eligibility determinations for medical assistance programs.

4.3.1.3.1 Medicaid Eligibility AS 47.07.020

Medicaid, an entitlement program created by the Federal government, is the primary public program financing basic health and long-term care services for low-income Alaskans. DHCS is responsible for provider payments. DPA is responsible for eligibility policy and access to the program and determining the eligibility of individuals and families in need of Medicaid benefits, including children and pregnant women under the Denali KidCare Program. The majority of Medicaid recipients are beneficiaries of other programs and services administered and delivered by DPA. Most recipients on the Alaska Temporary Assistance Program receive family Medicaid benefits. Many children, young adults, and elderly or disabled persons receiving Medicaid also receive food stamps or adult public assistance benefits.

4.3.1.3.2 Chronic and Acute Medical Assistance Eligibility AS 47.08.150

The Chronic and Acute Medical Assistance (CAMA) program is a state-funded program designed to help needy Alaskans who have specific illnesses get the medical care they need to manage these illnesses. It is a program primarily for people age 21 through 64 who do not qualify for Medicaid benefits, have very little income, and have inadequate or no health insurance. DHCS is responsible for provider payments. DPA is responsible for eligibility policy and access to the program.

4.3.1.3.3 SeniorCare Program AS 47.300

SeniorCare helps low-income seniors who are at least 65 years of age remain independent in the community by providing a cash benefit or paying the premiums and deductibles for Medicare Part D or similar prescription drug coverage. Effective January 2006, responsibility for determining eligibility for the SeniorCare program transferred from the Division of Alaska Pioneer Homes to the DPA. DHCS is responsible for premium and deductible payments. DPA is responsible for cash benefit payments, eligibility determination, policy development, and access to the program.

4.3.1.4 Division of Behavioral Health (DBH)

<http://www.hss.state.ak.us/dbh/>

DBH is responsible for the State's public behavioral health system, which includes the community mental health and substance disorder programs. DBH administers the statewide system of community behavioral health programs for delivery of residential and community-based treatment and recovery services; manages Alaska Psychiatric Institute (API), the state's only public psychiatric hospital; administers grants to the state's network of local community mental health and substance abuse programs; and coordinates with other government, tribal and private providers of behavioral health services to ensure the provision of comprehensive behavioral health services to Alaska residents. DBH works closely with the Alaska Mental Health Board (AMHB), the state's mental health and substance abuse planning councils, and provider organizations (Alaska Behavioral Health Association and Alaska's Substance Abuse Directors) on system planning and evaluation. (Note: The Division of Alcohol and Drug Abuse was reorganized and combined with other services to form the Division of Behavioral Health.)

4.3.1.5 Office of Children's Services (OCS)

<http://hss.state.ak.us/ocs/>

OCS is responsible for administering child protective services. Since most children under protective services are eligible for Medicaid, OCS supports DHCS in administering services for this population. These activities include monitoring the eligibility process for children in protective services, monitoring medical services, and developing specialty services for these children. OCS also acts as the billing agent for behavioral rehabilitation services, which are long term mental health services for children placed with OCS community providers.

4.3.1.6 Division of Juvenile Justice (DJJ)

<http://www.hss.state.ak.us/djj>

DJJ is responsible for juveniles adjudicated under the criminal justice system in Alaska, including juveniles in parole status. DJJ operates 8 regional juvenile correctional facilities.

4.3.1.6.1 Juvenile Detention and Treatment Facilities

Youth facilities in Alaska perform two primary functions:

- (1) Detention Units designed as short-term secure units for youth who are awaiting court hearings; and
- (2) Treatment Units designed for youth who have been ordered by the courts into long-term secure treatment.

Juveniles in parole status are usually eligible for Medicaid if they meet income guidelines. Juveniles incarcerated in juvenile correctional facilities are not eligible for Medicaid while residents of the facilities but may have Medicaid eligibility from previous community status. Claims for medical services provided to DJJ clients in regional correctional facilities are scheduled to be processed through the MMIS as part of the future MMIS development.

4.3.1.7 Division of Senior and Disabilities Services (DSDS)

<http://hss.state.ak.us/dsds/>

DSDS provides institutional, home and community-based services for older Alaskans and persons with disabilities, as well as protection of vulnerable adults. The Division administers four Medicaid Waiver and Senior Services and Community Developmental Disabilities Grants programs.

In addition to the four Medicaid waivers above, the Division operates the Personal Care Assistance and Nursing Home Authorization (Medicaid) programs. DSDS is responsible for the initial admitting authorizations of Medicaid eligible clients to Skilled Nursing Facilities. Reauthorizations are completed every three to six months for those consumers staying in these facilities (depending on level of care) throughout the state of Alaska and in other states if the appropriate care is not available in this state. The Division is also responsible for authorizing Await and Swing beds for hospitals, in-state and out-of-state, while Medicaid clients are waiting for admittance to a skilled nursing facility or if a skilled nursing facility is not available in the community. This responsibility includes approval for all services on the client care plans and transmittal of these approvals to the MMIS fiscal agent through a proprietary software program called Cost Sheet Interface (COSI). DSDS also authorizes all admissions to nursing homes using the COSI software and administers the Personal Care Attendant service.

There are 14 skilled nursing facilities around the state. The average yearly cost for a patient in a nursing home in FY05 was approximately \$164,742.

The Adult Protective Services Unit within DSDS protects adults over the age of 18 from abuse, neglect, and exploitation. APS staff investigates reports of harm and takes appropriate action (up to and including removal from the client's home) to ensure that

vulnerable adults are safe. The APS Unit also administers the General Relief Program which pays for temporary assisted living home costs for clients who need “emergency placement” and may qualify for but are not currently approved to receive services under a Medicaid waiver.

4.3.1.8 Division of Public Health (DPH)

<http://www.hss.state.ak.us/dph>

DPH operates programs that are primarily population-based and focus on protecting and promoting the health of entire communities and of all Alaskans. DPH conducts disease surveillance and investigation and provides treatment consultation, case management, and laboratory testing services to prevent epidemics and control outbreaks of communicable diseases. Many of the services and programs delivered by the DPH serve the population as a whole, rather than individuals, so statistics on individual services do not complete the picture of the Division’s work. Activities such as disease outbreak response, preparation and dissemination of epidemiology bulletins to all health practitioners in the state, planning and development of health systems, and educational campaigns such as those designed to influence children not to smoke are a few examples of DPH efforts to protect, promote, and improve the health of hundreds of thousands of Alaskans every day.

Public Health Nursing - Public health services are provided by nursing staff in public health centers in 23 communities and by itinerant public health nurses serving more than 250 communities. Grantees in four areas of Alaska – Norton Sound Health Corporation, Maniilaq Association, the North Slope Borough, and the Municipality of Anchorage are supported through grant funding and technical assistance to assure that public health nursing services are available statewide.

Women’s, Children’s and Family Health (WCFH) - Services and programs delivered statewide include Breast and Cervical Health Check; Family Planning; Perinatal Health; Oral Health for Children and Adults; Newborn Metabolic Screening; Early Hearing Detection, Treatment, and Intervention; Pediatric Specialty Clinics; and Genetics and Metabolic clinics. In addition, the WCFH Epidemiology unit collects, analyzes, and reports maternal and child health indicator data to provide an accurate picture of the health status of Alaskan women, children and their families.

Chronic Disease Prevention and Health Promotion Epidemiology Section - The Section of Epidemiology provides surveillance for reportable health conditions to accurately assess the health of Alaskans, to detect disease outbreaks requiring intervention, and to assess the effectiveness of prevention strategies, such as immunization programs. It also detects, investigates, and controls disease outbreaks through defining causal factors and by identifying and directing prevention and control measures.

Bureau of Vital Statistics - The Bureau of Vital Statistics oversees the registration of vital events in Alaska and is responsible for the preservation and security of records. Bureau staff work in partnership with hospitals, funeral directors, physicians, and the court

system to ensure all vital events are properly recorded, that they satisfy the legal requirements of Alaskans and their families, and that the information contained in vital records meet the statistical needs of researchers or health officials at the state and national level.

Information from vital records is used to monitor and assess the health status of Alaskans and help guide health policy issues affecting the state. The Bureau publishes an annual report of vital events in Alaska and provides public health statistics on its web site. These reports include statistics on births, fetal and infant deaths, induced terminations, adoptions, marriages and divorces, and deaths. Teen birth rates, chronic disease mortality, leading causes of death, infant mortality, pregnancy and fertility rates, local health profiles, and Healthy Alaskans 2010 statistics are examples of information published on the Bureau's web site.

Community Health and Emergency Medical Services- This section provides services and outreach training to reduce human suffering and economic loss to society resulting from disability and premature death from injuries and to assure access to community-based emergency medical services.

State Medical Examiner -The State Medical Examiner's Office is responsible for investigating and certifying all deaths that occur within the State of Alaska that are the result of violence, suspected violence, deaths due to accidental causes, deaths that occur during incarceration, deaths that are associated with conditions that pose a hazard to public safety or health, and all unattended or unexplained deaths.

Public Health Laboratories - The Section of Laboratories provides analytical and technical laboratory testing and information to support disease prevention programs, services, and activities. The Anchorage laboratory provides testing for microbial, parasitic, and fungal infectious agents, as well as testing for disease antibodies in the blood and for chemical and toxic agents. The Fairbanks lab provides virology testing. In addition to laboratory testing, this section provides technical consultation and continuing education to clinical laboratories throughout Alaska, as well as quality assurance and reference testing for Alaska's clinical laboratories to ensure the safety and efficacy of their services.

DPH administers a number of programs for prevention and treatment. They also are responsible for the EPSDT tracking system, including the interface with the EPSDT subsystem in the MMIS.

DPH programs generally cover individuals who are not eligible for Medicaid or services not covered by Medicaid. The Breast and Cervical Health Check and Family Planning grant programs provide screening and preventive services to women. The Health Care Program for Children with Special Needs provides specialty services to disabled children. Some of these DPH sections receive information from the MMIS on a regular basis. Others such as the Laboratories submit claims for Medicaid covered services. The Division also operates and uses the RPMS application for tracking services to clients.

4.3.1.8.1 Certification and Licensing Unit(C&L)

This unit is responsible for Medicare and Medicaid certification of healthcare facilities. Unit responsibilities include:

- (1) Licensing of all health facilities in Alaska accordance with State law.
- (2) Under contract with CMS, certifying of all facilities that wish to participate in Medicare and Medicaid in Alaska.
- (3) Investigating complaints and reports of harm made against the facilities it licenses.

4.3.1.9 Office of Finance and Management Services (FMS)

<http://www.hss.state.ak.us/das/default.htm>

The core services of this Office are to assist and be responsible for all the administrative service and management functions of the department. These responsibilities range from managing Department policy to insuring that all DHSS external and internal customer needs are met in an effective and efficient manner.

Commissioner's Office

The Commissioner's Office is responsible for upper-level management and policy development for the Department. (AS 18.05: Health, Safety and Housing)

Office of Program Review

The Office of Program Review ensures that DHSS programs accomplish their goals and helps Divisions identify and maintain funding for continued service delivery. (AS 37.10: Financial Management)

Rate Review

The Rate Review component establishes efficiency in rate-setting functions throughout the Department. (AS 47.07: Medical Assistance for Needy Persons).

Assessment and Planning

The Assessment and Planning component is tasked with planning, assessment, and forecasting improvements for the Medicaid program. (AS 47.07: Medical Assistance for Needy Persons).

Administrative Support Services

The Administrative Support Services component funds financial, budget, procurement, grant, and professional service contract administration, information services, as well as human resource liaison functions. (AS 37.10: Financial Management; AS 37.07: Budget Section; AS 36.30 Procurement Section, 7 AAC 78 and 81 Grant Regulations; Audit Section PL 98-502 Single Audit Act Amendments of 1996, PL 104-156 and OMB Circular A-133)

Hearings and Appeals

The Hearings and Appeals component conducts appeals for Medicaid, Chronic and Acute Medical Assistance, and Division of Public Assistance regarding rates and recipient benefit appeals. (AS 47.07; AS 47.08 and AS 47.25)

Facilities Management

The Facilities Management component includes the management of the Department's capital programs. (AS 37.07.062 Capital Projects - Responsible for preparation, submission and competent management of annual capital budget requests)

Health Planning and Infrastructure

The Health Planning and Infrastructure component core services include community health needs assessments, health indicators tracking, data analyses and reporting, technical assistance, health plan development, community health grants, and Certificate of Need (CON) (AS 18.07 and AS 18.20 – Health, Safety and Housing, Certificate of Need)

Medicaid School Based Claims

The Medicaid School Based Claims component improves health services access and availability for Medicaid-eligible children and families. (AS 18.05 Health, Safety and Housing)

Information Technology

The Information Technology component's focus is to improve the efficiency and effectiveness of IT services and develop a more capable IT organization for the Department.

The Office uses MMIS data to prepare the HCFA-64 report, request Federal fund draw downs, validate accounts receivable collections, and prepare cost allocation plans and audit responses. The Office is the liaison with AKSAS (State accounting system). In this capacity they assign collocation, ledger, and program codes for the MMIS accounting interface.

This Office also provides guidance to DHSS staff in procuring professional services contracts and reviewing Requests for Proposals.

4.3.1.9.1 Office of Program Review and Rate Review Executive Director of MRAC

Office of Rate Review (ORR) - Medicaid Rate Advisory Committee. The Medicaid Rate Advisory Commission (MRAC), authorized under AS 47.07, advises DHSS on facility rate setting and related policy issues. FMS Office of Rate Review (ORR) - The Executive Director is responsible for the operations of the Medicaid Rate Advisory Committee. The Medicaid Rate Advisory Commission (MRAC), authorized under AS 47.07, advises DHSS on facility rate setting and related policy issues.

4.3.1.9.2 Project Director (Special Projects Manager)

This position is responsible for management of the procurement and implementation processes associated with the new MMIS and Data warehouse/Decision Support contract. This position is responsible for coordinating and facilitating the work of the contracted consultants under this RFP. This Section will house the permanent and temporary State project staff during the MMIS replacement.

4.3.1.9.3 Hearings and Appeals Unit

The Office of Hearings and Appeals is within the Office of Finance and Management Services (FMS) and is responsible for client case hearings and provider rate appeals. Unit responsibilities include:

- (1) Scheduling hearings and coordinating pre-hearing arrangements
- (2) Holding pre-hearing and other conferences
- (3) Presiding over formal hearings
- (4) Analyzing and evaluating facts and pertinent laws
- (5) Preparing reports and findings
- (6) Recommending orders and decisions for consideration by the Commissioner

4.3.1.10 Division of Alaska Pioneer Homes

<http://hss.state.ak.us/dalp/>

The Division of Alaska Pioneer Homes provides residential and pharmaceutical services in Sitka, Fairbanks, Anchorage, Ketchikan, Palmer, and Juneau for qualified Alaska seniors. Services are designed to maximize independence and quality of life by addressing the physical, emotional, and spiritual needs of Pioneer Home residents. The Pioneer Home system served 573 Alaskan seniors during FY05. During FY 2005, all six Pioneer Homes and the Pioneer Home central Pharmacy became licensed Medicaid providers and Pioneer Home residents became eligible to apply for and receive Medicaid benefits. This significant change allows the Division access to federal funding thereby reducing general funds expended to operate the homes and subsidize residents who are unable to pay the full monthly charges. As of November 2004, 58 percent of Pioneer Home residents were subsidized by the state through the division's Payment Assistance Program.

The following paragraphs highlight other offices within the Alaska State Government that are either users of MMIS information or interface with DHSS. Their involvement in the MMIS procurement and development process will be necessary for successfully completing the requirements outlined in this RFP.

4.3.2 Department of Administration (DOA)

<http://www.state.ak.us/local/akpages/ADMIN/home.htm>

The following Divisions within DOA are involved in administration of DHSS medical assistance programs:

- Enterprise Technology Services (ETS)
- Division of General Services (DGS)
- Division of Finance (DOF)

4.3.2.1 Enterprise Technology Services (ETS)

<http://www.state.ak.us/admin/info/home.html>

ETS regulates the infrastructure (Wide Area Network or WAN) tying the State agencies together. The fiscal agent must connect the MMIS to the network of users through this WAN. The ETS also sets policy for procurement of computer services, system security and confidentiality, connectivity to the State's backbone, and hardware and software standards. A copy of the Comprehensive Telecommunications Service Agreement is provided in the Bidder's Library and is also available on the Internet at the above-referenced site.

4.3.2.2 Division of General Services (DGS)

<http://www.state.ak.us/local/akpages/ADMIN/dgs/home.htm>

DGS regulates purchasing (such as this professional services contract), provides office leasing for State agencies and provides mailroom and surplus property management services. This procurement process and resulting contract must be approved by this agency.

4.3.2.3 Division of Finance (DOF)

<http://fin.admin.state.ak.us/dof/main/index.jsp>

DOF manages the Alaska State Accounting System (AKSAS). AKSAS incorporates files for accounting transactions, check write, and electronic funds transfer EFT transactions. The DOF also authorizes release of the payments for each fiscal agent payment cycle.

4.3.3 Department of Commerce, Community and Economic Development (DCCED)

<http://www.dced.state.ak.us/occ/DCBPLAlaska>

<http://www.law.state.ak.us/department/criminal/mfcu.html>

Within the DCCED, the Division of Corporations, Business and Professional Licensing (DCBPL) <http://www.dced.state.ak.us/occ> is the primary occupational licensing agency for Alaska professional licenses. DCBPL regulates entry into professions and enforces performance standards for each professional licensing area. The Fiscal Agent must support an interface with DCBPL to verify status of professional licenses for Medicaid providers.

4.3.4 Department of Law

<http://www.law.state.ak.us>

4.3.4.1 Alaska Medicaid Provider Fraud Control Unit (MPFCU)

<http://www.law.state.ak.us/departments/criminal/mpfcu.html>

The MPFCU has been part of the State Attorney General's Office within the Department of Law since January 1992. The Unit is located in Anchorage and has statewide jurisdiction. It has the responsibility for investigating and prosecuting Medicaid fraud and abuse, neglect, or financial exploitation of patients in any health care facility that accepts Medicaid funds. The Fiscal Agent will be requested to provide claim records and other information to support ongoing investigations of MPFCU.

Additionally, the Collections and Support section of the Department of Law provides legal advice to and represents the Alaska Child Support Services Division in local and interstate child support actions. These include actions to establish or disestablish paternity, establish and modify child support orders, obtain and enforce medical support orders, and enforce support obligations through civil process.

4.3.5 Department of Revenue (DOR)

<http://www.revenue.state.ak.us>

The following Divisions within DOR are involved in administration of DHSS medical assistance programs:

- Child Support Enforcement Division (CSED)
- Division of Treasury

4.3.5.1 CSED

<http://www.csed.state.ak.us>

CSED is responsible for establishing child support orders, including orders for medical support, collecting child support payments, and disbursement of the payments. The automated interface between CSED and the MMIS needs to be reestablished. Currently, information on child support assignments is generated through manual look-up on the CSED case tracking system or secondhand through automated matches performed by the TPL contractor.

4.3.5.2 Division of Treasury

<http://www.revenue.state.ak.us/treasury>

The Division of Treasury is located in Juneau. This Division provides cash management, investment management, debt management, and accounting services for the State's General Fund, the Constitutional Budget Reserve Fund, various retirement funds, and other funds and trusts. Treasury maintains necessary payment and collection bank accounts for the Medicaid program. The rules for establishing electronic fund transfer payments and payment procedures are controlled by Treasury.

4.3.6 Department of Labor and Workforce Development (DOL/WD)

This Department works with DHSS to determine disability and return recipients to work. The Divisions of Vocational Rehabilitation and Disability Determination Services (DDS) are 100% federally funded by the Social Security Administration. DDS operates as a federally-regulated agency, and Federal funds are used solely to provide medical determinations for persons alleging disability. DDS adjudicates claims for the Social Security Administration for Title II (Social Security) and Title XVI (Supplemental Security Income) applicants for disability benefits. Referrals are made, when appropriate, to the vocational rehabilitation program for job training and placement.

4.3.7 Department of Education and Early Development (DE&ED)

Generally, children who have been determined to be eligible for Medicaid may be able to obtain these services in the school setting. School-Based Medicaid Administrative Claiming (MAC) is administered by DE&ED.

4.4 Medicaid Program Description

The Alaska Medicaid Program provides comprehensive coverage, including a number of Title XIX-optional services to Categorically Needy individuals. The following subsections summarize the present scope of the program:

- Eligible Groups
- Eligible Providers
- Medicaid Services
- EPSDT Services
- Waiver Services
- Reimbursement
- CAMA

4.4.1 Eligible Groups

Services are provided to certain eligible groups defined by the Federal government and adopted by the State Legislature. All residents of the state for whom the Social Security Act requires Medicaid coverage are eligible to receive medical assistance. These “mandatory eligible groups” include the Aged, Blind, Disabled, and Families with Dependent Children, as well as Pregnant Women.

In addition to the persons specified above, the State Legislature may select optional groups of persons for whom the state may claim Federal Financial participation for medical assistance. These “Optional eligible groups” include individuals under 21 with income less than 200% of the poverty level. These are collectively referred to as the Denali KidCare Program. Other optional groups include institutionalized individuals under a specified income level. The complete list of Medicaid eligible groups may be viewed at the DHCS website under the State Medicaid Plan.

Following are lists of services, eligibility categories, and provider types. Vendors should consult the State Medicaid Plan, Alaska Statute AS 47.07, and Medicaid Billing Manuals for complete information.

4.4.1.1 Mandatory Eligible Groups

These include mandatory eligibles and specialized mandatory eligible groups.

4.4.1.1.1 Mandatory Eligibles

- (1) Persons eligible for Medicaid under Section 1931 of the Social Security Act.
- (2) Persons receiving cash assistance from Supplemental Security Income (SSI.)
- (3) Infants born to a Medicaid-eligible mother throughout their first year, regardless of income or resources.
- (4) Children placed in foster care or adoption assistance under Title IV-E of the Social Security Act.
- (5) Families who lose their cash assistance under Section 1931, because of earnings or hours of work (for up to 12 months).
- (6) Families who lose their Medicaid eligibility under Section 1931 due to increased child support collections (for up to 4 months).

4.4.1.1.2 Specialized Mandatory Eligible Groups

- (1) Certain aliens who may receive coverage for emergency services.
- (2) Medicare beneficiaries with income under 100% of Federal poverty level. Medicaid will pay the Medicare co-insurance, deductible, and premiums.
- (3) Certain former Social Security disability beneficiaries who have returned to work and who have income under 200% of the Federal poverty level. Medicaid will pay the Medicare Part A premium.
- (4) Special low-income Medicare beneficiaries with income between 100% and 120% of Federal poverty level and resources no more than twice the SSI limit. Medicaid will pay the Medicare Part B premium only.

4.4.1.2 Optional Eligible Groups

- (1) Children 18 years old and younger who are disabled and qualify for an institutional level of care, and are receiving these same services in the community. Parental income is disregarded and the child's income does not exceed 300% of the SSI standard. This group is commonly known as the TEFRA Option, the acronym associated with the legislation authorizing the service (Tax Equity and Fiscal Responsibility Act of 1982).
- (2) Children placed into foster care by DHSS whose individual income and resources (not counting their parents) do not exceed the Temporary Assistance for Needy Families (TANF) limits.

- (3) Aged, blind, and disabled individuals who are not eligible to receive SSI, but who do receive a payment from the Adult Public Assistance Program.
- (4) Persons in a hospital or nursing home facility whose income does not exceed 300% of the SSI standard and who would be eligible for Medicaid outside the facility except for the amount of their income.
- (5) Persons who would receive their care in a nursing facility or an intermediate care facility for the mentally retarded (ICF/MR), but who are eligible for a Home and Community-Based Care program waiver and whose income does not exceed 300% of the SSI standard.
- (6) Children under the age of 18 in State-subsidized adoption assistance agreements.
- (7) Children age 18 years and younger with family income up to 150% of the Federal poverty level. No resource test applies to this group.
- (8) Children age 18 years and younger with family income between 150% and 200% of the Federal poverty level and no creditable health insurance coverage. No resource applies to this group.
- (9) Pregnant women with income up to 200% of the Federal poverty level. There is no resource test applied to this group.
- (10) Working disabled individuals who meet the SSI disability criteria and have income up to 250% of the Federal poverty level.
- (11) Women who have been screened for breast and cervical cancer under the Public Health Service Act.
- (12) Senior Care recipients and CAMA recipients while technically not Medicaid clients, these individuals receive eligibility through the Division of Public Assistance.

Information on the number of eligible persons by category of eligibility can be found in the bidder's library.

4.4.2 Eligible Providers

This is made up of the following:

- Provider Participation Requirements
- Provider Types

4.4.2.1 Provider Participation Requirements

Healthcare professionals must be enrolled as a provider in Alaska's Medical Assistance Programs to bill for services provided to eligible persons. Out-of-state health care providers must be enrolled in their State Medicaid Program and in Alaska's program to receive payment for services provided to Alaskan medical assistance beneficiaries.

To enroll, a provider must complete an Alaska Provider Enrollment form and a Provider Agreement and must agree to meet these initial and ongoing participation requirements:

- (1) Hold a current provider agreement and occupational/business license or certification, as appropriate.
- (2) Provide medical services to beneficiaries and bill the fiscal agent for those services which signifies agreement by the medical provider to cooperate in reports, surveys, or audits conducted by the DHSS.
- (3) Retain records necessary to fully disclose to the DHSS the extent of services provided to beneficiaries. Information regarding any payment must be made available, upon request, to DHSS and Federal personnel.
- (4) Allow on-site inspection of facilities by authorized officials of both State and Federal agencies with oversight responsibility for medical assistance programs.
- (5) Maintain responsibility for claims submitted or certified by an authorized representative.
- (6) The provider or agent's endorsement of a check received from the State certifies that the claim, for which the check is payment, is true and accurate unless written notice of an error is sent by the provider to DHSS within 30 days after the date that the check was issued.
- (7) Comply with the conditions of Title VI of the Civil Rights Act of 1964.

4.4.2.2 Provider Types

The following provider types are eligible to participate in Alaska's medical assistance program. Participation for some provider types is limited. Psychologists and social workers are only eligible to receive payment for Medicare crossover claims. Some provider types, such as mental health clinics and Federally Qualified Health Centers (FQHC) employ practitioners that are not eligible for independent practice under the Alaska program requirements.

- (1) Persons licensed by the State of Alaska, Division of Corporations, Business, Professional Licensing (DCBPL), to practice medicine, osteopathy, dentistry, optometry, podiatry, psychology, or chiropractic.
- (2) Independent physical therapists licensed by DCBPL and certified by the State of Alaska, C&L section of DPH for independent practice.
- (3) Speech therapists licensed by DCBPL and holding a current certificate of clinical competence in speech pathology from the American Speech and Hearing Association.
- (4) Occupational therapists licensed by DCBPL.
- (5) Audiologists and hearing aid dealers licensed by DCBPL.
- (6) General hospitals, psychiatric hospitals, long term care facilities, home health agencies, private duty nursing agencies, and outpatient surgical care centers licensed by the C&L section of DPH, and eligible for Medicare reimbursement.
- (7) Residential psychiatric treatment centers certified by OCS.
- (8) Pharmacies licensed by DCBPL.

- (9) Alaska Native hospitals and clinics, pharmacies, independent laboratories, FQHCs and Rural Health Clinics certified and/or licensed by the Federal Department of Health and Human Services (DHHS).
- (10) Mobil x-ray facilities and mammography centers certified by DHHS.
- (11) End stage renal centers, outpatient physical therapy centers, outpatient speech pathology services, rural health clinics, hospices, and occupational therapy centers currently licensed and/or certified by the C&L section of DPH and eligible for Medicare reimbursement.
- (12) Advanced nurse practitioners, certified nurse midwives and direct entry midwives licensed by DCBPL.
- (13) Respiratory therapists holding current registration/certification.
- (14) Medical suppliers (DME, medical supplies, orthotics and prosthetics, oxygen, hearing aids), transportation providers (taxis, airlines and charter airlines, ferries, ambulances and other evacuation transportation for medical necessity), and accommodation providers (motels, hotels, lodges, restaurants, and pre-maternal homes).
- (15) Opticians licensed by the DCBPL.
- (16) Personal care agencies approved by the Division of Senior and Disability Services.
- (17) Family planning clinics certified by DHHS.
- (18) Community mental health clinics certified by the DBH, and mental health physician clinics whose supervising psychiatrist is licensed by DCBPL.
- (19) Day treatment facilities that have a program approval letter from the DBH.
- (20) Alcohol and Drug Abuse centers that have a program approval letter from the DBH and a notification of grant award from the DHSS.
- (21) Home and community-based care agencies, residential supported living arrangements, environmental modification providers, and care coordination agencies holding a provider certification from DBH or DSDS.
- (22) Care coordinators who have a letter verifying employment at an enrolled care coordination agency.
- (23) EPSDT screening providers approved by DHCS to include school districts, municipal health departments, the DPH and public health nurses.
- (24) School districts licensed by DOL.
- (25) Community Health Aides certified by the DPH.
- (26) Residential Care Facilities certified by OCS as Behavioral Rehabilitation providers.
- (27) Dietitians and nutritionists licensed by DCBPL.
- (28) Home Infusion Therapy Provider.

4.4.3 Medicaid Services

The Alaska Medicaid Program provides both mandatory services and optional services. Eligibility for any specific service is determined by medical necessity, and the eligibility category of the recipient.

4.4.3.1 Mandatory Federal Services

Mandatory services including the following:

- (1) Inpatient hospital services
- (2) Outpatient hospital services
- (3) Rural health clinic (including Federally Qualified Health Center) services
- (4) Laboratory and x-ray services
- (5) Advanced nurse practitioners' services (family practice, pediatric, and OB-GYN)
- (6) Nursing facilities services
- (7) Home health services
- (8) Family planning services and supplies
- (9) Physicians' services and medical and surgical services of a dentist
- (10) Nurse midwife services
- (11) EPSDT services for persons under age 21

4.4.3.2 Optional Services

Optional services include the following:

- (1) Direct entry midwife services
- (2) Adult dental services for immediate relief of pain and infection
- (3) Emergency hospital services
- (4) Treatment of speech, hearing, and language disorders
- (5) Optometrists' services and eyeglasses
- (6) Occupational therapy
- (7) Mammography screening
- (8) Prosthetic device
- (9) Medical supplies and equipment
- (10) Targeted case management services
- (11) Rehabilitative services for substance abusers and emotionally disturbed or chronically mentally ill adults and children
- (12) Clinic services
- (13) Physical therapy

- (14) Consumer Directed and Agency Based Personal care services
- (15) Prescribed drugs
- (16) Hospice care
- (17) Long term care non-institutional services
- (18) Inpatient psychiatric facility services for under 21 years of age and over 65 years of age
- (19) ICF/MR (Intermediate Care Facility /Mental Retardation Facility Services)
- (20) Certified Outpatient Rehabilitation Facilities, swing bed, and administrative wait bed care
- (21) Nutrition services for high risk pregnant women
- (22) Behavior Rehabilitation Services for children under 21 years of age
- (23) Medical transportation (includes air and ground ambulance, commercial air services, ground and water taxi)
- (24) Home Infusion Therapy Provider

4.4.4 EPSDT Services

Under Federal law, all eligible children under 21 may receive any Medicaid-reimbursable service that is medically necessary, as determined through the EPSDT screening process, in addition to case management and waiver services. Mandatory services for children include all the child-appropriate mandatory and optional services listed in this section and the following:

- (1) EPSDT screens
- (2) Nutrition services for high risk children
- (3) Full dental services (including dentures)
- (4) Podiatry services
- (5) Private duty nursing services
- (6) Chiropractic services

4.4.5 Waiver services

This section describes the following:

- Waiver programs
- Special Services

4.4.5.1 Waiver Programs

The State operates four Medicaid Home and Community Based waiver programs:

- (1) Children with complex medical conditions: For children who qualify for hospital or nursing home level of care.

- (2) People with developmental disabilities: For people who qualify for ICF/MR level of care.
- (3) Adults with physical disabilities: For adults 21 and older who qualify for nursing facility level of care.
- (4) Older Alaskans: For adults age 65 and older who qualify for nursing facility level of care.

4.4.5.2 Special Services

The Medicaid waivers authorize special services not otherwise available under Medicaid, as listed below. Not all services are available in every waiver. Services are grouped in care plans, based on individual need:

- (1) Care coordination
- (2) Respite
- (3) Adult day care
- (4) Habilitation (residential, day, supported employment, education, and intensive active treatment)
- (5) Environmental modification
- (6) Specialized equipment and supplies
- (7) Chore and meal services
- (8) Private duty nursing
- (9) Residential supported living arrangements
- (10) Transportation services above and beyond those covered under non-waiver Medicaid funding

4.4.6 Reimbursement

Reimbursement for medical services under the Alaska Medicaid Program is pursuant to the following methodologies*:

- (1) Advanced Nurse Practitioners: Lesser of billed charges or 85% of the physician Resource Based Relative Value System (RBRVS). EPSDT services are paid at 100% of RBRVS. Lab services are paid at the Medicare Fee Schedule. Assistant-at-surgery services at 25% of their allowable rate. Medical supplies paid at the allowed amount for DME/supplies. Unlisted codes are manually reviewed and priced at 50% of billed charges.
- (2) Ambulatory Surgical Center (ASC) Services: Medicare ASC code group.
- (3) Behavioral Rehabilitation Services (BRS): Lesser of billed charges or a daily per diem rate (not to include room and board) established by the department.
- (4) Chiropractic Services: Lesser of billed charges or the physician RBRVS.

- (5) Community Health Aide: Lesser of billed charges or 85% of the Physician RBRVS for the same procedure.
- (6) Dental Services: Lesser of billed charges, encounter rates, or the state fee schedule (dental services may also be limited to a maximum dollar amount per recipient in the future).
- (7) Family Planning Services and Supplies: Lesser of billed charges or 85% of the physician RBRVS for services; medical supplies are paid at the allowed amount for DME/supplies.
- (8) FQHC and Rural Health Clinic: Facility specific all-inclusive encounter rate.
- (9) Home and Community-Based Waiver Services:
 - (a) Rates and methodologies set out in 7AAC43.1058.
 - (b) Care coordination, specialized equipment and supplies: Lesser of billed charges or the State maximum allowable for the unit of service.
 - (c) Specialized private duty nursing –The division will reimburse for in-state private duty nursing services at the lesser of the billed charges or the State maximum allowable for the unit of service.
 - (d) Environmental modifications service: 100% of billed charges up to the prior authorized amount with a maximum of \$10,000 per 36-month waiver period, plus an administrative fee for certain providers.
 - (e) Adult day care, chore, habilitation, meals, respite, or waiver transportation service: Provider-specific rate per unit of service, regional rates per unit of service, or client-specific rates as determined by the State.
 - (f) Residential supported living service: Provider-specific or regional rates set by the Department.
- (10) Home Health Services: 80% of billed charges.
- (11) Home Infusion Therapy: Lesser of billed charges or the State fee schedule.
- (12) Hospice Care Services: Lesser of billed charges or the CMS established Medicaid rates per service.
- (13) Inpatient Hospital: Facility specific per diem but historical reimbursement was facility specific percentage of billed charges.
- (14) Alaska Native (IHS) Hospital: All inclusive per diem rate.
- (15) Laboratory Services: Lesser of billed charges or the Medicare fee schedule (unique professional and technical component pricing requirements exist).
- (16) Long Term Care Facility Services: Facility specific per diem rate.
- (17) Mammography center and mobile x-ray provider: Lesser of billed charges or the physician RBRVS (unique professional and technical component pricing requirements exist).

- (18) Durable medical equipment, medical supplies and prosthetic devices: Lesser of billed charges or the State maximum.
- (19) Mental Health Clinic Services: Lesser of billed charges or the State maximum.
The Department will reimburse a provider for mental health clinic services and certain mental health rehabilitation services at the rates set in 7AAC 43.729 a & b.
- (20) Alaska Native (IHS) Clinic: All inclusive encounter rate.
- (21) Mental Health Rehabilitation Services: Lesser of billed charges or the State maximum.
- (22) Direct Entry-Midwife Services: Lesser of billed charges or 85% of the physician RBRVS. Laboratory services are paid at the Medicare fee schedule; unique professional and technical component pricing requirements exist. Medical supplies are paid at the allowed amount for DME/supplies. Unlisted codes are manually reviewed and priced at 50% of billed charges.
- (23) Nurse Midwives: Lesser of billed charges or 85% of the physician RBRVS. Laboratory services are paid at the Medicare fee schedule; unique professional and technical component pricing requirements exist. Medical supplies are paid at the allowed amount for DME/supplies. Unlisted codes are manually reviewed and priced at 50% of billed charges.
- (24) Nutrition Services: Lesser of billed charges or 85% of the physician RBRVS.
- (25) Outpatient Hospital Services: Percentage of billed charges for most services. Laboratory services are paid at Medicare fee schedule. Designated small hospitals receive percentage of billed charges for all services.
- (26) Personal Care Services: Lesser of billed charges or the State maximum.
- (27) Physical and Occupational Therapy Services: Lesser of billed charges or 85% of the physician RBRVS. Medical supplies are paid at the allowed amount for DME/supplies.
- (28) Physician Services: Lesser of billed charges or the RBRVS value for the procedure, with lower rates for surgical assistants and co-surgeon services. Laboratory services are paid at Medicare fee schedule (unique professional and technical component pricing requirements exist). The department will pay for anesthesiology services in accordance with the following calculation: $(\$42.90 \times \text{the number of base units for anesthesiology services} + \$36.00 \times \text{the number of time units})$, where the number of base units is determined according to the *Relative Value Guide* and the value of one time unit is 10 minutes. Additionally To be reimbursed for dispensing prescribed drugs, a licensed physician must separately enroll as a dispensing physician pharmacy provider and bill the division in accordance with 7 AAC 43.590. Prescribed drugs dispensed by a physician will be reimbursed in accordance with 7 AAC 43.591. Also the physician collaborator must be employed by, in a contractual relationship with, or under the supervision of the physician. The services must be billed to the division in accordance with 7 AAC 43.040, except that the division will pay 85% of the rate identified in the fee schedule established under 7 AAC 43.108. The physician

- shall indicate on the claim form the services provided by a physician collaborator by adding the appropriate modifier after the applicable procedure codes. Non-routine supplies will be reimbursed at the lesser of billed charges or the amounts listed in Table I-6 of the physician services section of the *Alaska Medicaid Provider Billing Manual*. Medical supplies are paid at the allowed amount for DME/supplies. Unlisted codes are manually reviewed and priced at 50% of billed charges.
- (29) Podiatry Services: Lesser of billed charges or the physician RBRVS.
 - (30) Prescribed Drugs: Lesser of billed charges, Federal maximum allowable cost, or 95% of the estimated acquisition cost plus a provider-specific dispensing fee, plus the reasonable and necessary postage or freight costs incurred in the delivery of the prescription from the dispensing pharmacy to a recipient in a rural area, paid through the pharmacy system. The Vendor should see 7AAC 43.591 for special payment methods involving dispensing physicians, unit dose dispensing, high technology drugs, postage, brand name vs. generic drugs, compounding prescriptions, and infusion therapy drugs.
 - (31) Private Duty Nursing for Children Under 21: The Department will reimburse for in-state private duty nursing services at the lesser of billed charges or the State maximum allowed.
 - (32) Residential Treatment for Children Under 21: All-inclusive daily rate established by DHSS. Negotiated rates for specific clients based on level of care.
 - (33) Respiratory Therapy Services: Lesser of billed charges or the State maximum.
 - (34) School Based Services -The department will pay for school-based services in accordance with 7 AAC 43.040; at the lesser of billed charges or: a) 85% of the Resource-Based Relative Value Scale (RBRVS) fee schedule determined under 7 AAC 43.108(b) and (c) for procedures with an established relative value unit (RVU); b) for services with no established RVU, the department will pay according to the established fee schedule.
 - (35) Speech, Hearing and Language Services: Lesser of billed charges or 85% of physician RBRVS. Medical supplies are paid at the allowed amount for DME/supplies.
 - (36) Substance Abuse Rehabilitation Services: Lesser of billed charges or the State maximum.
 - (37) Targeted Case Management: Lesser of billed charges or the State established monthly encounter rate.
 - (38) Transportation Services: The department will pay all providers of transportation and accommodations billed charges, except as specified in Table I-3 of the transportation and accommodations section of the *Alaska Medicaid Provider Billing Manual*. In general the following apply:
 - (a) Non-emergency ground ambulance within the same community: Lesser of billed charges or the State maximum.

- (b) Non-emergency ground ambulance outside the community: Lesser of billed charges or State maximum, plus a rate per mile.
 - (c) Emergency ground ambulance: State based rate plus a rate per mile.
 - (d) Emergency air ambulance: Lift-off fee plus per mile rate.
 - (e) Non-emergency air ambulance: Lesser of billed charges or the State maximum.
 - (f) Commercial airline: Billed charges.
 - (g) Lodging and meal costs for recipients and approved escorts: Lesser of billed charges or the State maximum.
- (39) Vision Care Services:
- (a) Examinations: Lesser of billed charges or physician RBRVS.
 - (b) Eyeglasses: The State awards a competitive-bid contract for eyeglasses; the department will pay an enrolled provider \$80 for dispensing and fitting contact lenses, \$30 for dispensing and fitting eyeglasses, and \$10 for eyeglass frame repair.
 - (c) Optometrist services: Lesser of billed charges or the physician RBRVS.
- (40) DJJ Services: Contract payments.
- (41) Payment for Services Provided in another State: Unless otherwise noted in Chapter 43 the Department will pay an out-of –State provider according to the following:
- (a) Out of state physicians, at the lowest of (1) the billed charges; (2) 70% of the in-state physician RBRVS rate ;(3) the rate established by the Medicaid agency in the State where the service was rendered.
 - (b) Out of state mid-level professionals, at the lowest of (1) the billed charges; (2) 85% of 70% of the in-state physician RBRVS rate; (3) the rate established by the Medicaid agency in the State where the service was rendered.
 - (c) Out-of-state facilities, at the lowest of (1) the billed charges; (2) the rate established by the Medicaid agency in the State where the service was rendered; (3) a rate negotiated by the Department.

*Note to vendors. The payment methods in this section are stated generically, the vendor should see the Billing Manuals and Alaska Administrative Codes for specifics and exceptions. For example 7 AAC 43.108. Resource-based relative value scale payment lists additional methods for handling codes lacking RVU (section e) or unlisted procedure codes (section f).

4.4.7 CAMA

The CAMA program began July 1, 1999. It replaced the General Relief Medical (GRM) program, which was not funded by the Legislature. CAMA is funded entirely by the State

general fund. CAMA provides only limited medical coverage and uses Medicaid providers and reimbursement rates. Service limits are as follows:

- (1) Major medical inpatient hospital care (limit 8 days per year).
- (2) Nursing home care and related lab and x-ray services.
- (3) Transportation necessary for a hospital admission or nursing home care.
- (4) Physician visits related to hospital admission and drug coverage.

Physician visits associated with these conditions are limited to 12 per year. Prescriptions are limited by the CAMA formulary and to three prescriptions per month.

5 SCOPE OF WORK

5.1 Background

The Department of Health and Social Services (DHSS) is issuing this RFP to obtain a new fiscal agent to operate the current MMIS and to design, develop, and implement a new MMIS and Data Warehouse (DW)/Decision Support System (DSS) for Alaska. The RFP requires proposers to: (1) offer operational takeover services to provide takeover and maintenance of on-going operations; and (2) offer a new MMIS system that will meet all the functional requirements described in this section and has to be certifiable by CMS for enhanced federal funding. The proposed solution must include all required components of an MMIS, including a pharmacy POS, claims processing and reporting modules, a DW/DSS and the SURS, MARS and TPL capabilities as well as perform DUR, prior authorization and drug rebate functions. These components and capabilities are referred to collectively as “system” or “MMIS” throughout this section. DHSS requires the system to be installed on the vendor’s server and supported through staff at both the vendor’s data center and the Anchorage, Alaska location.

The proposed solution for operational takeover services must include all required components currently preformed by the existing fiscal agent (excluding DSS, however DSS monthly claims extract is required). It is important that proposers present a solution that provides a smooth and transparent transition from the current fiscal agent to the new Contractor. Impact to internal and external stakeholders must be minimal. The solution must provide for uninterrupted service.

The proposed solution for the takeover MMIS must include all required components of the MMIS originally specified in the 1987 Alaska MMIS RFP and amendments, including POS, claims processing and reporting modules, a DSS extract and the SURS, MARS, and TPL capabilities as well as perform DUR, prior authorization and drug rebate functions. The DHSS requires the proposer to offer an approach for all functions of the takeover MMIS.

The DHSS is seeking to take advantage of recent technological advancements and replace the current MMIS with a system that meets all the automation and interfacing requirements presented in this section of the RFP. It is important that proposers present the best solution to satisfy all the functional and technological requirements and to provide a system that will be usable for the Alaska medical assistance programs well into the future. As part of the successful vendor’s proposal the State of Alaska expects a comprehensive management approach, system design and testing plan that results in a concurrent implementation of the MMIS and the DW/DSS. This concurrent implementation must include the conversion of all data from the current MMIS to the DW/DSS prior to the acceptance of the new system.

The proposed solution for the new MMIS must be flexible enough to support a variety of health care delivery systems, including fee-for-service and managed care. The system must provide the capability to process claims and data from multiple programs and multiple plans within programs. A program is defined as a group of recipients eligible to receive medical services paid by State and/or federal funds by virtue of the recipient’s demographic or other characteristics. A plan is defined as a subset of recipients in a program eligible to receive a specific subset of medical services. The proposed system must also support the information requirements necessary

medical services. The proposed system must also support the information requirements necessary for the evaluation, comparison, and management of alternate healthcare delivery systems. It is important that the proposer obtain a clear understanding of the Alaska medical assistance programs and the required MMIS and DW/DSS structure.

The Contractor will warrant that the solution proposed and implemented will meet CMS MMIS certification requirements, and the certification will be available retroactively to the first day of operation. CMS has utilized the MMIS General System Design (MMIS-GSD) as the standard for evaluation of systems for which funding is requested under Section 1903(a)(3) of the Act.

5.2 Schedule

The contract term and work schedule presented in section 1.2 represents the State's best estimate of the schedule that will be followed. If a component of this schedule, such as the opening date, is delayed, the rest of the schedule will be shifted by a similar amount.

5.3 Contract Activities

The project has been divided into four phases:

Phase	Section	Description
Operational Takeover	5.4	This phase encompasses all tasks and activities necessary to transfer the responsibilities for the current fiscal agent services and system to the new Contractor. This includes the period from the start of the new fiscal agent contract until the new DW/DSS, POS and new MMIS are accepted as an operational system by DHSS.
DDI	5.5	This phase encompasses all tasks and activities necessary to design, develop, and implement the new DW/DSS, POS, and MMIS. This includes the period from the start of the new fiscal agent contract until the new DW/DSS, POS and MMIS are accepted as an operational system by DHSS.
Operations	5.8	During this phase the Contractor will operate and maintain the entire MMIS, POS and DW/DSS for the life of the contract. System certification will be obtained retroactive to the first day of operation. The Contractor is responsible for achieving and maintaining system certification.
Turnover	5.9	During this phase the Contractor will ensure that all the procedures, schedules, and

Phase	Section	Description
		staffing are in place to turn over the system to DHSS or its Contractor.

5.4 Operational Takeover

This phase of the contract relates to all actions necessary for the Operational Takeover of the Alaska system from the current fiscal agent, First Health Services Corporation (FHSC), and perform the tasks necessary to implement and maintain the system. The Alaska MMIS responsibilities are detailed in the 1987 Alaska MMIS RFP and amendments available in the procurement library.

The Operational Takeover of the Alaska MMIS operations is a component of the contract, to be executed at the State's discretion. The transition of operations, from the current fiscal agent to the new Contractor, must be smooth, timely, and without adverse impact on the users of MMIS services.

DHSS expects the proposer to explain clearly and succinctly their approach to the operational takeover, including implementation and maintenance, to meet all user and programmatic requirements. The proposer must describe their approach to the operational takeover from the beginning of the contract through the operational takeover implementation and takeover maintenance of operations until implementation of the new MMIS. The proposed approach must address staffing, main tasks for takeover, and schedule. The proposed Operational Takeover Phase schedule must begin at the implementation of the contract and end at the beginning of Operations of the new MMIS and POS. Suggested activities are discussed below.

Communications between the Contractor and the State shall be open, clear and transparent. State management shall have access to all work processes, documentation, reporting, and resources involved in Operational Takeover. Communication between State and Contractor subject matter leads should occur daily as required.

Requirements relating to documentation and activities required of the Contractor contained in other sections of this RFP are applicable to the performance and deliverable requirements presented in this section. The State expects that the project management and reporting requirements at 5.5.1, deliverable review requirements at 5.5.2, and operations support requirements at 5.7 will be integrated into the project during legacy Takeover.

5.4.1 Takeover Initiation

This encompasses all tasks and activities necessary to begin takeover of the operational responsibilities from the current fiscal agent.

5.4.1.1 Operational Takeover Initiation

During this activity the Contractor shall form an operational takeover team and acquire knowledge of the current Alaska medical assistance programs and the detailed requirements of the current Alaska system. The Contractor will prepare a detailed Operational Takeover Plan and

review the proposed plan with the State project management staff. The Contractor will update the work plan to ensure complete understanding and integration of various Operational Takeover activities, tasks and sub-tasks.

5.4.1.1.1 DHSS Objectives

The Contractor must ensure that it clearly understands the programmatic requirements of the current Alaska system as well as the information access requirements of all users of the MMIS and POS data. It must also ensure that the project will progress according to the approved detailed Operational Takeover plan and that all requirements of the contract will be met. The Contractor must appoint the proposed managers and personnel to start and plan the Operational Takeover.

5.4.1.1.2 Operational Takeover Initiation Activities

The proposer must present a structured approach to kick-off the Operational Takeover. All operational takeover initiation activities outlined in this section should be consistent with industry standards. Operational Takeover Initiation activities will include but not be limited to the following:

- (1) Establish Contractor's DHSS-approved Operational Takeover team that will be responsible to review and define all general takeover requirements, review and discuss takeover timelines, make resource assignments, and establish reporting requirements and communication protocols with the DHSS Project Manager.
- (2) The Contractor will review the FHSC Turnover Plan and materials and identify any other requirements for support or documentation needed from FHSC.
- (3) The Contractor will schedule and prepare a "kick-off" meeting agenda with the DHSS Takeover team to discuss project initiation activities. Participation of all key Contractor Takeover team staff are required to attend the meeting in person unless otherwise approved by the DHSS.
- (4) Prepare the preliminary Detailed Operational Takeover plan (DOTP) for approval within thirty-five (35) calendar days of the implementation of the contract. This plan will encompass all Operational Takeover Phase activities. The Contractor will assign resource(s) to provide complete status and an updated copy of the work plan (in the media identified by DHSS) on the second and fourth Monday of each month.

The Operational Takeover detailed work plan must include at a minimum:

- (a) Approach
- (b) Schedule
- (c) Staffing
- (d) State staffing requirements
- (e) Requirements for support and documentation from the current fiscal agent MMIS Contractor
- (f) Requirements Analysis
- (g) Planning Tasks
- (h) Implementation Tasks
- (i) Systems Tasks

- (j) Data Tasks
 - (k) Interface Tasks
 - (l) System Testing Tasks
 - (m) Operations Testing Tasks
 - (n) Documentation Tasks
 - (o) Training and Notification Tasks (Contractor, other Contractors, State stakeholders, providers, and recipients)
 - (p) Site Visit and Orientation Tasks
 - (q) Other Tasks and subtasks associated with Takeover
 - (r) Maintenance Tasks
- (5) Present the DW/DSS detailed plan covering the methodology for extracting the data from the transferred system, record and field balancing, and methods for verifying and validating each processing step to the State.
 - (6) Present the Operational Takeover definition and the detailed Operational Takeover plan to DHSS within sixty (60) calendar days of the implementation of the contract, and obtain DHSS approval to proceed.
 - (7) Use the same system for Operational Takeover that is used for project control to control and report during the Operational Takeover Phase. DHSS will have the option of requiring that a licensed copy of the approved project control system be loaded on DHSS machines for its independent monitoring of Operational Takeover control tasks and activities.
 - (8) Train designated stakeholders to enable them to understand the operational transfer and takeover proposed by the Contractor in its proposal. The training curriculum will be prior-approved by DHSS.

5.4.1.2 DHSS Responsibilities

DHSS responsibilities for the Operational Takeover Initiation activity will be as follows:

- (1) Approve Contractor Operational Takeover site.
- (2) Approve Contractor Operational Takeover staff.
- (3) Designate DHSS Operational Takeover team.
- (4) Provide access to all current MMIS documentation.
- (5) Provide access to all turnover plans and other turnover documentation.
- (6) Provide responses to policy questions.
- (7) Review and approve Operational Takeover deliverables.
- (8) Review and approve the preliminary and detailed Operational Takeover plans.
- (9) Review and approve Operational Takeover control and status reporting protocols.
- (10) Provide official approval to proceed to the Requirements Analysis Activity upon completion of all Project Initiation task activities.

5.4.1.3 Contractor Responsibilities

Contractor responsibilities for the Operational Takeover Initiation activity will be as follows:

- (1) Prepare and submit preliminary Operational Takeover facility and data security plan to DHSS for approval.
- (2) Prepare and submit preliminary Operational Takeover equipment and technology plan to DHSS for approval.
- (3) Prepare and submit Operational Takeover staffing plan to DHSS for approval.
- (4) Prepare and submit preliminary and detailed Operational Takeover Plan(s) to DHSS for approval.
- (5) Present the Operational Takeover approach to DHSS for approval.
- (6) Update the takeover facility and data security plan and submit it to DHSS for approval.
- (7) Prepare and submit the preliminary takeover disaster recovery plan and submit it to DHSS for approval.
- (8) Prepare and submit the preliminary takeover safety plan to DHSS for approval.
- (9) Prepare and submit preliminary Operational Takeover system and operations test plan to DHSS for approval.
- (10) Prepare and submit a preliminary Operational Takeover implementation checklist to DHSS for approval.
- (11) Prepare and submit the preliminary takeover cost allocation plan to DHSS for approval.
- (12) Prepare and submit the takeover documentation standards plan and submit it to DHSS for approval.
- (13) Prepare and submit the Operational Takeover control and management plan to DHSS for approval.
- (14) Review and accept the turnover plan and materials from the current fiscal agent.

5.4.1.4 Milestones

In its work plan, the proposer should present the milestones and its approach describing how these milestones will be achieved for the Operations Takeover initiation activity. At a minimum, the following milestones must be included:

- (1) Occupation of the Contractor facility.
- (2) Establishment of equipment and linkages between the State and Contractor equipment.
- (3) Schedule for DHSS sign-off of all deliverables related to this activity.
- (4) Written approval by DHSS to proceed to the next activity.

5.4.1.5 Deliverables

At a minimum, the following deliverables must be included:

- (1) Facility plan

- (2) Equipment and technology plan
- (3) Staffing plan
- (4) Preliminary and Detailed Operations Takeover Plans
- (5) Takeover Approach presentation and Definitions document
- (6) Facility and data security plan
- (7) Disaster recovery plan
- (8) Safety plan
- (9) Data Takeover plan
- (10) Test plan
- (11) Implementation checklist
- (12) Cost allocation plan
- (13) Operations Takeover control and management plan

5.4.2 Requirements Analysis

The Contractor is required to conduct an abbreviated operational takeover requirements analysis. The product of this process will be an inventory and assessment of all business and functional requirements that must be accommodated in the takeover phase.

5.4.2.1 DHSS Objectives

It is the objective of DHSS that all functional and technological capabilities provided by the current system and fiscal agent be met by the proposed takeover solution. The Operational Takeover Information System Requirements Analysis must clearly address the current requirements for the Alaska medical assistance programs.

5.4.2.2 DHSS Responsibilities

DHSS responsibilities for the Operational Takeover Requirements Analysis tasks are:

- (1) Provide documentation on the current MMIS.
- (2) Provide access to the State Medicaid Plan.
- (3) Respond to Contractor inquiries related to program policy.
- (4) Provide State resources as agreed to in the detailed operational takeover implementation plan.
- (5) Review draft and final deliverables and provide timely feedback.
- (6) Monitor DOTP activities related to the Operational Takeover Requirements Analysis.
- (7) Review and approve all deliverables from the Operational Takeover Requirements Analysis task.

5.4.2.3 Contractor Responsibilities

Contractor responsibilities for the Requirements Analysis tasks are:

- (1) Update the DOTP to include new information from DHSS and project execution activities.
- (2) Conduct DOTP walkthrough.
- (3) Conduct approach walkthrough.
- (4) Review all current fiscal agent Turnover Plans and Materials and identify any other requirements for support and documentation needed from the current fiscal agent.
- (5) Review and understand all current Alaska MMIS and POS requirements.
- (6) Conduct in-depth analysis of all current user requirements.
- (7) Update the operational takeover approach document, including system takeover and testing with appropriate descriptions, charts and diagrams, for review and approval by DHSS.
- (8) In consultation with the DHSS Project Manager, prepare a schedule for operational takeover MMIS structured walkthroughs (may require travel within or outside the State).
- (9) Update operational takeover MMIS hardware and software platform approach for review and approval by DHSS.
- (10) Conduct operational takeover MMIS requirements structured walkthroughs.
- (11) Obtain DHSS comments and approval on the final operational takeover approach and the hardware/software platform.
- (12) Update the DOTP as advised by DHSS.
- (13) Ensure continued staff availability for the duration of the operational takeover Information Requirements Analysis task.
- (14) Coordinate work activities with the turnover fiscal agent.

5.4.2.4 Milestones

At a minimum, the following milestones must be identified:

- (1) Written approvals of all deliverables from DHSS.
- (2) Written approvals from DHSS to proceed to Takeover Documentation Task.

5.4.2.5 Deliverables

At a minimum, the following deliverables must be included:

- (1) Operational Takeover Requirements Analysis Document, including:
 - (a) Identification of any updates or changes necessary to implement the current data model for the MMIS, POS, and DW/DSS extract, including data elements to be captured in each function, their derivation, source, validation, definition, residence, and use
 - (b) Identification of any updates or changes necessary to implement the current business process models for all MMIS, POS, and DW/DSS extract automated and manual functions, including edits and audits for each of the input and processing systems

- (c) Identification of any updates or changes necessary to implement the current final formats for all input and output documents
 - (d) Identification of any updates or changes necessary to implement the current interfaces and data acquisition
 - (e) Identification of any updates or changes necessary to implement the current recommended cycle times, report formats and frequencies, database updates, etc.
 - (f) Meeting notes from all operational takeover requirements analysis meetings
 - (g) Open items
 - (h) Other issues affecting the Operational Takeover Alaska MMIS implementation and recommended State or Contractor action
- (2) Operational Takeover MMIS architecture document.
 - (3) Hardware/software platform configuration chart.
 - (4) Events and entity relationships.
 - (5) Updated data takeover plan.
 - (6) Updated detailed operational takeover implementation plan.
 - (7) Updated operational takeover test plan.

5.4.3 Takeover Documentation

The Operational Takeover system must be accompanied by accurate, complete, and current documentation. Documentation must be available at critical milestones during the Operational Takeover Phase of the project. The Contractor is responsible for the maintenance of all current system documentation turned over by the current fiscal agent.

The documentation includes all:

- (1) User documentation.
- (2) System documentation.
- (3) Provider and Recipient Services documentation.

The purpose of the user documentation is to provide information on how to access inputs, reports, and screens used in the MMIS and POS systems. The user documentation also includes Operating Procedure documentation. The purpose of the operating procedures is to detail the manual operations of the Contractor and the interface between the manual operations and the system. The purpose of systems documentation is to provide definition, specifications and other detailed information of the MMIS and POS systems. The purpose of provider and recipient services documentation is to provide stakeholders with complete, accurate, and current information to bill and access services provided under the Alaska Medical Assistance programs.

5.4.3.1 DHSS Objectives

Takeover Documentation must continue to provide detailed written information to support users in their daily functions, including operational functions, system functions, and operating functions. Additionally, the documentation must continue to provide detailed written information to support providers to bill and recipients to access the Medical Assistance program services.

5.4.3.2 DHSS Responsibilities

DHSS responsibilities for the Takeover Documentation task are:

- (1) Provide State resources as agreed to in the DOTP.
- (2) Provide access to the State Medicaid Plan.
- (3) Respond to Contractor inquiries related to program policy.
- (4) Review draft and final deliverables and provide timely feedback.
- (5) Monitor DOTP activities related to the Takeover Documentation.
- (6) Review and approve all deliverables from the Takeover Documentation task.

5.4.3.3 Contractor Responsibilities

Contractor responsibilities for the Takeover Documentation tasks are:

- (1) Review all user, system, and provider and recipient documentation turned over by the current fiscal agent.
- (2) Update DOTP tasks based on information from the State.
- (3) Prepare takeover documentation approach and provide a detailed plan to accomplish the approach.
- (4) Update provider and recipient documentation (including all form letters and web site) with the Contractor's billing and contact information.
- (5) Update user documentation to clearly reflect Contractor Operational Takeover Phase processes and procedures.
- (6) Update system documentation to accurately reflect any changes necessary and made to Takeover the Alaska system.
- (7) Prepare all draft and final deliverables.
- (8) Provide walkthrough of all draft and final deliverables.
- (9) Obtain State written approval of all draft and final deliverables.
- (10) Ensure continued staff availability for the duration of the Takeover Documentation task.
- (11) Coordinate work activities with the turnover fiscal agent.

5.4.3.4 Milestones

The following milestones must be identified:

- (1) Walkthrough of the updated DOTP.
- (2) Walkthrough of the Contractor's approach to Takeover Documentation.
- (3) DHSS approval of all takeover documentation task deliverables.
- (4) DHSS approval of takeover approach and tasks for Takeover Documentation.
- (5) Written approval from DHSS to proceed to the System Takeover and Testing Task Deliverables.

5.4.3.5 Deliverables

The following deliverables must be included:

- (1) Updated user documentation.
- (2) Updated system documentation.
- (3) Updated provider and recipient documentation, including all form letters and web site.
- (4) Updated process flow diagrams.

5.4.4 Takeover DW/DSS Extract

The Takeover DW/DSS Extract activities will conform to current operations requirements. The STARS/JUCE DSS was implemented in 1995 and is currently maintained by the State. The Takeover DW/DSS extract must continue to occur without interruption during the takeover implementation and maintenance Phase. The DW/DSS will be used in the testing of the Operational Takeover implementation. The extract and any changes to the extract will be documented during requirements analysis.

5.4.5 System Takeover Testing

The Contractor must propose an approach to testing of the takeover MMIS and POS systems and operations. The proposed testing approach must address all the functionality and operational requirements of the MMIS and POS. The testing approach must be approved by the State and will include unit tests, integration tests, structural tests, acceptance tests, operations tests, pilot tests, and other tests necessary.

In addition, the Contractor must ensure that the Anchorage operations facility will be ready for occupancy including six (6) DHSS staff members, staff from DHSS's consultant, and the current fiscal agent staff who will participate in the testing. This includes provision for space, equipment, furniture, terminals, and LAN/WAN support for all takeover staff.

Key elements that must be addressed in this approach are:

- (1) Test all aspects of the system and operations as proposed in the Contractor's approach to include:
 - (a) Running the tests
 - (b) Producing and reviewing test outputs
 - (c) Submitting final test results to DHSS for approval
 - (d) Providing a weekly report of testing activity, including identification of test status (i.e., passed, failed, rerun)
- (2) Provide system walkthroughs and system demonstrations to State staff and its consultants.
- (3) Demonstrate all on-line system functionality.
- (4) Present all standard output reports.
- (5) Demonstrate that all hardware, software, and teleprocessing linkages are functional and will support the State's requirements.

- (6) Demonstrate functionality of all external interfaces.
- (7) Demonstrate all operations functions.
- (8) Prepare Anchorage facility for occupancy prior to takeover acceptance testing.
- (9) Hire and train at least half of the Contractor's operational takeover staff prior to takeover testing so that the staff can participate in the Takeover Acceptance Test.

5.4.5.1 DHSS Objectives

The testing of the system will be in accordance with the takeover planning documentation approved by DHSS. The system will meet or exceed the functional and technological requirements approved in the takeover analysis activities. Any change in takeover system specifications or timelines must be pre-approved by the DHSS.

5.4.5.2 DHSS Responsibilities

DHSS responsibilities for the System Takeover and Testing activity are:

- (1) Provide State resources as agreed to in the DOTP.
- (2) Support Contractor's effort to establish all communication linkages between various State offices.
- (3) Monitor DOTP activities related to testing.
- (4) Review and approve all deliverables from the Takeover System Testing activity.

5.4.5.3 Contractor Responsibilities

Contractor responsibilities for the Takeover System Testing activity are:

- (1) Update DOTP tasks based on input from the State.
- (2) Conduct DOTP walkthrough.
- (3) Conduct approach walkthrough.
- (4) Provide training to State staff on the access and use of any testing tools, software, and methodologies that may be needed to enable them to participate in submitting test scripts and reviewing test results.
- (5) Perform all approved testing.
- (6) Obtain State approval of testing results before proceeding to the next testing task.
- (7) Test all external and internal interfaces.
- (8) Prepare all draft and final deliverables.
- (9) Provide walkthrough of all draft and final deliverables.
- (10) Obtain State approval of all draft and final deliverables.
- (11) Ensure continued staff availability for the duration of the System Testing activity.
- (12) Prepare Anchorage facility for occupancy, including all required furniture, equipment, supplies and telecommunications linkages.
- (13) Complete Contractor's staffing plan and provide resumes of all key operations staff.

- (14) Hire and train at least half of the Contractor's Alaska operations takeover staff so that this staff can participate in the Takeover Acceptance Test. DHSS encourages the incoming Contractor to hire current fiscal agent staff and work with both the incoming and the current Contractors to assist in the transition of staff.
- (15) Present weekly and monthly status reports to the State.
- (16) Provide the State with on-line capability to review and comment on all problem issues, including the proposed and final resolution.
- (17) Demonstrate system compliance with all timeliness, responsiveness, and accuracy issues.
- (18) Coordinate work activities with the turnover fiscal agent.
- (19) Establish and monitor quality control procedures within the MMIS structure.

5.4.5.4 Milestones

The following milestones must be included:

- (1) DHSS approval of Contractor's takeover system approach.
- (2) DHSS approval of Contractor's takeover system test approach.
- (3) DHSS approval of Contractor's takeover data approach.
- (4) DHSS approval of Contractor's takeover operations approach.
- (5) DHSS approval of the updated user procedures document.
- (6) DHSS approval of the updated operating procedures document.
- (7) DHSS approval of updated provider manuals; recipient booklet; and form letters.
- (8) DHSS approval of Contractor's takeover test results.
- (9) DHSS approval of disaster recovery plan document.
- (10) Occupy facility.
- (11) Hire and train staff.

5.4.5.5 Deliverables

The following deliverables must be included for the State's review and approval:

- (1) Contractor's plan to conduct a comprehensive takeover system test, including testing of all interfaces.
- (2) Contractor's plan to conduct a comprehensive operational test.
- (3) Contractor's plan to conduct a takeover data test.
- (4) Completed takeover test criteria, including expected outcomes.
- (5) Updated documentation.
- (6) Takeover Test results document.
- (7) Draft and final updated provider billing manuals; recipient booklet; and form letters.
- (8) Draft and final updated operating procedures document.

- (9) Draft and final disaster recovery plan and safety plan.
- (10) Updated DOTP.
- (11) Problem tracking and problem resolution document.
- (12) Final hardware and software configuration chart.
- (13) Operations staff list and resumes of all key operations staff.

5.4.6 Provider and Recipient Support Services Takeover

The Contractor will be responsible for ensuring a smooth transition for providers and recipients from the current fiscal agent to the takeover Contractor. This will include training providers in any changes to billing and inquiry processes, notification of new contact and mailing addresses, and testing all electronic interfaces with providers.

5.4.6.1 DHSS Objectives

DHSS's primary objective for provider and recipient support services takeover is to ensure that the transition to new Contractor operations is accomplished with the least disruption to providers, recipients, and State staff. During the transition, the Contractor must provide the notification, training, and support necessary to accomplish this objective.

5.4.6.2 DHSS Responsibilities

DHSS responsibilities for the provider and recipient support services takeover are:

- (1) Approve Contractor's training plan, if necessary, for the provider support services takeover. It will be at the State's discretion to determine the need for provider training.
- (2) Approve the provider notification letters.
- (3) Approve recipient notice and distribution plan.
- (4) Approval of provider training materials, if necessary.
- (5) Approve the Contractor's plan for enhanced support during implementation.
- (6) Approve the Contractor's plan for testing provider electronic interfaces.
- (7) Monitor the training and implementation.

5.4.6.3 Contractor Responsibilities

- (1) Develop and obtain DHSS approval of an initial training plan, if necessary, for all providers.
- (2) Develop and obtain DHSS approval for the enhanced provider support during implementation.
- (3) Develop and obtain DHSS approval of the plan for testing provider interfaces.
- (4) Prepare a letter to all providers notifying them of the change in Contractor and the training (if necessary) to be conducted.
- (5) Prepare a notice to recipients notifying them of the change in Contractor and plan for distribution.

- (6) Prepare initial provider training materials, if necessary.
- (7) Prepare and obtain approval of the provider notification letter and training materials.
- (8) Notify providers of the change in Contractors as approved by the State.
- (9) Obtain DHSS approval and implement plan for notification to recipients of change of Contractor.
- (10) Conduct initial training for providers (if necessary as determined by the State) in the following locations: Anchorage, Fairbanks, Juneau, Kenai/Soldotna, Wasilla/Palmer, Ketchikan, and Bethel.
- (11) Comply with all federal mandates as of the date of signing the contract, such as NPI.
- (12) Test provider interfaces, including conducting the tests, identifying and resolving problems, and re-testing as necessary. Provide a report to DHSS on the testing.
- (13) Provide enhanced provider relations support during the takeover implementation and first six months of operation of the takeover Alaska MMIS. This enhanced support may include:
 - (a) Additional telephone lines and staff to handle increased provider inquiries regarding billing instructions, claims submission, and claim resolution
 - (b) Increased front-end screening to identify and resolve provider billing problems resulting from changed billing practices initiated with the takeover MMIS
 - (c) Distribution of provider bulletins relating to the takeover operations

5.4.6.4 Milestones

- (1) Approval of Contractor's training plan (if necessary as determined by the State) for the provider takeover.
- (2) Approval of provider notification letters and provider training materials.
- (3) Approval of recipient notification and plan for distribution.
- (4) Approval of Contractor's plan for enhanced support during Operational Takeover phase.
- (5) Approval of Contractor's plan for testing provider electronic interfaces.
- (6) Completion of initial provider training, if requested by the State.
- (7) Completion of provider interface testing.

5.4.6.5 Deliverables

- (1) Provider training plan, if requested by the State.
- (2) Provider notification letter.
- (3) Recipient notification and plan for distribution.
- (4) Provider training materials, if requested by the State.
- (5) Enhanced provider support plan.
- (6) Provider interface testing plan.

- (7) Provider interface testing report.

5.4.7 HIPAA Takeover

The Contractor will be responsible for maintaining compliance with the HIPAA requirements for transactions, code sets, NPI, privacy and security, and any other HIPAA requirement federally mandated as of the date of contract signing and as approved by the DHSS. Providers will be free to pursue their independent strategy for use of clearinghouses or other means to make their internal administration HIPAA compliant. Contractor is required to provide information on the HIPAA requirements, options for meeting compliance and maintain the software application and training that would allow providers to transmit HIPAA compliant transactions and NPI. The Contractor is required to thoroughly review the current fiscal agent's HIPAA solution and provide an explanation of its approach to takeover HIPAA responsibilities.

5.4.7.1 DHSS Objectives

DHSS's objective in the HIPAA takeover is to have a smooth transition from the current fiscal agent to the takeover contractor. The Contractor must provide the necessary training and software maintenance to facilitate this transition. The Contractor is also required to maintain data currently stored in the HIPAA translator database and continue to provide uninterrupted access to the database for all State designated users.

5.4.7.2 DHSS Responsibilities

DHSS responsibilities for the provider HIPAA takeover are:

- (1) Provide policy guidance to providers and Contractor on HIPAA regulations.
- (2) Approve Contractor's approach and plan for HIPAA takeover.
- (3) Approve Contractor's training plan for the HIPAA takeover.
- (4) Monitor all HIPAA takeover activities.

5.4.7.3 Contractor Responsibilities

- (1) Describe takeover activities in DOTP.
- (2) Prepare and submit to the DHSS the Contractor's approach and plan for HIPAA takeover.
- (3) Review, takeover, and maintain current claim submission software.
- (4) Review, takeover, and maintain current provider enrollment submission.
- (5) Provide information to providers on options for HIPAA transaction and NPI compliance.
- (6) Provide training to providers on HIPAA transaction compliance and NPI option(s) provided by Contractor.
- (7) Test submission software.

5.4.7.4 Milestones

- (1) DHSS approval of Contractor's approach and plan for HIPAA takeover.

- (2) DHSS approval of Contractor's plan for takeover and maintenance of submission software.
- (3) DHSS approval of Contractor's information and training materials.
- (4) Successful uninterrupted submission and acceptance of HIPAA compliant transactions and NPI.

5.4.7.5 Deliverables

- (1) Contractor's approach and plan for HIPAA takeover, including both Contractor takeover activities and approach to provider technical support.
- (2) Contractor's informational materials to be furnished to providers.
- (3) Contractor's plan for takeover and maintenance of submission software along with description of obstacles and recommendations.
- (4) Updated user manuals for Contractor's HIPAA takeover.
- (5) Training package for providers.

5.4.8 Takeover Operational Readiness and Operability Testing

Takeover Operational Readiness and Operability Tests will focus on testing the Contractor's readiness to assume and start operations in the following areas:

- (1) Hardware and software takeover.
- (2) Hardware operation.
- (3) Data.
- (4) Telecommunications.
- (5) Interfaces.
- (6) Staffing.
- (7) Staff training.
- (8) Provider training, as necessary.
- (9) Enhanced provider support.
- (10) State staff training.
- (11) All system, user, provider and recipient, and operations documentation.
- (12) Facility.
- (13) Toll free and other phone lines.
- (14) Claim forms distribution.
- (15) Mail room operations.
- (16) Imaging operations.
- (17) System security.

- (18) Building security.
- (19) Confidentiality of data.
- (20) Report generation and distribution processes.
- (21) AVR and Voice Response System readiness.
- (22) System backout procedures.

The Takeover Operational Readiness and Operability Test will involve testing all the operations and hardware/software/telecommunications aspects of the system. This test will involve preparing extensive checklists and testing all takeover operational components of the MMIS against these checklists. The Contractor will be responsible for tracking and responding to all problem conditions reported during the Takeover Operational Readiness and Operability Testing and preparing a corrective action plan for problem correction and resolution. The key components of the Takeover Operational Readiness and Operability Testing are:

- (23) Complete takeover operational readiness/operability test plan.
- (24) Schedule staff for the entire test.
- (25) Prepare test environment and load test data sets.
- (26) Complete takeover operational readiness/operability checklist.
- (27) Conduct takeover operational readiness/operability test.
- (28) Implement corrective action plan for all problems identified during takeover operational readiness/operability testing.
- (29) Correct the problems and retest.
- (30) Prepare weekly test results document.
- (31) Monitor takeover operational readiness/operability test results.

5.4.8.1 DHSS Objectives

DHSS, with the help of its consultant, will review and approve the Contractor's comprehensive list of items to be reviewed and tested to ensure complete takeover operations readiness and operability of the system. DHSS wants to ensure that Contractor and the State operations are well tested, that Contractor and State staff are well trained, and that all external and internal interfaces have been fully tested and reconciled before starting the takeover Alaska MMIS. Total staff readiness and total equipment and software operability are critical for a smooth takeover operational implementation. DHSS will require the Contractor to track each issue and problem situation and ensure a quick and timely resolution.

5.4.8.2 DHSS Responsibilities

DHSS's responsibilities for this task are:

- (1) With the assistance of the MMIS procurement consultant, review and approve all takeover operational readiness and operability check-off matrices.
- (2) Respond to Contractor inquiries related to program policy.

- (3) Monitor DOTP activities related to the Takeover Operational Readiness and Operability Testing task.
- (4) Review the takeover operations readiness and operability test results and the list of all outstanding issues and problems resulting from these tests.
- (5) Approve corrective action plans developed by the Contractor.

5.4.8.3 Contractor Responsibilities

At a minimum, the Contractor will have the following responsibilities for this task:

- (1) Develop a comprehensive check-off list of all takeover MMIS start-up tasks and activities.
- (2) Conduct all takeover testing activities and report results to DHSS.
- (3) Provide DHSS assurance that all takeover check-off activities have been satisfactorily completed and signed-off by DHSS.
- (4) Provide walkthroughs as deemed necessary by DHSS.
- (5) Develop and implement a corrective action plan for all outstanding activities for review and approval by DHSS.
- (6) Provide DHSS a “certificate of system fitness” that the takeover system is ready for implementation.
- (7) Develop a comprehensive contingency plan addressing all potential scenarios of implementation problems. Establish a notification tree and designate responsible individuals for each scenario.
- (8) Develop a disaster recovery plan to be in place for the duration of the takeover maintenance period to provide fallback measures in the event of data center or network disasters. Test disaster recovery mechanisms.
- (9) Complete Anchorage takeover facility preparation, including build-out, space renovation, wiring, and telecommunications.
- (10) Ensure facility is ready for occupancy.
- (11) Conduct training for fiscal agent staff.
- (12) Conduct training for State staff.
- (13) Complete plans and begin provider training.
- (14) Obtain a written sign-off from DHSS to begin implementation of the takeover MMIS and POS.

5.4.8.4 Milestones

The following milestones must be included:

- (1) Check off of all takeover hardware test activities.
- (2) Check off of all takeover software test activities.
- (3) Check off of all takeover networking test activities.

- (4) Check off of all takeover training activities.
- (5) Check off of all takeover staffing and staff training activities.
- (6) Signoff of takeover volume test by DHSS.
- (7) Signoff of takeover facility security and data security tests by DHSS.
- (8) Anchorage takeover facility ready for occupancy.
- (9) Complete fiscal agent takeover staff training.
- (10) Complete State staff takeover training.
- (11) DHSS approval of updated operational procedures documents.
- (12) DHSS approval of Contractor's takeover operations readiness.

5.4.8.5 Deliverables

The following deliverables must be included for the State's review and approval:

- (1) Complete checklist matrix for all takeover MMIS hardware.
- (2) Complete checklist matrix for all takeover MMIS software.
- (3) Complete checklist matrix for all takeover MMIS network operations.
- (4) Complete checklist matrix for all takeover MMIS mail room activities.
- (5) Complete checklist matrix for all takeover MMIS training activities.
- (6) Complete checklist matrix for all takeover MMIS interface operations.
- (7) Complete checklist matrix for all takeover MMIS documentation activities.
- (8) Complete checklist matrix for all takeover MMIS functional operations.
- (9) Complete checklist matrix for all takeover provider and recipient support service activities.
- (10) Complete checklist matrix for all MMIS data takeover activities.
- (11) Complete checklist matrix for all takeover MMIS provider certification, provider enrollment, provider manuals, and all provider correspondence related tasks.
- (12) Complete checklist matrix for all takeover MMIS outstanding issues and problems with a plan to correct or resolve these issues.
- (13) Contingency plan addressing scenarios of potential implementation problems.
- (14) Disaster recovery plan.
- (15) Updated operational procedures documents.

5.4.9 Takeover Implementation

The Contractor must ensure that the takeover system is ready to be implemented and that DHSS approvals have been obtained to begin operations of the takeover MMIS and POS. DHSS staff must be given sufficient time to review all system, user, provider and recipient, and security documentation for completeness prior to implementation. The system response time and all user

and automated interfaces must be clearly assessed and operational. A complete file transfer plan must be developed and executed. This plan must identify:

- (1) The name of each file, table or database.
- (2) Destination of takeover data.
- (3) Takeover start and completion times.
- (4) Location and phone numbers of person(s) responsible to execute the takeover.
- (5) A complete fall back plan if the file takeover does not go as planned.

5.4.9.1 DHSS Objectives

DHSS expects the implementation of the takeover system to be transparent to the recipient and the provider community and that all functions and processes work correctly, timely, and efficiently. The response time from the takeover system must be within acceptable limits. All documentation must be current and available to State and Contractor staff to assist them in their new job functions and responsibilities.

5.4.9.2 DHSS Responsibilities

For takeover implementation, DHSS's responsibilities are:

- (1) Provide State resources as agreed to in the DOTP.
- (2) Respond to Contractor inquiries related to program policy.
- (3) Monitor DOTP activities related to the takeover implementation task.
- (4) Review, comment, and if correct, approve all deliverables associated with this task.
- (5) Approve the corrective action plan developed by the Contractor.

5.4.9.3 Contractor Responsibilities

At a minimum, the Contractor will have the following responsibilities for this task:

- (1) Repeat portions of the takeover operability test as requested by DHSS.
- (2) Develop and obtain DHSS approval of an emergency backout strategy.
- (3) Propose organizational changes for DHSS staff to effectively use the takeover MMIS.
- (4) Update all system, user, provider, and operations documentation.
- (5) Update and distribute report distribution schedule.
- (6) Establish production environment.
- (7) Establish hardware, software, and facility security procedures.
- (8) Develop and obtain DHSS approval of production schedule.
- (9) Implement backup and recovery procedures.
- (10) Ensure complete and accurate data takeover.
- (11) Complete all fiscal agent, State, and provider training.

- (12) Ensure that communications between State users and the fiscal agent systems have been established and meet performance requirements.
- (13) Ensure that all system performance monitoring mechanisms are operational.
- (14) Establish and begin mailroom operations.
- (15) Obtain written approval from DHSS to start takeover operations.
- (16) Begin takeover operations.
- (17) Execute any contingency plans that may be necessary upon implementation.

5.4.9.4 Milestones

The following milestones must be included:

- (1) All transfer and takeover activities completed.
- (2) Takeover Operations environment established.
- (3) Security and backup procedures signed off by DHSS.
- (4) Emergency backout plan accepted by DHSS.
- (5) Report distribution schedule approved by DHSS.
- (6) Production schedule approved by DHSS.
- (7) Mailroom procedures reviewed and approved by DHSS.
- (8) Approval to start operations granted by DHSS.
- (9) Completion of all training activities.

5.4.9.5 Deliverables

The following deliverables must be included for the State's review and approval:

- (1) Report distribution schedule.
- (2) Software release plan.
- (3) Results of takeover operational readiness test.
- (4) Emergency backout plan.
- (5) Backup and recovery plan.
- (6) Hardware, software, and facility security manual.
- (7) Certificate that the transfer and takeover is complete and accurate.
- (8) DHSS proposed staffing plan.
- (9) Final operational takeover implementation checklist.
- (10) Final documentation and policy manuals.

5.4.10 Post Takeover Implementation

The Contractor will be required to assign Contractor resources at DHSS's request to conduct a post-takeover implementation evaluation to validate State stakeholder; provider; and recipient service satisfaction.

5.4.10.1 DHSS Objectives

DHSS will require an evaluation of the takeover MMIS operations services after the first 60 days of operation. This analysis will focus on validation and verification that the system and support services are performing consistent with performance standards. The Contractor will have complete responsibility to resolve all problems or deficiencies identified during the evaluation process and will have sole responsibility for any consequential damages resulting from those problems or deficiencies.

5.4.10.2 DHSS Responsibilities

DHSS will assign the project leader for the evaluation team. DHSS will:

- (1) Approve the evaluation team.
- (2) Approve the evaluation plan.
- (3) Manage the evaluation process.
- (4) Review and approve the evaluation report.
- (5) Review and approve the corrective action plan.
- (6) Notify CMS that the system is operational.

5.4.10.3 Contractor Responsibilities

Contractor's responsibilities for the post-implementation evaluation task will be to:

- (1) Provide free access to the evaluation team to review operational and system areas.
- (2) Prepare corrective action plan for problems or deficiencies identified by the evaluation team for review and obtain approval by DHSS.
- (3) Develop the Post Implementation Evaluation Report for review by DHSS.
- (4) Execute the corrective action plan.
- (5) Archive all first-run federally required reports for inclusion in the certification documentation.
- (6) Participate in federal certification review activities, including the CMS site visit.

5.4.10.4 Milestones

The following milestones must be identified:

- (1) Development of the evaluation report.
- (2) Development of the corrective action report.
- (3) Approval of the corrective action report by DHSS.
- (4) Completion of the corrective action plan and sign-off by DHSS.

5.4.10.5 Deliverables

The following deliverables will be produced as part of the takeover post-implementation evaluation task:

- (1) Post-Implementation Evaluation plan.
- (2) Post-Implementation Evaluation report.
- (3) Post-Implementation Corrective action plan.
- (4) Certification manuals for each required system function, including first-run reports for federally-required reports.

5.4.11 Takeover Maintenance

Takeover maintenance encompasses all tasks and activities necessary to maintain operations from takeover implementation until the implementation of the new MMIS, DW/DSS extract support, and POS.

The functional areas are as follows:

- (1) General Requirements
- (2) Recipient Eligibility
- (3) Provider Enrollment and Relations
- (4) Reference Databases
- (5) Prior Authorization
- (6) Reimbursement
- (7) Claims Processing
- (8) Claims Payment
- (9) Financial Services
- (10) Third Party Liability (TPL)
- (11) Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
- (12) Managed Care
- (13) Home and Community-Based (HCB) Waivers
- (14) Pharmacy Point-of-Sale (POS)
- (15) Drug Utilization Review
- (16) Drug Rebate
- (17) Decision Support System (DW/DSS)
- (18) Management and Administrative Reporting (MARS)
- (19) Utilization Review and Quality Assurance
- (20) Fiscal Agent Internal Quality Assurance

- (21) Contract Management
- (22) System Maintenance and Modification
- (23) Other Requirements

Each section within the 1987 Alaska MMIS RFP and amendments describe State responsibilities, Contractor responsibilities, interfacing systems, inputs, outputs and performance standards for the functional areas.

The Contractor is responsible for maintaining the takeover Alaska MMIS from takeover implementation until implementation of the new MMIS, POS, and DW/DSS.

5.5 DDI

This section addresses all tasks and responsibilities associated with the design, development, and implementation of the new Alaska system. DHSS expects the Contractor to present and utilize proven technological and implementation approaches for accomplishing this work, meeting all operational and programmatic requirements, and achieving the State's project schedule. At a minimum, DDI must address the System Development Life Cycle activities described in this section.

The Contractor will be responsible for ensuring that all system modifications or enhancements implemented during Takeover operation of the legacy system are incorporated in the design and development of the new system. If the State opts to not accept a contractor's takeover bid, but does contract for DDI services, the DDI contractor must incorporate in the new system design any modifications or enhancements that are implemented in the legacy system by the current fiscal agent while the DDI phase is being completed.

Requirements relating to documentation and management activities required of the Contractor contained in other sections of this RFP are applicable to the performance and deliverable requirements presented in this section. The State expects that the methods and tools that will be used for on-going operations to support requirements at 5.7 will be integrated into the project during legacy Takeover and will be used during DDI.

5.5.1 Project Management and Reporting

The State will provide oversight of the entire project, but the Contractor must provide overall project management for the tasks under this contract, including the day-to-day management of its staff. The Contractor must exert control to assure completion of all tasks according to the approved Project Plan. The Contractor also must assist the State with coordinating assignments for State staff working on the project.

5.5.1.1 Project Management Methodology

The project management methodology used by the Contractor shall include industry best practices and the functions of Project Management Knowledge Areas contained in the Project Management Institute's Project Management Body of Knowledge (PMBOK). Throughout the project the Contractor must ensure that the comprehensive Project Implementation Plan (PIP) is

developed, executed, maintained, monitored, and reported using MS Project or a similar industry accepted tool. An issue escalation process shall be developed and utilized. The Contractor will work with the State to address any variance in a manner that will assure completion of the project within time and budget constraints.

The Contractor must provide one fulltime Project Manager throughout the project. The Project Manager must be located full-time at the Alaska project site. Requirements for key personnel are defined in section 3.11.

The Contractor must propose a system development methodology (SDM) that is defined, documented, repeatable, and consistent with the Software Engineering Institute (SEI) Level 3 or higher Capability Maturity Model (CMM).

The project scope must include training of the State project team on the Contractor's SDM. The State will provide staff, as it deems appropriate, to perform project monitoring.

5.5.1.2 Project Implementation Plan Baseline

The PIP baseline will be established during the Initiation activity of DDI. Once established, the baseline will be modified through an agreed upon change management process. The approved baseline will be used for all project metrics reporting.

5.5.1.3 Reporting and Project Status Meetings

The Contractor must provide weekly, bi-weekly, and monthly project status reporting and attend regularly scheduled weekly and monthly status meetings. The Contractor Project Manager will be responsible for ensuring that all reporting is accurate, complete, and current. The Contractor's proposed formats and level of detail for all status reporting will be approved by the State.

The Contractor shall be responsible for preparing and distributing meeting agendas, updating all documents with results from status reporting meetings, and preparing meeting minutes, in a format agreed to by the State, within two days following meetings.

5.5.1.3.1 Weekly Status Report and Meeting

Throughout the project, the Contractor Project Manager and appropriate key or primary project staff shall attend weekly meetings with the State Project Manager and other members of the project team. The weekly meetings will follow a preset agenda which will be distributed to regular attendees twenty-four hours before the meeting. Weekly status reports will be distributed with the agenda. Weekly status reports will contain, at a minimum, the following information:

- (1) Executive summary.
- (2) Weekly project metrics (i.e. schedule performance index, schedule variance percent).
- (3) Key issues and their current status.
- (4) Deliverable and milestone reporting.
- (5) Anticipated tasks to be completed in the next week.
- (6) Issues that must be addressed before proceeding with next tasks.

- (7) Updated risk and mitigation planning.
- (8) Status of any testing.

5.5.1.3.2 Bi-weekly Status Reports

In addition to the contents specified for weekly status reports, bi-weekly status reports will include:

- (1) Updated Project Implementation Plan (PIP) and subsidiary Testing Develop Plan (TDP) (2nd and 4th weeks).
- (2) Cost variance report showing the planned value of the work completed to date, the actual cost of the work completed to date, and the variance.
- (3) Scheduled variance report showing the earned value of work completed, planned value of work completed, and the variance.

5.5.1.3.3 Monthly Status Reports

The Contractor shall present a monthly project status report, which is due the second working day following the end of each month during the project. Generally, monthly reports will be prepared from information presented in weekly and bi-weekly reports, including information regarding project hours and expenditures. Monthly reports shall include documentation for presentation to oversight bodies. Monthly status reports must contain the following information:

- (1) Complete set of updates and current output from the project management software including the Project Implementation Plan.
- (2) Description of the overall completion status of the project in terms of the approved project schedule.
- (3) Plans for activities scheduled for the next month.
- (4) Proposed changes to the project schedule if any.
- (5) Deliverable status, with percentages of completion.
- (6) Quality performance report.
- (7) Problems encountered, proposed resolutions, and actual resolutions.
- (8) Analysis of risks anticipated, proposed mitigation strategies, and resolved risks.
- (9) Updates required in the change management strategy.
- (10) Testing status and test results.
- (11) List of change requests.
- (12) Identification of Contractor employees assigned to specific tasks.

5.5.1.3.4 Financial Reporting Requirements

The Contractor shall maintain accounting records relating directly to the performance of this contract. These accounting records shall be maintained in accordance with generally accepted accounting principles. Further, these records shall be maintained separate and distinct from other corporate accounting records.

For the DDI portion of the contract, the Contractor shall maintain, document, and submit quarterly reporting on cost data. The report must include an accounting of all resources expended specifically for the DD&I effort of Alaska, as well as any other expenses attributed to the project, but which may be shared expenses with other projects or accounts. The reports must reasonably identify categories of expenses, and for any expense over \$50,000.00, a specific line item is required. Personnel hours must be recorded at the time incurred for all personnel working on the project, and reported by personnel category. For the operational portions of the contract, at a minimum, the Contractor shall maintain, document, and submit operations cost data in accordance with the State Medicaid Manual, Section 11276.10, whenever required by the State. Documentation shall support and differentiate between contract operations costs for MMIS and non-MMIS services provided by the Contractor that are matchable at the ninety percent (90%) rate, the seventy five percent (75%) rate, other matching percentages, or are attributable to State-funded programs or funding sources.

Authorized representatives or agents of the State and CMS shall have access to the accounting records upon reasonable notice and at reasonable times during the performance and/or retention period of this contract for purposes of review, analysis, inspection, audit, and/or reproduction. Copies of any accounting records pertaining to the contract shall be made available by the Contractor within five (5) calendar days of receiving a written request from the State for specified records. If such original documentation is not made available as requested, the Contractor agrees to provide transportation, lodging, and subsistence at no cost, for DHSS and other State and/or Federal representatives to carry out their audit function at the principal offices of the Contractor or other locations of such records. DHSS and other State and Federal agencies and their respective authorized representatives or agents shall have access to all accounting and financial records of any individual, partnership, firm, or corporation insofar as they relate to transactions with any department, board, commission, institution, or other State or Federal agency connected with this contract.

Financial records pertaining to the entire period of this contract shall be maintained for three (3) years following the end of the Federal fiscal year during which the contract is terminated or State and Federal audits of the contract have been completed, whichever is later. However, accounting records pertaining to the contract shall be retained until final resolution of all pending audit questions and for one (1) year following the termination of any litigation relating to the contract if the litigation has not terminated within the above three-year (3) period. The content of the accounting records and procedures shall be subject to State and Federal approval.

5.5.1.3.5 Financial Records Supplied to the Department

During the entire life of the contract, the Contractor, for itself and all its subcontractors, shall provide the Department with copies of its annual report and all disclosure or reporting Statements or forms filed with the State and/or the Securities and Exchange Commission (SEC) as soon as they are prepared in final form and are otherwise available for distribution or filing. In the event that the Contractor or its subcontractors are not required to or do not prepare either an annual report or SEC disclosure or reporting Statements or forms by virtue of being a subsidiary of another corporation, the Contractor shall fulfill the requirements of this section with respect to all such documents for any parent corporation which reflect, report or include any of their

operations on any basis. Upon the written request of the Project Director, the Contractor, for itself and/or all subcontractors shall furnish the most recent un-audited and audited copies of its Statement of Operations and a Statement of Changes in Retained Earnings within fourteen (14) calendar days of receipt of such request.

5.5.1.3.6 Communications and Meetings

Implementation of a project of this complexity requires daily collaboration of all project participants. Time is critical in communicating issues, solutions, and decisions among the functional, technical, and management resources involved in the project.

5.5.1.3.6.1 Expectations for Communications

Communications between the Contractor and the State shall be open, clear and transparent. State management shall have access to all work processes, documentation, reporting, and resources involved in DDI. Communication between State and Contractor subject matter leads should occur daily as required. Notification regarding requirements for changes in the project schedule and resource availability shall be provided as early as possible. The Contractor must be open in communications during the development of deliverable and system documentation and accommodate State review of document outlines and drafts at any stage of development at the State's request.

5.5.1.3.6.2 Expectations for Meetings and Walkthroughs

The Contractor must conduct participatory meetings and walkthroughs with State staff throughout the project as business and systems requirements are defined during requirements verifications sessions, as deliverables and other system documents are drafted, and as subsequent meetings for requirements gathering and clarification are scheduled. To the extent possible, meetings should be held on a regular schedule, include an agenda, and conclude with a written summary prepared by the Contractor of all decisions and action items, including persons responsible and completion dates.

5.5.2 Deliverable Reviews

The scope of work in this phase has been structured to encourage iterative development of deliverables. Preliminary and draft versions of deliverables are specified in DDI activities with the goal of building a participatory working relationship between the Contractor and the State through which early review will provide immediate feedback on design concepts and content. The objective is to minimize misunderstandings relating to functional and business requirements, simplify the deliverable approval process, and speed development.

“Deliverables” includes all deliverables specified in DDI activities, milestones, key activities such as testing, and other items for which delivery is required under the contract.

5.5.2.1 Presentation of Deliverables

All designs and required deliverables will be presented in writing for formal approval, in accordance with a schedule and format agreed upon by the State and the Contractor. The Contractor is responsible for providing professional deliverables that have received quality assurance review for proper formatting, spelling, punctuation, grammar, contents, and indices.

Each deliverable must be written in a manner that is understandable by relevant State subject matter experts and meeting all business and technical requirements it is intended to achieve.

Version control and documentation requirements specified at 5.7.5.4 and 5.7.5.5 are applicable to DDI deliverables as well as deliverables prescribed for the operations phase of the project.

Deliverables will be accepted at specific locations and times designated by the Project Manager.

5.5.2.2 Disposition of Deliverables

When a deliverable is ready for review by the State, the Contractor shall submit the deliverable, including a Deliverable Transmittal. A Deliverable Transmittal shall be the record of delivery, signed and dated by the Contractor Project Manager and the Quality Manager, where applicable. The Deliverable Transmittal will be the vehicle for communication concerning the status of that Deliverable. The Deliverable Transmittal sets forth the nature and condition of the Deliverable, references to all requirements the deliverable is intended to satisfy, the medium of delivery, the date of delivery, and document tracking identifier. The medium of the Deliverable Transmittal (e.g., paper, fax, electronic), and the project document identification and tracking process shall be agreed to in advance by the State Project Manager.

The State will review deliverables and provide written comments within specified review periods. The State reserves the right to reject any deliverable that does not meet agreed upon standards. Review periods shall be ten (10) business days, provided that, if the deliverable encompasses the full MMIS, or a major component thereof, the review period shall be thirty (30) business days. The State shall provide notice to the Contractor regarding acceptance, conditional acceptance, or rejection of the deliverable by indication on the Deliverable Transmittal, signed by the Project Manager and returned to the Contractor.

5.5.2.2.1 Acceptance

Indicates all requirements are met and no further updates are required.

5.5.2.2.2 Conditional Acceptance

This is designated for use with those deliverables which substantially comply with the requirements but require modification or update in some respect. The State will provide the vendor the specific issues within a deliverable upon completion of the review period (see 5.5.2.2.4).

For deliverables with multiple updates and submission requirements throughout the development cycle, the items requiring modification must be updated and all identified issues resolved with the next submission.

For deliverables with a single submission requirement, the identified modifications must be completed and resubmitted for review and acceptance to the Project Manager as described above in 5.5.2.2.

5.5.2.2.3 Rejection

This indicates that the deliverable did not comply with material requirements and specifications, including quality standards, and/or contained material errors or omissions. A rejected deliverable must be resubmitted for review and acceptance to the Project Manager as described above in 5.5.2.2.

5.5.2.2.4 Deliverable Review and Comment Period

Contractor revisions of a deliverable will be reviewed to confirm completeness and acceptability. Comments and input on deliverables and Contractor revisions will be returned within ten business days of submission by either party. Discussion of deliverables will be scheduled for clarification and to facilitate approval as required.

In specific cases, based on project demands and schedules, additional review and response time may be allowed at the discretion of the Project Manager. Iterative deliverable development coupled with on-going open communications is intended to streamline deliverable review and approval processes.

5.5.2.3 Criteria for Deliverable Reviews

Four areas of analysis will be used to determine the acceptability of deliverables:

- (1) General requirements that the deliverable must meet such as spelling, grammar, punctuation, and formatting. Not all of the general requirements defined below may apply to all deliverables. A deliverable will consist of:
 - (a) A cover page clearly labeled with the Project Name, Deliverable Tracking or Reference Number, Deliverable Version Number, and data
 - (b) A Table of Contents when appropriate
 - (c) Headers and footers are consistent and accurate
 - (d) A Version Control Log when appropriate
 - (e) An Executive Summary when appropriate
 - (f) An accurate list of figures, tables, and illustrations
 - (g) Contains consistent fonts, type sizes, pagination, and page numbers
- (2) Criteria for achieving technical accuracy, completeness, and ensuring that the document meets its intended purpose. The following five items will be reviewed:
 - (a) Correctness: The deliverable is correct in respect to its methodologies, conclusions, and logic
 - (b) Completeness: The deliverable addresses all required objectives and satisfies the full scope required in such a deliverable
 - (c) Accuracy: The deliverable is accurate in fact and computation
 - (d) Consistency: The deliverable is consistent within itself and with other documents that have been submitted

- (e) Readability: The deliverable is clearly written at the appropriate technical level for the expected reader/user of the document
- (3) Specific deliverable content requirements contained in the RFP. Minimal requirements for many deliverables are presented throughout the RFP. The deliverable must contain references to applicable requirements. This includes quality standards reflected in the RFP and Contractor proposal.
- (4) Proper application of industry standards and best practices for particular documents. These standards include:
 - (a) Standards from the Institute of Electrical and Electronic Engineers (IEEE)
 - (b) Capability Maturity Model Integration (CMMI)
 - (c) The Project Management Body of Knowledge (PMBOK)

5.5.3 Project Initiation

During this activity the Contractor shall acquire knowledge of the Alaska medical assistance programs and the detailed requirements of the Alaska MMIS. The Contractor will also review the proposed Project and initial Project Implementation Plans with the DHSS project management staff and update the plans to ensure complete understanding and integration of various implementation activities, tasks and sub-tasks.

Also during this activity the Contractor will install the base transfer system in a Contractor-based hardware and software environment that will remain accessible by State staff for training and to establish a controlled development baseline.

5.5.3.1 DHSS Objectives

The Contractor must ensure that it clearly understands the functional and programmatic requirements of the Alaska MMIS as well as the information access requirements of all users of MMIS data. It must also ensure that the project will progress according to the approved plans and that all requirements of the contract will be met. The Contractor must confirm appointment of the proposed key staff to start and plan the project.

5.5.3.2 Project Initiation Activities

The Contractor must present a structured, efficient, and timely approach to kick-off the project. All project initiation activities outlined in this section should be consistent with the structured system development methodology presented by the proposer. Project Initiation activities will include but not be limited to the following:

- (1) Establish Contractor's DHSS-approved project team that will be responsible to review and define all general project requirements, review and discuss project timelines, make resource assignments, and establish reporting requirements and communication protocols with the DHSS Project Manager and project team.
- (2) Prepare the PIP and initial Testing Development Plan (TDP) with approval from the DHSS Project Manager. The TDP is a subsidiary plan of the PIP and will encompass all DDI activities with qualified resources assigned to each task. Minimum requirements for these plans are presented at 6.2.4.2. The Contractor will assign resource(s) to provide

complete status and an updated copy of the PIP/TDP (in the media identified by DHSS) on the second and fourth Monday of each month.

- (3) Prepare and present a preliminary conversion plan. It is critical that planning and detailing of this activity begin in the early stages of the project. The conversion plan must include MMIS data conversion, DW/DSS data conversion, and provider conversion from current claim submission requirements to the requirements of the new system. The DW/DSS will require heavy conversion, and the State expects a detailed plan covering the methodology for extracting the data from the old system, record and field balancing, conversion and translating schemas, methods for verifying and validating each processing step to the State, and the steps necessary to build, maintain and validate the new DW/DSS.
- (4) Present the updated Project plan and subsidiary management plans to DHSS, and obtain DHSS approval to proceed. Basic requirements for the Project plan are presented at 6.2.3 and 6.2.4.2.
- (5) Establish and use throughout the project a DHSS-approved requirements tracking and project control system for project management and reporting. The requirements tracking tool will be accessible and updatable by DHSS as well as Contractor staff. DHSS will have the option of requiring that licensed copies of the approved project control system be loaded on DHSS machines for its independent monitoring of project control tasks and activities.
- (6) Acquire tools and establish a process for disseminating project status information to DDI project stakeholders; including State staff, service providers, and the community.
- (7) Present a Policy Requirements manual that is a compilation of all State and federal policies, rules, and regulations that establish processing requirements for the Alaska MMIS. These requirements include, as a minimum, reimbursement mechanisms and rates, system audits and edits, recipient eligibility, and provider enrollment. This manual should include:
 - (a) Listing and description of policies and rules categorized by business process functional requirements contained in 5.6
 - (b) For each policy and rule, identification of the system module and program that will address, or be modified to address, the requirement
 - (c) Listing of policies and rules that cannot be categorized by module or program due to unclear documentation
- (8) Prepare and submit a Quality Assurance (QA) plan and supporting procedures for DDI tasks. At a minimum the QA plan must address the following key components:
 - (a) An overview of quality assurance activities and tasks to be performed during DDI
 - (b) Processes and procedures for conducting quality assurance activities, including:
 - i) Project planning development, review, update, and communication
 - ii) Development, review, and approval of all RFP work products and deliverables. This will address a process for accommodating a walkthrough and State review of

- deliverable outline and draft documents to ensure common understanding of the purpose and content of documentation prior to final version delivery
- iii) Execution, documentation and reporting of all testing results
 - iv) Change control management processes that encompass the control of modifications to requirements or defect resolution
 - v) Issue and risk management processes
 - vi) Resource management including the management, tracking, and control of all project resources over time. This will include human and material resources
 - vii) Performance monitoring reviews, measures, and reports cross-project status for project management review and decision making
 - viii) Communication between and among all groups involved in the project
- (c) Procedures for documenting, resolving, and reporting issues and risks identified during quality assurance activities; including problems that may be identified by the State
 - (d) Description of the roles and responsibilities of the Contractor, subcontractors, and the State in performing quality assurance activities and resolving identified problems. This will include identification of the Contractor quality assurance team members and their roles and responsibilities
- (9) Install the transfer system in a Contractor-based hardware and software environment that will support access by State staff. This task is a prerequisite to design and development tasks that follow. Completion of this task will establish a base system training environment for use during the requirements analysis as well as provide a controlled development baseline. The transfer includes acquisition and implementation of the Contractor specified software development tools.
 - (10) Train designated State staff to enable them to understand the new technology proposed by the Contractor in its proposal and transfer system. The training curriculum will be prior-approved by DHSS.
 - (11) Develop a Contractor cost allocation plan in conjunction with State accounting and budgeting staff. This plan will specify the format and accounting definitions that will be used to report costs and expenditures during the project. Financial accounting requirements for this report are described in 5.5.1.3.4.

5.5.3.3 DHSS Responsibilities

DHSS responsibilities for the project initiation activities will be as follows:

- (1) Approve project site.
- (2) Approve project staff.
- (3) Provide access to all current MMIS documentation.
- (4) Provide responses to policy questions.
- (5) Review and approve contract deliverables.

- (6) Review and approve all plans required as part of the standard contract.
- (7) Review and approve project control and status reporting protocols.
- (8) Provide official approval to proceed to the Requirements Analysis Activity upon completion of all Project Initiation task activities.

5.5.3.4 Contractor Responsibilities

Contractor responsibilities for the project initiation activity will be as follows:

- (1) Prepare and submit DDI Facility plan to DHSS for approval. Minimum content requirements: 1.4, 5.7.5.9, 6.2.4.2 (4).
- (2) Prepare and submit Staffing plan to DHSS for approval. Minimum content requirements: 6.2.4.2 (3).
- (3) Prepare and submit the Project Implementation and Testing Development Plan to DHSS for approval. Minimum content requirements: 6.2.4.2 (2).
- (4) Prepare and submit Project Definition Document. Minimum content requirements: 6.2.4.2 (7).
- (5) Present System Development Methodology to DHSS for approval.
- (6) Prepare and submit Policy Requirements Manual to DHSS for approval. Minimum content requirements: 5.5.3.2 (7)
- (7) Prepare and submit preliminary Facility and Data Security plan to DHSS for approval. Minimal content requirements: 5.7.5.3
- (8) Prepare and submit preliminary Disaster Recovery plan to DHSS for approval, including special considerations specific to Alaska, such as earthquakes, volcanic eruptions, and extreme temperatures. Minimum content requirements: 5.7.5.6.
- (9) Prepare and submit preliminary Safety plan to DHSS for approval.
- (10) Prepare and submit preliminary MMIS Data Conversion plan to DHSS for approval. Minimum content requirements: 5.5.8.
- (11) Prepare and submit a Quality Control Assurance plan.
- (12) Prepare and submit preliminary Acceptance Test plan to DHSS for approval. Minimum content requirements: 5.5.9.
- (13) Prepare and submit preliminary Transition plan to DHSS for approval.
- (14) Prepare and submit preliminary Cost Allocation plan to DHSS for approval. Minimum content requirements: 5.5.3.2 (11).
- (15) Prepare and submit equipment and technology acquisition plan to DHSS for approval. Minimum content requirements: 5.7.5.10, 6.2.4.2 (4)(5).
- (16) Prepare and submit documentation standards plan to DHSS for approval. Minimum content requirements: 5.7.5.5, 5.5.2.
- (17) Prepare and submit Project plan to DHSS for approval. Minimum content requirements 6.2.4.2.

- (18) Determine hardware and software requirements for supporting installation of the transfer system for access by State staff and establishing a development environment.
- (19) Review and accept the turnover plan from the current Contractor

5.5.3.5 Milestones

In its PIP/TDP, the proposer must present the milestones and its approach describing how these milestones will be achieved for the project initiation activity. At a minimum, the following milestones must be included:

- (1) Occupation of the Contractor facility.
- (2) Establishment of equipment and linkages between the State and Contractor equipment.
- (3) Installation of the base transfer system.
- (4) Schedule for DHSS sign-off of all deliverables related to this activity.
- (5) Written approval by DHSS to proceed to the next activity.

5.5.3.6 Deliverables

At a minimum, the following deliverables must be included:

- (1) DDI Facility plan
- (2) Staffing plan
- (3) Quality Assurance Plan
- (4) Project Implementation Plan
- (5) Testing and Development Plan
- (6) Project Definition Document
- (7) System Development Methodology
- (8) Policy Requirements Manual
- (9) Facility and Data Security Plan
- (10) Disaster Recovery Plan
- (11) Safety Plan
- (12) Data Conversion Plan
- (13) Acceptance Test Plan
- (14) System transfer Plan
- (15) Cost Allocation Plan
- (16) Equipment and Technology Acquisition Plan
- (17) Documentation Standards Plan
- (18) Project Plan

5.5.4 Requirements Analysis

The proposer must describe the proposed system development methodology, the type of tools planned for use, and how these tools will assist the State of Alaska in installing a State-of-the-art MMIS in accordance with MITA principles and guidelines.

In preparation for this RFP, DHSS conducted a requirements development effort in light of the Alaska State Information Technology Plan and Enterprise Architecture (<http://www.State.ak.us/local/akpages/ADMIN/info/plan/>) that resulted in a business process model reflective of DHSS's current operations and the functional requirements described in section 5.6.

The Contractor will be required to conduct requirements verification sessions at the Alaska site; however, during the requirements analysis, DHSS may send up to ten (10) DHSS staff members to the Contractor's facility, which may be outside of Alaska, for up to two or three weeks if requested by the Contractor. Expenses for State staff travel, accommodations, and per diem will be paid by DHSS.

During Requirements Analysis, the Contractor must perform a MITA assessment. This deliverable will explain the approach to mapping the DHSS functional requirements to the MITA business capabilities (MITA Volume 2) and the associated technical capabilities that the proposed system is capable of supporting, resulting in the DHSS target MITA capabilities. The Contractor must specify the MITA Maturity Levels that these capabilities represent and explain why the system meets those levels with respect to each capability.

Successful MMIS implementation is dependent upon business transformation that accommodates the needs of staff, improves business processes, and utilizes current technology. A major task of this procurement effort will be preparing users for new ways of performing their business through the use of a new system and interaction with a new Contractor. DHSS will work with the Contractor to manage these changes and minimize the impact that transitioning to a new system can have on staff and stakeholders. During the Requirements Analysis, the Contractor must prepare a plan that describes how the Contractor will facilitate this transformation.

5.5.4.1 DHSS Objectives

It is the objective of DHSS that all functional and technological requirements outlined in this RFP are met by the proposed MMIS in accordance with MITA principles and guidelines. The Contractor must also develop an approach for managing business process transformation that will occur as a result installing a new system. The Requirements Analysis must clearly address the requirements for the Alaska medical assistance programs.

5.5.4.2 DHSS Responsibilities

DHSS responsibilities for the Requirements Analysis tasks are:

- (1) Provide documentation on the current MMIS.
- (2) Provide access to the State Medicaid Plan.
- (3) Provide access to the State Enterprise Architecture policies, guidelines, and standards as appropriate.
- (4) Respond to Contractor inquiries related to program policy.
- (5) Provide State resources as agreed to in the Testing and Development.
- (6) Review draft and final deliverables and provide timely feedback.
- (7) Monitor PIP/TDP activities related to the Requirements Analysis.
- (8) Review and approve all deliverables from the Requirements Analysis task.

5.5.4.3 Contractor Responsibilities

Contractor responsibilities for the Requirements Analysis tasks are:

- (1) Update PIP/TDP tasks based on information from DHSS.
- (2) Conduct PIP/TDP walkthrough.
- (3) Conduct approach walkthrough.
- (4) Become familiar with Alaska DHSS programs, policies, services and administration, as well as existing MMIS requirements through interviews with State staff and documentation review.
- (5) Conduct in-depth requirements verification (RV) sessions and follow-up interviews with State staff to define and finalize requirements ensuring that all requirements contained in the RFP are fully addressed. RV sessions will include demonstration of the Contractor's base system proposed for transfer to Alaska.
- (6) Conduct a walkthrough and educate State staff regarding transfer system reporting conceptual equivalency.
- (7) Prepare appropriate requirements analysis documentation.
- (8) Conduct a MITA Assessment and prepare report.
- (9) Prepare a preliminary MMIS structure (including all internal and external interfaces) with appropriate descriptions, charts and diagrams, for review by DHSS and other State entities and for approval by DHSS.
- (10) Prepare a Business Transformation/Cultural Change Management Plan.
- (11) In consultation with the DHSS Project Manager, prepare a schedule for MMIS structured walkthroughs (may require travel within or outside the State).
- (12) Prepare MMIS hardware and software platform for review and approval by DHSS.
- (13) Conduct MMIS requirements structured walkthroughs.

- (14) Obtain DHSS comments and approval on the final MMIS structure and the hardware/software platform.
- (15) Ensure continued staff availability for the duration of the Information Requirements Analysis task.
- (16) Coordinate work activities with the incumbent Contractor if applicable.

5.5.4.4 Milestones

At a minimum, the following milestones must be identified:

- (1) Written approvals of all deliverables from DHSS.
- (2) Written approvals from DHSS to proceed to Systems Design Task.

5.5.4.5 Deliverables

At a minimum, the following deliverables must be included:

- (1) Requirements Analysis Document, including:
 - (a) Executive Summary of the process used to complete the analysis and significant results
 - (b) Overview of all business processes identified and documented; including initial business process models for all MMIS and DW/DSS automated and manual functions
 - (c) Presentation of the design requirements and the system architecture that integrates system components
 - (d) Presentation of a gap analysis describing the system design that supports requirements or modifications necessary to complete the project; including, a traceability matrix that links RFP requirements as well as requirements identified during requirements verification sessions with system entities and processes
 - (e) Overview of all interfaces and data acquisition
 - (f) Formats for all input and output documents
 - (g) High-level data flow diagrams
 - (h) Initial data model for the entire MMIS and DW/DSS, including data elements to be captured in each function, their derivation, source, validation, definition, residence, and use
 - (i) Recommended cycle times, report formats and frequencies, database updates, etc.
 - (j) Meeting notes from all requirements analysis meetings
 - (k) Open items
 - (l) Other issues affecting the Alaska MMIS implementation and recommended State or Contractor action
- (2) MITA Assessment Report. This assessment must include:
 - (a) Business View Mapping. Evaluation of DHSS systems mapped to business areas within the MITA Business Capability Matrix

- (b) Technical View Mapping. Evaluation of the proposed system against the MITA Technical Capability Matrix
 - (c) Identification of additional MMIS capabilities, business and technical, not included in the MITA Capability Matrix. Use operational definitions present in the MITA Maturity Model.
 - (d) Mapping of the new system to the MITA Maturity Model. Explain the basis for this mapping
 - (e) Identification of capabilities at higher levels of the MITA Maturity Model that best align with the State's Medicaid goals and will be the most beneficial. Prioritize the top five opportunities
 - (f) Prepare an outline of a plan that can be used to modify the system and increase MITA Maturity Levels
- (3) Business Transformation/Cultural Change Management Plan. This plan must include:
- (a) Description of the Contractor's approach to performing business and cultural change processes; including, review of existing processes and documentation, development of future business models, completion of gap analyses, preparation of migration plans, and provision of necessary training
 - (b) Description of the approach used to manage the business and cultural transition process including identification of deliverables and tasks to be included in project planning and scheduling documents
 - (c) Description of the approach that will be used to communicate the scope and schedule for transition to stakeholders
 - (d) Identification of Contractor and State responsibilities in the transition process
 - (e) Methods used to ensure State approval and buy-in to the transition process
- (4) Description of the hardware/software platform configuration that will be used for MMIS and DW/DSS processing
- (5) Updated Data Conversion plan
- (6) Updated PIP/TDP
- (7) Updated Acceptance Test plan

5.5.5 Systems Design

At a minimum, the MMIS system design must meet the requirements described in section 5.7.5.5.3.1 Detailed System Design (DSD).

5.5.5.1 DHSS Objectives

The proposed Systems Design must address all the functional and operational requirements of the Alaska MMIS. DSD documentation will incorporate all requirements addressed during the requirements verification sessions, as well as findings documented through follow-up sessions involving State and Contractor staff. The Contractor is responsible for ensuring that all changes incorporated in the legacy system during Takeover and Takeover operation are developed and

included in the design of the new system. The system must be fully certifiable by CMS and must provide for all defined data and information access requirements of DHSS and provider groups across the State. The system must provide seamless interfaces with State and Federal agencies providing or using MMIS data. The system must meet all the security and backup requirements mandated by State and CMS regulations or policies.

5.5.5.2 DHSS Responsibilities

DHSS responsibilities for the Systems Design task are:

- (1) Provide State resources as agreed to in the PIP/TDP.
- (2) Provide access to the State Medicaid Plan.
- (3) Respond to Contractor inquiries related to program policy.
- (4) Review draft and final deliverables and provide timely feedback.
- (5) Monitor PIP/TDP activities related to the System Design.
- (6) Review and approve all deliverables from the System Design task.

5.5.5.3 Contractor Responsibilities

Contractor responsibilities for the Systems Design tasks are:

- (1) Prepare Detailed System Design.
- (2) Update PIP/TDP tasks based on information from the State.
- (3) Conduct PIP/TDP walkthrough.
- (4) Conduct approach walkthrough.
- (5) Prepare acceptance test criteria and data sets for testing, and submit to DHSS for approval. Once the data sets have been approved, the Contractor may use the same data sets for all testing activities.
- (6) Prepare all draft and final deliverables.
- (7) Provide walkthrough of all draft and final deliverables.
- (8) Obtain State approval of all draft and final deliverables.
- (9) Ensure continued staff availability for the duration of the System Design task.
- (10) Coordinate work activities with the incumbent Contractor.

5.5.5.4 Milestones

At a minimum, the following milestones must be identified:

- (1) Walkthrough of the updated PIPTDP.
- (2) Walkthrough of the Contractor's Detailed Systems Design.
- (3) DHSS approval of all design task deliverables.
- (4) DHSS approval of test criteria and data sets.
- (5) Written approval from DHSS to proceed to the Development and Testing Tasks.

5.5.5.5 Deliverables

At a minimum, the following deliverables must be included:

- (1) Produce System Design documents as defined at 5.7.5.5.3.1; including updated versions of documentation presented during requirements analysis.
 - (a) Network topology map and requirements for interfacing with other systems
 - (b) Design overview document
 - (c) MMIS Data Dictionary (5.7.5.5.3.3)
 - (d) Entity Relationship diagrams
 - (e) Internal data structures and data flow diagrams
 - (f) Process flow diagrams
 - (g) Edit and audit rules
 - (h) Business information model
 - (i) Information system model
- (2) Test criteria and data sets.
- (3) Updated PIP/TDP plans.

5.5.6 DW/DSS Development and Implementation

The DW/DSS Development and Implementation activities will conform to the requirements for the MMIS Development and Implementation. The main difference is that the schedule for development and implementation will ensure that the DW/DSS becomes operational as soon as possible after design of the system is approved. The Contractor will serve as system integrator for the DW/DSS and must coordinate with all the appropriate agencies for infrastructure/hardware and software procurement, data acquisition, installation and testing, and the resolution of communications and interface problems.

5.5.6.1 DHSS Objectives

The development and testing of the DW/DSS proposed system will be in accordance with the Detailed System Design approved by DHSS. The developed system will meet or exceed the functional and technological requirements prior-approved in the analysis and design activities. All development and testing work must be completed according to the State-approved implementation plan. Although the State and its consultant resources will be available for consultations, the Contractor should not rely heavily on the availability of State or consultant resources for the System Development and Testing activity. Any change in system specifications or timelines must be prior-approved by DHSS.

5.5.6.2 DHSS Responsibilities

DHSS responsibilities for the DW/DSS Development and Testing activity are:

- (1) Provide State resources as agreed to in the PIP/TDP.
- (2) Support Contractor's effort to establish all communication linkages between various State offices.

- (3) Monitor PIP/TDP activities related to DW/DSS Development and Testing.
- (4) Review and approve all deliverables from the Development and Testing activity phases.
- (5) Ensure that all designated State resources are present for training as scheduled in the project plan.

5.5.6.3 Contractor Responsibilities

Contractor responsibilities for the Development and Testing activity are:

- (1) Update PIP/TDP tasks based on input from the State.
- (2) Conduct PIP/TDP walkthrough.
- (3) Conduct approach walkthrough for the installation and enhancement, and development of the DW/DSS system in accordance with State-approved design specifications and deliverable requirements at 5.5.6.5 (1). This deliverable is due no later than sixty (60) calendar days after initiation of DDI..
- (4) Provide a dedicated in-house trainer to support all functional, user-oriented, and integrated training.
- (5) Develop DW/DSS training materials. Materials are to include workshops, on-going professional development (basic user to more experienced user specific training), and periodic re-training as defined by the State.
- (6) Respond to DHSS requests for information concerning the operation of DW/DSS system and production of ad hoc reports.
- (7) Perform all functional and integrated testing during the Development and Testing phases.
- (8) Before performing integration testing, obtain State approval of all functionality testing.
- (9) Develop and test all external and internal interfaces.
- (10) Prepare all draft and final deliverables.
- (11) Provide walkthrough of all draft and final deliverables.
- (12) Obtain State approval of all draft and final deliverables.
- (13) Ensure continued staff availability for the duration of the Development and Testing activity.
- (14) Complete Contractor's staffing plan and provide resumes of all key operations staff.
- (15) Hire and train at least half of the Contractor's DW/DSS Alaska operations staff so that this staff can participate in the Acceptance Test of the DW/DSS. DHSS encourages the incoming Contractor to hire current fiscal agent staff, and will work with both the incoming and the incumbent Contractors to assist in the transition of staff.
- (16) Present weekly and monthly status reports to the State.
- (17) Provide the State with on-line capability to review and comment on all problem issues, including the proposed and final resolution.
- (18) Demonstrate system compliance with all timeliness, responsiveness, and accuracy issues.

- (19) Provide walkthrough of procedure documents, operations documents, provider documents, system documents, conversion test results, security documents, and disaster recovery plans.
- (20) Coordinate work activities with the incumbent Contractor.
- (21) Establish and monitor quality control procedures within the MMIS structure.

5.5.6.4 Milestones

At a minimum, following milestones must be included:

- (1) DHSS approval of Contractor's test plan.
- (2) DHSS approval of the user procedures document.
- (3) DHSS approval of the training material and plan.
- (4) DHSS approval of the operating procedures document.
- (5) DHSS approval of Contractor's test results.
- (6) DHSS approval of disaster recovery plan document.
- (7) Occupy facility.
- (8) Hire and train staff.
- (9) Provide end-user (DHSS) training.

5.5.6.5 Deliverables

At a minimum, the following deliverables must be included for the State's review and approval:

- (1) DW/DSS System Design Document - This deliverable shall include (1) a summary of the overall DW/DSS System; (2) a detailed System description (including description and specification for machine and user interfaces, record programs, reusable modules, objects, files and databases, procedures, System and user documentation, user training, and data dictionary); (3) descriptions of DW/DSS System controls; (4) a recommended System design and programming alternative (if any); (5) program design techniques and standards; (6) implementation techniques; and (7) a preliminary Structured System test plan and preliminary Operational Readiness and Operability testing support plan.
- (2) Contractor's plan to conduct a comprehensive system test, including testing of all interfaces.
- (3) Completed test criteria and test cases, including expected outcomes.
- (4) System user manuals.
- (5) Training Plan and material.
- (6) Test results document.
- (7) Draft and final operating procedures document.
- (8) Draft and final disaster recovery plan and safety plan.
- (9) Updated PIP/TDP.

- (10) Problem tracking and problem resolution document.
- (11) Final hardware and software configuration chart(s).
- (12) Operations staff list and resumes of all key operations and training staff.

5.5.7 MMIS Development and Testing

The new system will be installed and developed on the Contractor's hardware. All application development must be structural, modular, and use the technology and hardware/software platform approved by the State of Alaska. The Contractor will use its own hardware and software resources to develop the system. The Contractor will ensure that the development will be based on the State-approved Detailed System Design and will comply with all current State and federal requirements.

Key elements associated with this task are:

- (1) Ensure that the developed solution meets design criteria and satisfies the intended purpose.
- (2) Install and enhance or modify components of the proposed system according to the specifications developed and approved by the State in the Systems Design Task.
- (3) Developing and testing all aspects of the system both in a "unit test" mode and the "integration test" mode including:
 - (a) Running the tests
 - (b) Producing and reviewing test outputs
 - (c) Submission of successful test results to DHSS for approval
 - (d) Providing a weekly report of testing activity and status, including identification of test status (i.e., passed, failed, rerun)
- (4) Provide system walkthroughs and system demonstrations to State and designated staff.
- (5) Present all standard output reports.
- (6) Demonstrate that all hardware, software, and teleprocessing linkages are functional and will support the State's requirements.
- (7) Demonstrate functionality of all external interfaces.
- (8) Prepare Anchorage facility for occupancy prior to acceptance testing. The Anchorage operations facility will accommodate twelve (12) DHSS staff members and the fiscal agent staff who will participate in the Acceptance Test. This includes provision for space, equipment, furniture, terminals, and LAN/WAN support for all staff.
- (9) Hire and train at least half of the Contractor's operations staff prior to acceptance testing so that the staff can participate in the Acceptance Test.

5.5.7.1 DHSS Objectives

The development and testing of the proposed system will be in accordance with the Detailed System Design approved by DHSS, and the developed system will meet or exceed the functional and technological requirements prior-approved in the analysis and design activities. All development and testing work must be completed according to the State-approved implementation plan. Any change in system specifications or timelines will not be accepted unless prior-approved by the DHSS.

5.5.7.2 DHSS Responsibilities

DHSS responsibilities for the MMIS Development and Testing activity are:

- (1) Provide State resources as agreed to in the PIP/TDP.
- (2) Support Contractor's effort to establish all communication linkages between various State offices.
- (3) Monitor PIP/TDP activities related to MMIS Development and Testing.
- (4) Review and approve all deliverables from the Development and Testing activity phases.
- (5) Ensure that all designated State resources are present for training as scheduled in the project plan.

5.5.7.3 Contractor Responsibilities

Contractor responsibilities for the Development and Testing activity are:

- (1) Update PIP/TDP tasks based on input from the State.
- (2) Conduct PIP/TDP walkthrough.
- (3) Conduct approach walkthrough.
- (4) Install and enhance, or develop the system in accordance with State approved design specifications.
- (5) Perform all functional and integrated testing during the Development and Testing task.
- (6) Develop and test all external and internal interfaces.
- (7) Prepare all draft and final deliverables.
- (8) Provide walkthrough of all draft and final deliverables.
- (9) Obtain State approval of all draft and final deliverables.
- (10) Ensure continued staff availability for the duration of the Development and Testing activity.
- (11) Complete Contractor's staffing plan and provide resumes of all key operations staff.
- (12) Hire and train at least half of the Contractor's Alaska operations staff so that this staff can participate in the Acceptance Test of the system. DHSS encourages the incoming Contractor to hire current fiscal agent staff, and will work with both the incoming and the incumbent Contractors to assist in the transition of staff.
- (13) Present weekly and monthly status reports to the State.

- (14) Provide the State with on-line capability to review and comment on all problem issues, including the proposed and final resolution.
- (15) Demonstrate system compliance with all timeliness, responsiveness, and accuracy issues.
- (16) Provide walkthrough of procedure documents, operations documents, provider documents, system documents, conversion test results, security documents, and disaster recovery plans.
- (17) Coordinate work activities with the incumbent Contractor.
- (18) Establish and monitor quality control procedures within the MMIS structure.

5.5.7.4 Milestones

At a minimum, following milestones must be included:

- (1) DHSS approval of Contractor's test plan.
- (2) DHSS approval of the user procedures document.
- (3) DHSS approval of the training material and plan.
- (4) DHSS approval of the operating procedures document.
- (5) DHSS approval of Contractor's test results.
- (6) DHSS approval of Emergency Procedures and Disaster Recovery Plan document.

5.5.7.5 Deliverables

At a minimum, the following deliverables must be included for the State's review and approval:

- (1) Contractor's plan to conduct a comprehensive system test, including all interfaces associated and dependent systems.
- (2) Completed test criteria and test cases, including expected outcomes.
- (3) System user manuals.
- (4) Training Plan and material.
- (5) Test results delineating results, development cycles, and outcomes.
- (6) Draft and final provider handbooks.
- (7) Draft and final operating procedures document.
- (8) Draft and final emergency procedures, disaster recovery plan and safety plan.
- (9) Updated PIP/TDP.
- (10) Problem tracking and problem resolution document.
- (11) Final hardware and software configuration chart(s).
- (12) Operations staff list and resumes of all key operations and training staff.
- (13) Draft transition plan.

5.5.8 Conversion

DHSS views conversion as one of the critical activities in the entire implementation process. The conversion effort includes but is not limited to four (4) major activities: MMIS data conversion, DW/DSS data conversion, HIPAA data conversion, and provider conversion. The proposer must outline, in detail, its plan to ensure that all conversion tasks result in an accurate and timely conversion. All conversion steps must be clearly defined and documented. The proposal must include the staffing needs for this activity along with a contingency plan if conversion cannot be accomplished timely and accurately. At a minimum, the proposal must outline the following approaches in detail:

- (1) Approach to identify all system files, tables, and interface files to be converted.
- (2) A data mapping approach that addresses every data element in all components of the current system (all data elements contained in MMIS, HIPAA data, POS date files, and DW/DSS interface files), linking them to populate the new system appropriately.
- (3) Approach to correct error situations in the existing data and new data.
- (4) Approach to resolve data inconsistencies and missing data situations.
- (5) Approach to automated and manual conversion effort.
- (6) Contingency plan.

5.5.8.1 DW/DSS Data Conversion

The Contractor will be required to convert claims history and other supporting data for use in the DW/DSS. Claims data must be converted from the DHSS approved claims history files.

5.5.8.1.1 DHSS Objectives

The Contractor must ensure that conversion activities start early in the implementation phase, are error free, and are completed on time. The planning and execution of the conversion activity must be comprehensive and well documented. The new databases must be able to distinguish converted data from new data and all converted data must be date stamped. All data mapping and conversion modules must be well documented to research any conversion problems uncovered during the operations phase.

5.5.8.1.2 DHSS Responsibilities

DHSS responsibilities for the DW/DSS conversion task are:

- (1) Provide State resources as agreed to in the Conversion Plan (CP).
- (2) Assist the Contractor in identifying the source(s) of data for the DW/DSS.
- (3) Respond to Contractor inquiries related to program policy and MMIS and DW/DSS data.
- (4) Monitor CP activities related to the conversion of data.
- (5) Review and approve mapping documents and other deliverables from the DW/DSS conversion.

5.5.8.1.3 Contractor Responsibilities

Contractor responsibilities for the conversion task are:

- (1) Prepare a list of all DWDSS conversion input and conversion output files.
- (2) Coordinate work activities with the incumbent Contractor.
- (3) Identify all the data requirements as well as the source of data for the new DSS.
- (4) Develop a DW/DSS conversion plan and provide State walkthroughs.
- (5) Develop DW/DSS default values and new data requirements, and provide State walkthroughs.
- (6) Develop staffing plan to accomplish all DW/DSS conversion activities.
- (7) Develop and test DW/DSS conversion modules.
- (8) Conduct pre-production DW/DSS conversion run and identify problems or deficiencies.
- (9) Update and submit CP.
- (10) Update PIP/TDP.

5.5.8.1.4 Milestones

At a minimum, the following milestones must be included:

- (1) DHSS approval of Contractor's DW/DSS conversion plan.
- (2) DHSS approval of Contractor's DW/DSS conversion mapping document.
- (3) DHSS approval of the plan to create/populate manual data.
- (4) DHSS approval of the DW/DSS conversion test document.
- (5) DHSS approval of updated CP.
- (6) DHSS approval of DW/DSS conversion test results document.

5.5.8.1.5 Deliverables

At a minimum, the following deliverables must be included for the State's review and approval:

- (1) DW/DSS conversion test plan.
- (2) DW/DSS conversion mapping document.
- (3) Comprehensive list of DW/DSS input files and tables.
- (4) DW/DSS conversion module specifications.
- (5) DW/DSS conversion test results document.
- (6) DW/DSS conversion problem tracking and problem resolution document.
- (7) Updated PIP/TDP.

5.5.8.2 MMIS and HIPAA Data Conversion

The Contractor will be required to convert recipient, provider, reference, claims, and other data from the current MMIS to the new MMIS system, the HIPAA database and translator including conversion required for the POS system.

5.5.8.2.1 DHSS Objectives

The Contractor must ensure that MMIS conversion activities start early in the implementation phase, are completely error free, and are completed on time. The planning and execution of the conversion activity must be comprehensive and well documented. The new databases must be able to distinguish converted data from new data and all converted data must be date stamped. All data mapping and conversion modules must be well documented to research any conversion problems uncovered during the operations phase.

5.5.8.2.2 DHSS Responsibilities

DHSS responsibilities for the MMIS conversion task are:

- (1) Provide State resources as agreed to in the CP.
- (2) Assist the Contractor in identifying the source(s) of data for all MMIS/POS/HIPAA databases.
- (3) Respond to Contractor inquiries related to program policy and MMIS data.
- (4) Monitor CP activities related to the conversion of data.
- (5) Review and approve mapping documents and other deliverables from the MMIS conversion activity.

5.5.8.2.3 Contractor Responsibilities

Contractor responsibilities for the MMIS conversion task are:

- (1) Prepare a list of all conversion input and conversion output files.
- (2) Coordinate work activities with the incumbent Contractor.
- (3) Identify all the data requirements as well as the source of data for the new databases.
- (4) Develop an MMIS conversion plan and provide State walkthroughs.
- (5) Develop default values and new data requirements for all MMIS databases, and provide State walkthroughs.
- (6) Develop staffing plan to accomplish all MMIS conversion activities.
- (7) Develop and test MMIS conversion modules.
- (8) Conduct pre-production MMIS conversion run and identify problems or deficiencies.
- (9) Update and submit CP.
- (10) Update PIP/TDP.

5.5.8.2.4 Milestones

At a minimum, the following milestones must be included:

- (1) DHSS approval of Contractor's MMIS conversion plan.
- (2) DHSS approval of Contractor's MMIS conversion mapping document.
- (3) DHSS approval of the plan to create/populate manual data.
- (4) DHSS approval of the MMIS conversion test document.
- (5) DHSS approval of updated CP.
- (6) DHSS approval of MMIS conversion test results document.

5.5.8.2.5 Deliverables

At a minimum, the following deliverables must be included for the State's review and approval:

- (1) MMIS conversion test plan.
- (2) MMIS conversion mapping document which must account for every data element in the system.
- (3) Comprehensive list of MMIS/POS input files and tables.
- (4) MMIS conversion module specifications.
- (5) MMIS conversion test results documentation.
- (6) MMIS conversion problem tracking and problem resolution document.
- (7) Updated PIP/TDP.

5.5.8.3 Provider Conversion

The Contractor will be responsible for ensuring a smooth transition for providers from the current system to the new MMIS. This will include training providers in any changes to billing and inquiry procedures and testing all electronic interfaces with providers.

5.5.8.3.1 DHSS Objectives

DHSS's primary objective for provider conversion is to ensure that the conversion to the new system provides the least disruption to providers. During the transition, the Contractor must provide the training and provider support necessary to accomplish this objective. In addition, the Contractor will test provider interfaces for claims submission and inquiry.

5.5.8.3.2 DHSS Responsibilities

DHSS responsibilities for the provider conversion are:

- (1) Approve Contractor's training plan for the provider conversion.
- (2) Approve the provider notification letters and provider training materials.
- (3) Approve the Contractor's conversion plan.
- (4) Approve the Contractor's plan for enhanced support during implementation.
- (5) Approve the Contractor's plan for testing provider electronic interfaces.
- (6) Monitor the training and implementation.

5.5.8.3.3 Contractor Responsibilities

- (1) Develop and obtain DHSS approval of an initial training plan for all providers.
- (2) Develop and obtain DHSS approval of the plan for conversion of all providers.
- (3) Development and obtain DHSS approval for the enhanced provider support during implementation.
- (4) Develop and obtain DHSS approval of the plan for testing provider interfaces.
- (5) Prepare a letter to providers notifying them of the change in Contractor and the training to be conducted.
- (6) Prepare initial provider training materials.
- (7) Prepare and obtain approval of the provider notification letter and training materials.
- (8) Notify providers of the change in Contractors.
- (9) Conduct initial training for providers in all locations listed in Section 5.6.4.3.15 (1).
- (10) Test provider interfaces, including conducting the tests, identifying and resolving problems, and re-testing as necessary. Provide a report to DHSS on the testing.
- (11) Provide enhanced provider relations support during the implementation and first six months of operation of the Alaska MMIS. This enhanced support may include:
 - (a) Additional telephone lines and staff to handle increased provider inquiries regarding new billing instructions, claims submission, and claim resolution
 - (b) Increased front-end screening to identify and resolve provider billing problems resulting from new billing practices initiated with the MMIS
 - (c) Distribution of provider bulletins relating to start up of operations.

5.5.8.3.4 Milestones

- (1) Approval of Contractor's training plan for the provider conversion.
- (2) Approval of provider notification letters and provider training materials.
- (3) Approval of Contractor's conversion plan.
- (4) Approval of Contractor's plan for enhanced support during implementation.
- (5) Approval of Contractor's plan for testing provider electronic interfaces.
- (6) Completion of initial provider training.
- (7) Completion of provider conversion.
- (8) Completion of provider interface testing.

5.5.8.3.5 Deliverables

- (1) Provider training plan.
- (2) Provider notification letter.
- (3) Provider training materials.

- (4) Provider conversion plan.
- (5) Enhanced provider support plan.
- (6) Provider interface testing plan.
- (7) Provider interface testing report.
- (8) Updated staffing plan for the operations phase
- (9) Updated PIP/TDP.

5.5.9 Acceptance Testing

The Contractor will be responsible for Acceptance Testing of the entire MMIS, including the POS, DW/DSS, HIPAA database and translator, and any other component to ensure that the entire solution has been rigorously tested. The acceptance test will also examine the completeness and accuracy of conversion and interface file processing. Testing should be a collaborative activity between the Contractor and the State with the common goal of ensuring the system meets the operational and technical requirements of the State.

The Contractor will provide a Requirements Cross-Reference Matrix that links the unit and system test case scenarios and test cases designed to demonstrate that RFP requirements are met. This automated tool will be updated routinely as test cases are developed and executed and will be available to State staff for monitoring testing results.

Acceptance Testing will take place in both Anchorage and the Contractor's primary processing facility. The DHSS staff will provide oversight for the Contractor's Acceptance Testing activity. The State will reserve the right to conduct their own testing with either Contractor supplied test cases and test scenarios or ones that the State will develop. A separate testing region will be established for the State to conduct this testing.

Also during the Acceptance Test task, the Contractor must complete plans for full occupancy of the Anchorage facility including collocation of ten (10) State staff. DHSS will be responsible for the costs associated with their move to a new facility

ACCEPTANCE TESTING		
System	Operational Readiness	Pilot

Acceptance testing will focus on three major activities:

- (1) System Testing
- (2) Operational Readiness Testing
- (3) Pilot Testing

5.5.9.1 System Testing

The System Testing will focus on the testing of all system functions for their completeness and accuracy. This will involve generating test scenarios and test conditions and ensuring that the system performs as expected. The Contractor will be responsible for tracking and responding to all problem conditions reported during the System Testing and preparing a corrective action plan for problem correction and resolution. The Contractor must incorporate parallel testing in the system testing strategy to validate that system processing is consistent with legacy system processing and that new functionality has been properly built into the new system. All testing will be completed with converted data. The key components of the Structured System Testing are:

- (1) Complete Acceptance Test Plan (ATP). This plan is comprehensive for all components of the MMIS system.
- (2) Schedule staff for the entire test.
- (3) Prepare system test environment and load acceptance test data sets.
- (4) Develop test case scenarios and test case to meet all requirements in Section 5.6 (Functional Requirements).
- (5) Develop a Requirements Cross-Reference Matrix indicating the test case scenarios and test cases that meet the requirements listed in Section 5.6.
- (6) Conduct system and parallel testing.
- (7) Implement corrective action plan for all problems identified during testing.
- (8) Correct the problems and re-test the system.
- (9) Provide weekly test results and status reporting.
- (10) Maintain system test results at the individual, unit, module, and system levels.

5.5.9.1.1 DHSS Objectives

It is critical that the new MMIS meet all the functional, technological, and operational requirements of the Alaska medical assistance programs. To accomplish this, DHSS will require the Contractor to test all aspects of the system before declaring it ready for operation. DHSS with the procurement consultant will review and evaluate the test results and decide if any of the uncovered system or operational deficiencies can be corrected during the operations phase.

As the Contractor completes system testing of individual modules and declares them ready for operation, these modules will be promoted to the separate testing region established for the State. The State will conduct their own testing using either Contractor supplied test cases and test scenarios or ones which the State will develop. All critical errors will require immediate attention. These will be corrected and re-tested to ensure compliance. Parallel testing will take advantage of the opportunity provided by the fact that the Contractor is responsible for the processing of both systems, assuming takeover has occurred.

DHSS will have the option to postpone certain non-critical error situations and require the Contractor to develop a corrective action plan to correct these problems during the operations

phase. All costs incurred by the Contractor, DHSS, and DHSS's consultant for additional testing that are required due to failures in testing will be borne by the Contractor.

5.5.9.1.2 DHSS Responsibilities

DHSS responsibilities for the System Testing tasks are:

- (1) Approve final system test plan.
- (2) Approve final system test scenarios and test transactions.
- (3) Provide oversight of the testing activity.
- (4) Monitor Contractor activities related to system testing.
- (5) Review and approve Contractor's resolution and results from re-test.
- (6) Review and approve Contractor's corrective action plan.
- (7) Approve test results.
- (8) Approve the completion of Acceptance Testing.

5.5.9.1.3 Contractor Responsibilities

Contractor responsibilities for the System Testing tasks are:

- (1) Update ATP tasks based on information from DHSS.
- (2) Prepare system test plan.
- (3) Prepare system test scenarios and system test transactions.
- (4) Coordinate work activities with the incumbent Contractor.
- (5) Conduct State and consultant training for the system testing task.
- (6) Provide a separate system test 'region' dedicated to State users.
- (7) Provide hardware, software, and data support for DHSS and consultant staff.
- (8) Provide complete data entry and system support staff to ensure a timely and comprehensive system test and resolution of error conditions.
- (9) Conduct system, transaction volume, and parallel testing.
- (10) Execute system test cycles in accordance with the approved acceptance test plan.
- (11) Review test results.
- (12) Identify and correct errors.
- (13) Document and report results of system tests to DHSS weekly, including errors identified and corrective actions taken.
- (14) Conduct re-tests as necessary.
- (15) Develop corrective action plan for unresolved testing errors for DHSS review and approval.
- (16) Compile and submit to DHSS the system test results document.

- (17) Prepare facility for occupancy by all Contractor and DHSS staff.
- (18) Complete schedule and begin relocation of DHSS staff.

5.5.9.1.4 Milestones

At a minimum, the following milestones must be included:

- (1) Contractor's letter of system fitness for system testing.
- (2) DHSS approval of updated ATP.
- (3) DHSS approval of acceptance test resolution document.
- (4) DHSS approval of updated user documents.
- (5) DHSS approval of updated provider handbooks.
- (6) DHSS approval of final conversion plan.
- (7) DHSS approval of updated disaster recovery and safety plan.
- (8) DHSS approval of final hardware and software configuration chart.
- (9) DHSS approval of updated staffing plan for the operations phase.
- (10) Completion of Anchorage facility.
- (11) DHSS approval to proceed with Operational Readiness Testing.

5.5.9.1.5 Deliverables

At a minimum, following deliverables must be included for the State's review and approval:

- (1) Problem tracking and resolutions document.
- (2) Test case scenarios and test case to meet all requirements in Section 5.6.
- (3) Requirements Cross-Reference Matrix listed in Section 5.6 (Ongoing Operations) indicating the test case scenarios and test cases that meet the requirements. Other RFP requirements that affect the requirements and scope of work defined for ongoing operations will be included in this matrix.
- (4) System test results document to include test case scenarios and test cases that met requirements as well as those which failed.
- (5) Corrective action plan for test case scenarios and test cases that failed to meet requirements upon re-testing.
- (6) Final conversion plan.
- (7) Updated user documents.
- (8) Updated provider handbooks.
- (9) Updated operating procedures document.
- (10) Updated disaster recovery plan.
- (11) Updated ATP.
- (12) Final hardware and software configuration chart.

- (13) Updated staffing plan and job descriptions for the operations phase.
- (14) Updated transition plan.
- (15) Updated PIP/TDP.

5.5.9.2 Operational Readiness Testing

The Contractor must provide a comprehensive operational readiness test (ORT) plan to the State that demonstrates they are ready to begin operations and assume all fiscal agent functions using the new system. The Contractor must aggressively test for production based on estimates of transaction volume supplied by the State. The Contractor must use volume simulating tools and methods. The comprehensive operations readiness test plan should document the complete process and serve as a guide for its execution. The plan should also clearly identify the strategy and procedures along with roles and responsibilities for all activities in the testing effort.

The ORT plan should include a strategy, methodology, schedule, demonstrations planned, load testing plans, staff readiness testing plans, communications testing and corrective action processes and procedures to resolve issues that occur during the execution of the ORT. The ORT should include at least the following areas:

• Hardware operation	• Telecommunications
• Interfaces	• Staffing
• Staff training	• Provider training
• State staff training	• All system, user, and operations documentation including procedure manuals
• Facility	• Toll free and other phone lines
• Claim forms distribution	• Mail room operations
• Imaging operations	• System security
• Building security	• Confidentiality of data
• Report generation and distribution processes	• AVR and Voice Response System readiness
• System back out procedures	• Hardware and software installation

The Operational Readiness Test will involve testing all the operations and hardware/software/telecommunications aspects of the system. This test will involve preparing extensive checklists and testing all operational components of the MMIS against these checklists. The Contractor will be responsible for tracking and responding to all problem conditions reported during the Operational Readiness Testing and preparing a corrective action plan for problem correction and resolution. The key components of the Operational Readiness Testing are:

• Complete operational readiness test plan.	• Schedule staff for the entire test.
• Prepare test environment and load test data sets.	• Complete operational readiness checklist.
• Conduct operational readiness test.	• Implement corrective action plan for all

	problems identified during operational readiness testing.
• Correct the problems and retest.	• Prepare weekly test results document.
• Monitor operational readiness test results.	

5.5.9.2.1 DHSS Objectives

DHSS will review and approve the Contractor's comprehensive list of items to be reviewed and tested to ensure complete operations readiness and operability of the system. DHSS wants to ensure that Contractor and the State operations are well tested, that Contractor and State staff are well trained, and that all external and internal interfaces have been fully tested and reconciled before starting the new MMIS. Total staff readiness and total equipment and software operability are critical for a smooth implementation. DHSS will require the Contractor to track every issue and problem situation and ensure a quick and timely resolution.

5.5.9.2.2 DHSS Responsibilities

DHSS's responsibilities for this task are:

- (1) With the assistance of the MMIS procurement consultant, review and approve all operational readiness check-off matrices.
- (2) Provide up to six (6) full time equivalent (FTE) State staff for oversight of the testing activity.
- (3) Respond to Contractor inquiries related to program policy.
- (4) Monitor ATP activities related to the Operational Readiness Testing task.
- (5) Review the Operations Readiness Test results and the list of all outstanding issues and problems resulting from these tests.
- (6) Approve corrective action plans developed by the Contractor.

5.5.9.2.3 Contractor Responsibilities

Demonstrate a complete operationally ready MMIS system in all respects. At a minimum, the Contractor will have the following responsibilities for this task:

- (1) Develop a comprehensive check-off list of all MMIS operational start-up tasks and activities.
- (2) Conduct all testing activities and report results to DHSS.
- (3) Provide DHSS assurance that all check-off activities have been satisfactorily completed and signed-off by DHSS.
- (4) Provide walkthroughs as deemed necessary by DHSS.
- (5) Develop and implement a corrective action plan for all outstanding operational activities for review and approval by DHSS.
- (6) Provide DHSS a "certificate of system fitness" that the system is ready for operational implementation.

- (7) Complete Anchorage facility preparation, including build-out, space renovation, wiring, and telecommunications.
- (8) Ensure facility is ready for occupancy.
- (9) Conduct training for fiscal agent staff.
- (10) Conduct training for State staff.
- (11) Complete plans and begin provider training.
- (12) Obtain a written sign-off from DHSS to begin implementation of the new MMIS.

5.5.9.2.4 Milestones

At a minimum, the following milestones must be included:

- (1) Successful completion of all hardware test activities.
- (2) Successful completion of all software test activities.
- (3) Successful completion of all networking test activities.
- (4) Successful completion of all staffing and staff training activities.
- (5) Signoff of volume test by DHSS.
- (6) Signoff of facility security and data security tests by DHSS.
- (7) Anchorage facility ready for occupancy.
- (8) DHSS approval of updated operational procedures documents.
- (9) DHSS approval of Contractor's operations readiness.
- (10) DHSS approval to proceed with Pilot Testing.

5.5.9.2.5 Deliverables

At a minimum, the following deliverables must be included for the State's review and approval:

- (1) Complete checklist matrix for all MMIS hardware.
- (2) Complete checklist matrix for all MMIS software.
- (3) Complete checklist matrix for all MMIS network operations.
- (4) Complete checklist matrix for all MMIS mail room activities.
- (5) Complete checklist matrix for all MMIS training activities.
- (6) Complete checklist matrix for all MMIS interface operations.
- (7) Complete checklist matrix for all MMIS documentation activities.
- (8) Complete checklist matrix for all MMIS functional operations.
- (9) Complete checklist matrix for all MMIS data conversion activities.
- (10) Complete checklist matrix for all MMIS provider certification, provider enrollment, provider manuals, and all provider correspondence related tasks.

- (11) Complete checklist matrix for all MMIS outstanding issues and problems with a plan to correct or resolve these issues.
- (12) Updated operational procedures documents.
- (13) Updated PIP/TDP.

5.5.9.3 Pilot Test

The Contractor must provide a comprehensive Pilot Test Plan (PTP) to the State that demonstrates the Contractor's ability to assume complete operational responsibilities for the new MMIS for a representative sample of providers within the Medicaid program. The selected providers will include all types and service programs served by the current MMIS.

The PTP will be conducted to confirm the stability of the new MMIS in a production environment. DHSS will define the scope and duration of the pilot test and will select providers to be included in the pilot test. The Contractor shall be responsible for developing the details of the pilot test plan. Pilot testing will be conducted in an environment using fully operational components of the MMIS and operationally trained and ready fiscal agent and DHSS resources.

5.5.9.3.1 DHSS Objectives

The Pilot Test is designed to demonstrate that the Contractor is ready to process all inputs, pay and adjust claims correctly, meet all reporting requirements, utilize a properly functioning data communications network, and have a stable back-up capacity. Pilot testing will include actual claims processing in a full operational environment, from receipt of claims through financial processing, history update, and reporting.

For the duration of the pilot test the State will be in a dual production operating MMIS environment. The MMIS, including pharmacy POS processing, will be fully tested, and production of output files and reports will be required.

5.5.9.3.2 DHSS Responsibilities

- (1) Define the scope of the pilot test.
- (2) Provide up to ten (10) full time equivalent (FTE) State staff for oversight of the pilot testing activity.
- (3) Select providers to be included in the pilot test.
- (4) Provide appropriate DHSS staff to support business activities that will be the responsibility of the State under the new MMIS environment.
- (5) Approve the pilot test plan and schedule.
- (6) Monitor Contractor operations and system performance during execution of the pilot test.
- (7) Monitor Contractor response and resolution of discrepancies or problems.
- (8) Monitor the testing activities after correction of any problems.
- (9) Develop Corrective Action Plans, as required, to resolve issues and problems that are the responsibility of the DHSS.

5.5.9.3.3 Contractor Responsibilities

- (1) Develop and obtain approval of the pilot test plan.
- (2) Develop and obtain approval of the pilot test schedule.
- (3) Provide a thoroughly tested version of the operational system and all tables and files in a production region that is separate and distinct from development and test system regions.
- (4) Provide additional training and follow-up support to those selected providers and DHSS staff who will participate in the pilot operations test.
- (5) Execute pilot operations cycles according to the Operations Phase schedule approved by the State.
- (6) Identify, document, and correct any discrepancies.
- (7) System problem identification, resolution, re-test and implementation as necessary.
- (8) Document pilot test results.

5.5.9.3.4 Milestones

- (1) Approval of the pilot test plan and schedule.
- (2) Completion of pilot test training.
- (3) Resolution of identified issues and operational problems.
- (4) Completion of the pilot test.
- (5) DHSS approval to proceed with State-wide implementation.

5.5.9.3.5 Deliverables

- (1) Pilot test plan and schedule.
- (2) Pilot test results.
- (3) Corrective Action Plans (as required) for:
 - (a) All MMIS hardware issues and identified problems
 - (b) All MMIS software issues and identified problems
 - (c) All MMIS network operations issues and identified problems
 - (d) All MMIS mail room activities issues and identified problems
 - (e) All MMIS training activities issues and identified problems
 - (f) All MMIS interface operations issues and identified problems
 - (g) All MMIS documentation activities issues and identified problems
 - (h) All MMIS functional operations issues and identified problems
 - (i) All MMIS data conversion activities issues and identified problems
 - (j) All MMIS provider certification, provider enrollment, provider manuals, and all provider correspondence related tasks issues and identified problems

- (k) All MMIS system related errors, issues and problems with a plan to correct or resolve these issues identified problems
- (l) Updated operational procedures documents to resolve issues and identified problems

5.5.10 Implementation

The Contractor must ensure that the system is ready to be implemented and that DHSS approvals have been obtained to begin operations of the new MMIS. To be ready for implementation, the MMIS must satisfy all the functional and technological requirements specified in the RFP and documented during the requirements analysis and systems design activities. DHSS staff must be given sufficient time to review all system, user and security documentation for completeness prior to implementation. The system response time and all user and automated interfaces must be clearly assessed and operational. A complete file transfer plan must be developed and executed. This plan must identify:

- (1) The name of each file, table or database.
- (2) Destination of transferred data.
- (3) Transfer start and completion times.
- (4) Location and phone numbers of person(s) responsible to execute the transfer.
- (5) A complete fall back plan if the file transfer does not go as planned.

5.5.10.1 DHSS Objectives

DHSS expects the implementation of the new system to be transparent to the recipient and the provider communities and that all functions and processes work correctly, timely, and efficiently. The new system must function without interruptions or non-scheduled downtimes. The response time from the new system must be within acceptable limits. All documentation must be current and available to State and Contractor staff to assist them in their new job functions and responsibilities.

5.5.10.2 DHSS Responsibilities

For implementation, DHSS's responsibilities are:

- (1) Provide State resources as agreed to in the TDP.
- (2) Respond to Contractor inquiries related to program policy.
- (3) Monitor TDP activities related to the implementation task.
- (4) Review, comment, and if correct, approve all deliverables associated with this task.
- (5) Approve the corrective action plan developed by the Contractor.
- (6) Make all arrangements and pay all costs associated with the relocation of DHSS staff.

5.5.10.3 Contractor Responsibilities

At a minimum, the Contractor will have the following responsibilities for this task:

- (1) Repeat portions of the operability test as requested by DHSS.
- (2) Develop and obtain DHSS approval of an emergency back out strategy.

- (3) Propose organizational changes for DHSS staff to effectively use the new MMIS.
- (4) Produce and update all system, user, provider, and operations documentation.
- (5) Produce and distribute report distribution schedule.
- (6) Establish production environment.
- (7) Establish hardware, software, and facility security procedures.
- (8) Develop and obtain DHSS approval of production schedule.
- (9) Develop and implement backup and recovery procedures.
- (10) Ensure complete and accurate data conversion.
- (11) Complete all fiscal agent, State, and provider training.
- (12) Ensure that communications between State users and the fiscal agent systems have been established and meet performance requirements.
- (13) Establish and begin mailroom operations.
- (14) Obtain written approval from DHSS to start operations.
- (15) Begin operations.

5.5.10.4 Milestones

At a minimum, the following milestones must be included:

- (1) All conversion activities completed.
- (2) Operations environment established.
- (3) Security and backup procedures signed off by DHSS.
- (4) Emergency back out plan accepted by DHSS.
- (5) Report distribution schedule approved by DHSS.
- (6) Production schedule approved by DHSS.
- (7) Mailroom procedures reviewed and approved by DHSS.
- (8) Approval to start operations granted by DHSS.
- (9) Relocation of all DHSS staff in new facility.
- (10) Completion of all training activities.

5.5.10.5 Deliverables

At a minimum, the following deliverables must be included for the State's review and approval:

- (1) Report distribution schedule.
- (2) Software release plan.
- (3) Results of operational readiness test.
- (4) Emergency back out plan.
- (5) Backup and recovery plan.

- (6) Hardware, software, and facility security manual.
- (7) Certificate that the conversion is complete and accurate.
- (8) DHSS proposed staffing plan.
- (9) Final implementation checklist.
- (10) Final documentation and policy manuals.
- (11) Final transition plan.
- (12) Updated PIP/TDP.

5.5.11 Post-Implementation Evaluation

The Contractor will be required to assign resources at DHSS request to conduct a pre-certification review and validation of certification readiness. Also during the post-implementation period, the Contractor will be required to prepare for and participate in the certification of the MMIS.

5.5.11.1 DHSS Objectives

DHSS will require a comprehensive evaluation of the system and operations of MMIS after the first 60 days of operation. This analysis will focus on validation and verification that the system is ready for CMS certification. The Contractor will have complete responsibility to resolve all problems or deficiencies identified during the evaluation process and will have sole responsibility for any consequential damages resulting from those problems or deficiencies.

DHSS will also require that the Contractor prepare for and participate in the certification of the MMIS, including preparing certification manuals, ensuring that first-run reports are collected and maintained for the certification review, and ensuring that all certification requirements are met to allow certification back to the first day of operations.

5.5.11.2 DHSS Responsibilities

DHSS will assign the project leader for the evaluation team. DHSS responsibilities will be:

- (1) Approve the evaluation team.
- (2) Approve the evaluation plan.
- (3) Manage the evaluation process.
- (4) Review and approve the evaluation report.
- (5) Review and approve the corrective action plan.
- (6) Notify CMS that the system is operational.
- (7) Review and approve certification manuals.
- (8) Participate in federal MMIS certification review.

5.5.11.3 Contractor Responsibilities

At a minimum, Contractor's responsibilities for the post-implementation evaluation task will be:

- (1) Provide free access to the evaluation team to review operational and system areas.
- (2) Prepare corrective action plan for problems or deficiencies identified by the evaluation team for review and obtain approval by DHSS.
- (3) Develop the Pre-Certification Evaluation Report for review by DHSS.
- (4) Execute the corrective action plan.
- (5) Prepare certification manuals and submit to DHSS for approval.
- (6) Archive all first-run federally required reports for inclusion in the certification documentation.
- (7) Participate in federal certification review activities, including the CMS site visit.

5.5.11.4 Milestones

At a minimum, the following milestones must be identified:

- (1) Development of the evaluation report.
- (2) Development of the corrective action report.
- (3) Approval of the corrective action report by DHSS.
- (4) Completion of the corrective action plan and sign-off by DHSS.
- (5) Federal certification of the Alaska MMIS.

5.5.11.5 Deliverables

At a minimum, the following deliverables will be produced as part of the post-implementation evaluation task:

- (1) Post-Implementation Evaluation plan.
- (2) Post-Implementation Evaluation report.
- (3) Post-Implementation Corrective action plan.
- (4) Certification manuals for each required system function, including first-run reports for federally-required reports.

5.6 Functional Requirements

This section of the RFP outlines the requirements for the system and ongoing operational responsibilities of the Alaska MMIS, POS/PRO-DUR, and DW/DSS (collectively referred to as MMIS) that the Contractor will be responsible for maintaining during the operational phase (5.8) of the project. The section is divided into the following subsections corresponding to functional areas:

- 5.6.1 General Requirements
- 5.6.2 Recipient Eligibility
- 5.6.3 Benefit Packages
- 5.6.4 Provider Enrollment and Relations

- 5.6.5 Reference Databases
- 5.6.6 Prior Authorization
- 5.6.7 Reimbursement
- 5.6.8 Claims Processing
- 5.6.9 Claims Payment
- 5.6.10 Financial Services
- 5.6.11 Third Party Liability (TPL)
- 5.6.12 Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
- 5.6.13 Managed Care
- 5.6.14 Home and Community-Based (HCB) Waivers
- 5.6.15 Pharmacy Point-of-Sale (POS)
- 5.6.16 Drug Utilization Review
- 5.6.17 Drug Rebate
- 5.6.18 Data Warehouse/Decision Support System (DW/DSS)
- 5.6.19 Management and Administrative Reporting (MARS)
- 5.6.20 Utilization Review and Quality Assurance
- 5.6.21 Case Tracking

Each subsection describes the State responsibilities, Contractor responsibilities, interfacing systems, inputs, outputs and performance standards for the functional area.

Text within subsections describing output requirements refers to reporting currently produced by the legacy system. The State recognizes that the Contractor's proposed solution for meeting these requirements may include alternative reporting methods, definitions, and formatting. During Requirements Analysis the Contractor will present, walk through, and educate State staff about this reporting conceptual equivalency. Reporting methods, Alaska-specific data requirements, and formatting will be resolved through this process, addressing both the program management requirements of the State and the new functionality offered by the Contractor.

5.6.1 General Requirements

Following implementation of the Alaska MMIS, the Contractor will be responsible for ongoing operations. The Contractor will perform all duties necessary for the continuing operation and certification of the Alaska MMIS. This section of the RFP describes the general requirements for the system and operations of the Alaska MMIS.

5.6.1.1 General Objectives

The overall objectives of the Alaska MMIS system and operations are:

- (1) Meet current CMS functional and reporting requirements at all times including the Medicaid Manual, Part 11, and MMIS functional equivalency requirements.

- (2) Meet all of the specific requirements of DHSS as specified in this RFP.
- (3) Provide batch and on-line capability to meet the special and ad hoc reporting needs of State users, including user-friendly on-line report request capability and replacement of printed reports with on-line viewing of information.
- (4) Incorporate maintenance and operational efficiencies that are made possible through the use of modern computer and communications technologies.
- (5) Provide flexibility in approaches to reimbursement methodologies and the structures to support them.
- (6) Provide effective, sophisticated editing capabilities.
- (7) Provide flexibility to support changes in the Alaska medical assistance programs and the service delivery system.
- (8) Incorporate functionality that meets or exceeds all functionality provided in the current Alaska MMIS, including maintenance of all data elements used in the current system.

These objectives are further described in the text below and in the requirements for each functional area, which are presented in the subsections that follow.

5.6.1.2 General System Requirements

To meet the objectives stated above, the State of Alaska is seeking an MMIS that may consist of modification and integration of component parts of multiple systems or the customization of an existing MMIS. The State of Alaska is interested in optimizing cost-effective and efficient automated processing by using proven and appropriate technological solutions to streamline and enhance system and operational performance. The State is not predisposed to a specific technical solution or platform to support these activities.

The Contractor must operate and maintain an Alaska MMIS which incorporates the following capabilities:

- (1) Ensure efficient, accurate, timely, and complete a) logging, b) tracking, c) response, d) documentation, and e) reporting of all activities.
- (2) Maximize the Contractor's responsiveness to the needs of the Department, providers, and recipients.
- (3) Ensure accurate, complete, and timely records management.
- (4) Maximize ease of use, and improve DHSS and Contractor staff productivity by providing efficient and user-friendly interface capabilities.
- (5) Provide easy and quick access to both data and information from users' workstations on the State's LAN/WAN, including the following capabilities:
 - (a) Query all MMIS databases.
 - (b) Build and run queries from their desktops.
 - (c) Traverse and drill down the data.
 - (d) View all MMIS reports on-line.

- (e) Export data and reports to desktop packages such as Excel, Word, Quattro, ACCESS, and other software packages available on the State LAN/WAN.
 - (f) Develop and save queries for future use, including assistance to DHSS staff in converting selected JUCE and STARS queries
 - (g) View on-line documentation, including dictionary of data and data fields.
- (6) a) Provide for on-line viewing of all MMIS reports with the capability to print the report or selected portions of the report from the users desktop. b) On-line reports will be available on request by DHSS in the media specified by the user (e.g., downloadable file, diskette, optical storage, or hard copy). c) All MMIS outputs must be archived for permanent storage in electronic media approved by DHSS.
- (7) Provide user friendly systems navigation technology and a graphical user interface (GUI) that allows all MMIS users to move freely throughout the system using a) pull down menus, b) window tabs, and c) “point and click” navigation. d) In addition, the navigation process must be completed without having to enter identifying data multiple times and must be standardized throughout the system.
- (8) Provide a user-friendly menu system, understandable by non-technical users, that provides access to all functional areas. a) This menuing system must be hierarchical and provide sub-menus for all functional areas of the MMIS. b) The system must not restrict the ability of experienced users to directly access a screen, or the ability to access a screen or to move from one screen to another without reverting to the menu structure. c) Menus should reflect the hierarchical or tree structure of the screens. d) Each menu item may indicate a list of screens or a list of sub-menus to indicate screen dependencies to the users. e) The system should remain available to the user from log on to system log off, without the need for intermediate system prompts.
- (9) Provide context-sensitive “Help” screens in order to provide for ease of use.
- (10) The State will view favorably the use of a) web-based applications, b) Internet, and c) middleware based reporting. These technologies extend the reach of quick, user-based reporting across a variety of system platforms without extensive investments in desktop software by the user. c) Proposals that utilize web and Internet applications must be accompanied by a thorough discussion of security and confidentiality issues, such as firewalls, encryption, and other technologies which shall provide appropriate safeguards while supporting the increased accessibility to the Alaska MMIS and other data.
- (11) Enhance accountability of the Contractor to DHSS management, and provide DHSS with the direct means to monitor Contractor compliance with performance expectations.
- (12) Ensure that response times and on-line availability are maintained in accordance with DHSS specifications.
- (13) Ensure that the technology used is readily adaptable to accommodate ongoing State and Federal system change requirements and new policy implementations.
- (14) Meet all State and Federal system security requirements without impeding the usability and user-friendliness.

The proposed technology platform and the total technological structure should take advantage of the technological advancements that have been successfully applied in the health care industry

over the last few years. The proposed platform must take into consideration the LAN/WAN and the desktop environment within DHSS. The Contractor will be required to provide connectivity to the MMIS via the State WAN for DHSS users. The Contractor will be required to work with GCI, the State's IT contractor, to arrange for connectivity.

Location of State offices and the geography of the State must be taken into consideration in designing the platform. The system must meet the needs of provider communities in both the rural and urban areas of the State. Access to information by DHSS staff and management is of critical importance. The proposer must demonstrate an effort to design a State-of-the-art MMIS that will take the State into the future without major revamping of the technology platform.

All MMIS software for the operational system, with the exception of approved proprietary software and publicly available third party software, will be the property of the State of Alaska. The MMIS must be fully and accurately documented according to the requirements specified in this RFP.

The Contractor acknowledges and agrees that pursuant to 45 CFR, 95.617 Software and Ownership rights, the State will have all ownership rights in software or modifications thereof and associated documentation designed, developed or installed with Federal financial participation under this subpart. The Federal Department of Health and Human Services reserves a royalty-free, nonexclusive, and irrevocable license to reproduce, publish, or otherwise use and to authorize others to use for Federal Government purposes, such software, modifications, and documentation. Proprietary operating/vendor software packages which are provided at established catalog or market prices and sold or leased to the general public shall not be subject to the ownership provisions as described above. FFP is not available for proprietary applications software developed specifically for the public assistance programs covered under this subpart.

Pursuant to 45 CFR 92.34 Copyrights, the Federal awarding agency reserves a royalty-free, nonexclusive, and irrevocable license to reproduce, publish or otherwise use, and to authorize others to use, for Federal Government purposes: (a) The copyright in any work developed under a grant, subgrant, or contract under a grant or subgrant; and (b) Any rights of copyright to which a grantee, subgrantee or a contractor purchases ownership with grant support.

5.6.1.3 Performance Standards

Performance Standards for operational responsibilities are included within the discussion of each functional area. The Performance Standards will become the focus for contract monitoring activities for the State. The Contractor will prepare a report card of fiscal agent performance based on their compliance with the standards referenced in Section 3.12 and throughout Section 5. This report card will reflect self-reported performance standards from the fiscal agent's automated tracking systems each month, beginning the month following the month of initial operation of the MMIS. The DHSS will consult with the Contractor on the standards to be included in the report card and the methodology for calculating each standard.

5.6.2 Recipient Eligibility and Relations

Recipient Eligibility is responsible for accepting and maintaining an accurate, current, and historical source of eligibility and demographic information on individuals eligible for medical assistance in Alaska and for supporting analysis of the data contained within the recipient database. The maintenance of recipient data is required to support claims processing, EPSDT, eligibility verification and reporting functions. In addition, the function is responsible for maintaining an accurate and current identification of Medicare-eligible recipients. Maintenance of recipient-related data is also described in other functional sections such as Claims, TPL, Prior Authorization, Benefit Packages, and Managed Care. Inquiry capability is required to allow authorized access to client information using a variety of methods including Web portal, AVR/EVS, point-of-service devices, and workstations. Client inquiry transactions will support retrieval of recipient basic demographic, historical program eligibility, TPL, Benefit Packages, and other data as specified.

5.6.2.1 Business Needs

The primary objectives of the Recipient Eligibility function are to:

- (1) Maintain a timely, accurate, automated, and date-sensitive data repository of eligible recipients, including current and historical status; categories of eligibility; Medicare eligibility history including Buy-in; LTC authorizations; recipient cost of care data; third party coverage data; hospice data; recipient lock-in data; recipient service limit data; etc.
- (2) Provide for unique identification of all recipients eligible for Alaska medical assistance programs.
- (3) Provide for updating of the recipient eligibility database with data from the State's Eligibility Information System (EIS) each business day and for monthly full-file reconciliation of the eligibility data.
- (4) Provide data for generation of Medicaid identification cards for all eligible recipients.
- (5) Maintain a database of recipient eligibility to support inquiry, service authorization request/response and billing/payment activities (e.g., automated voice response, eligibility verification inquiries, and point-of-sale inquiries).
- (6) Provide on-line inquiry access to sixty (60) months of historical and current recipient information data on the recipient eligibility database.

5.6.2.2 State Responsibilities

- (1) Determine which individuals are eligible to receive Medicaid benefits.
- (2) Determine benefit limits and applicable periods.
- (3) Determine and provide to the Contractor service limitation criteria.
- (4) Serve as the liaison between the Division of Public Assistance, CMS, and the Social Security Administration to ensure reliable data exchanges and data updates.
- (5) Establish and maintain security and control over the production of Medicaid identification cards and the inventory of identification card stock and equipment.

- (6) Generate and mail Medicaid identification cards (including replacement cards as necessary).
 - (a) To each recipient as their eligibility is added and periodically thereafter at a schedule determined by the State
 - (b) That include eligibility category, subtype, and dates as well as indicators for Medicare or TPL coverage, provider restrictions, and other pertinent information
- (7) Provide EIS update transactions to the MMIS via the daily update process.
 - (a) Each business day, provide recipient eligibility data required to maintain the MMIS recipient eligibility database, through electronic transfer, hardcopy transactions, and/or online updates.
 - (b) On a monthly basis, provide full-file recipient reconciliation data, through electronic transfer.
 - (c) Correct critical errors and discrepancies resulting from the recipient update process if the correction requires update of the State's Eligibility Information System (EIS).
 - (d) Assist in defining update and reconciliation parameters between the EIS and MMIS.
- (8) Develop policy and monitor the performance of the Contractor in all areas of the Recipient Function.
- (9) Review and approve all inputs (hardcopy forms, electronic formats and content standards, printed and on-line displays) and all outputs (reports, letters, publications, website, quality assurance/quality improvement content standards, printed and on-line displays) used in the automated and operational recipient functions.
- (10) Approve Contractor's plan, including all procedures and systems used by the Contractor, for managing the recipient functions.
- (11) Approve Contractor's plan for workflow, business processes, automated tracking system, scripts, guidelines for release of information, etc for use by Contractor staff in the performance of recipient customer service in relation to telephonic and written inquiries/correspondence.
- (12) Review and resolve certain problematic recipient eligibility discrepancies or issues referred to DHSS by the Contractor.
- (13) Convey policy and approve procedures/processes for use by Contractor to resolve suspended claims with edits and/or errors related to recipient issues.
- (14) Convey policy and approve procedures/processes for use by Contractor to resolve recipient reimbursement and claims resolution when recipients have made payment for their health care services.
- (15) Convey policy and approve procedures/process for use by Contractor to authorize the pending of a recipient's claims, (selected services, selected programs, or all claims) for medical review.
- (16) Convey policy and approve procedures/processes for use by Contractor to obtain State approval of the content of all publications and information posted to the website prior to distribution and the process for producing and distributing publications.

- (17) Convey policy and approve procedures/processes for use by Contractor to perform functions related to support of the department in preparation and representation for recipient fair hearings.
- (18) Represent the department in recipient fair hearing proceedings; present information gathered by Contractor and provide information to the department's legal representation when required.
- (19) Provide a fair hearing officer who will make the fair hearing determination. It is expected that hearings will be conducted in person in Anchorage, or telephonically in Anchorage.
- (20) Provide policy and approve procedures for timely resolution of Buy-in data discrepancies.
- (21) Receive buy-in invoice from CMS and process payment.
- (22) Validate the State Contribution for Prescription Drug Benefit invoice and process payment.

5.6.2.3 Contractor Responsibilities

The Recipient Eligibility function has seven major processes:

- (1) Recipient Database Maintenance, Update, Inquiry, and Edit Function.
- (2) Medicare Buy-In.
- (3) Automated Tracking Capability.
- (4) Automated Correspondence Generator.
- (5) Recipient Relations.
- (6) Recipient Fair Hearing Support.
- (7) Quality Assurance Improvement – Recipient Eligibility and Relations.

5.6.2.3.1 Recipient Database Maintenance, Update, Inquiry, and Edit Functions

- (1) Maintain current and historical date-sensitive information on recipients' Medical Assistance and other program eligibility, including:
 - (a) Program codes
 - (b) Eligibility codes
 - (c) Medicaid subtypes
 - (d) Cash grant
 - (e) Beginning and ending dates of coverage
 - (f) Categorical program indicator
 - (g) Location indicator
- (2) Allow for day-specific eligibility on the MMIS eligibility database, and process claims against day-specific eligibility.
- (3) Maintain recipient identification data including:

- (a) Client ID number
 - (b) Name
 - (c) Social security number
 - (d) Health insurance claim number (HICN)
 - (e) Case identification number
 - (f) Alias
 - (g) Date of birth
 - (h) ID type
 - (i) Name source
 - (j) Case number
- (4) Maintain recipient demographic data including:
- (a) Mailing address
 - (b) Residential address
 - (c) Region code assignment(s)
 - (d) Guardian, custodian, representative payee name and address
 - (e) Date of birth
 - (f) Date of death
 - (g) Race
 - (h) Sex
 - (i) Marital status
 - (j) Ethnicity
 - (k) Emancipated youth indicator
 - (l) Deprivation code
 - (m) Primary language
 - (n) Benefit address
 - (o) Custody status
 - (p) Telephone number – i.e. home, cell, work, guardian
 - (q) Email address
- (5) For each address maintained in the recipient database, provide an address type and effective dates, and provide the capability to select the type of address when mailings are prepared for recipients (e.g., REOMBs, EPSDT letters, prior authorization determinations).
- (6) Maintain insurance coverage data in the recipient eligibility database including:
- (a) Carrier
 - (b) Policy number
 - (c) Group number
 - (d) Pharmacy Benefit Manager (PBM) ID and BIN number
 - (e) Sponsor, subscriber, or policy holder name/identification number(s)
 - (f) Type(s) of coverage, dates of coverage
 - (g) Date the coverage was added to the database
 - (h) Date the coverage was updated
 - (i) Court order including date ranges
 - (j) Part D enrollment type indicator
- (7) Allow for multiple insurance policies for a single recipient.

- (8) Maintain historical and date-sensitive Medicare coverage data including:
 - (a) Part A, B, C, D (other future types) of Medicare coverage
 - (b) Beginning and ending dates of coverage
 - (c) Successful Buy-in transactions and dates
 - (d) Date the coverage data was added to the eligibility database
 - (e) An indicator to identify recipients who will never have Medicare coverage
 - (f) Low-Income Subsidy (LIS) information for Part D eligibility
 - (g) Ability to derive and/or end Part D eligibility based on Part A and/or Part B coverage add or end
 - (h) Update date
 - (i) Current and historical date
- (9) Maintain LTC, hospice, and waiver program patient liability data including:
 - (a) Authorization tracking number
 - (b) Current and prior periods of authorization
 - (c) Long term care and hospice stays, including service provider ID
 - (d) Level of care
 - (e) Add and update dates and source
 - (f) Patient status
 - (g) Patient liability amounts for those recipients approved for long term care, hospice, or Home and Community based waiver programs
 - (h) Effective dates for each of the above
 - (i) LTC, hospice, and/or waiver program provider identifiers as applicable
- (10) Provide the capability to identify recipients of special programs, such as home and community-based waiver, case-management, and other medical assistance programs with effective dates and other data required by the State.
- (11) Provide the capability to identify recipients of the following other State programs with effective dates, eligibility data, demographic data, and other data necessary to process claims for these recipients. Such programs include, but are not limited to the following:
 - (a) Division of Senior and Disabilities Services (DSDS)
 - (b) Division of Behavioral Health (DBH)
 - (c) Division of Juvenile Justice (DJJ)
 - (d) Office of Children's Services (OCS)
 - (e) Division of Public Health (DPH)
 - (f) AIDS Drug Assistance Program (ADAP)
 - (g) DPA Temporary Assistance Program – Work Services
- (12) Support overlapping eligibility segments between Medicaid and other State programs listed above, and develop the hierarchy for processing claims against multiple open segments according to instructions provided by DHSS.
- (13) Maintain recipient lock-in data including lock-in dates and lock-in provider ID numbers.
- (14) Provide the capability to add additional provider types to the lock-in function.
- (15) Provide the capability to allow overlapping lock-in segments for the same service.

- (16) Maintain service limit data, including updating the information using paid original, adjustment, and voided claims data.
- (17) Allow service limits to apply to various unit types including dollars.
- (18) Provide for data elements to support primary care case management (PCCM) including:
 - (a) Primary care provider identification
 - (b) Beginning and ending dates of PCCM
- (19) Provide the capability to capture and maintain the indicator that identifies recipients who are referrals from Child Support and Enforcement Division (CSED) and to use the indicator to identify recipients for whom TPL collections and payments must be reported to CSED.
- (20) Maintain all dates in the recipient database with day, month, year, and century.
- (21) Provide a daily transaction update interface with the State's eligibility information system (EIS) to obtain all necessary data for the Alaska MMIS recipient database, including information from SDX, EDB, and BENDEX.
- (22) Apply updates received to the MMIS eligibility database, either in real-time or other schedule as defined by the department, prior to the claims adjudication cycle.
- (23) Notify DHSS if the update is not received or if the update was not applied as scheduled.
- (24) Provide a monthly full-file reconciliation process with the State's Eligibility Information System (EIS) and provide monthly reconciliation with all the other external sources of data.
- (25) Accept and update the MMIS recipient database with date of death data provided by Vital Statistics via a file or electronic interface.
- (26) Develop and provide for on-line and automated input of eligibility data for recipients enrolled in other State programs. Such programs include, but are not limited to the following:
 - (a) Division of Senior and Disabilities Services (DSDS)
 - (b) Division of Behavioral Health (DBH)
 - (c) Division of Juvenile Justice (DJJ)
 - (d) Office of Children's Services (OCS)
 - (e) Division of Public Health (DPH)
 - (f) AIDS Drug Assistance Program (ADAP)
 - (g) DPA Temporary Assistance Program – Work Services
- (27) Edit eligibility transactions to allow only valid data to update recipient information as defined by the Department.
- (28) Provide capability to update lock-in information, LTC segment information, exception date, date of death, Medicare history information, and other State-specified data through an on-line update process, including beginning and ending dates as appropriate.
- (29) Provide the capability to place a recipient on review, including the capability to include or exclude claims for specific programs, plans, categories of service, specific

- procedure/revenue codes, or diagnoses. Include a review reason code and beginning and ending dates of the review.
- (30) Maintain update and reconciliation reports accessible through on-line inquiry including balancing and control, and audit trail reports from the daily update, on-line update, and reconciliation processes.
 - (31) Provide assistance to the State in researching recipient database discrepancies.
 - (32) Link current and past identification numbers and eliminate any duplicate names. There is no limit on the number of prior client ID numbers for one recipient. Provide the capability to access recipient data and process claims using any valid (current and historical) recipient number.
 - (33) Maintain historical data of eligibility changes on the recipient record.
 - (34) Maintain a batch process to access purged and archived eligibility data by recipient ID number.
 - (35) Provide tools to support user-friendly, on-line access and query support to recipient data.
 - (36) Provide on-line inquiry by recipient name, recipient number (current and any prior issued ID number), SSN, case number, or HIC number by the State, fiscal agent, and other Contractor staff from all available networked terminals.
 - (37) Provide the capability to access recipient data on-line and in reporting using the current recipient identification number or any prior recipient identification number.
 - (38) Provide capability to request recipient reports using recipient program code, eligibility code, eligibility subtype, village/district/region code, and other data elements on the eligibility database as selectable data elements.
 - (39) Produce and provide recipient operational reports accessible on-line which can be printed and downloaded on request by DHSS.
 - (40) Allow on-line input, change, or void of recipient data by authorized users for State-specified fields.
 - (41) Receive and process electronic and hard-copy LTC certification data, including level of care and date ranges, from the Division of Senior and Disabilities Services or other State-designated agency or Contractor.
 - (42) Maintain audit trails and history log of changes made on-line.
 - (43) Edit on-line input to only allow valid data values within predetermined ranges, or valid alphanumeric, or valid dates. Provide error messages and maintain an error log.
 - (44) Provide on-line inquiry and update for reconciliation reports including balancing and control, and audit trail reports from the daily update and reconciliation processes. All documents used in balancing must be imaged and made available on-line, including all action items and their resolution.
 - (45) Produce recipient mailing labels on request of DHSS in hardcopy or on an electronic file based on user-defined parameters.

- (46) Provide for the distribution of eligibility data and reporting to other divisions of DHSS, other State agencies, and outside entities as defined and approved by DHSS.
- (47) Provide accurate and current information to other MMIS components that utilize recipient information to support recipient and provider customer service inquiries, service authorization functions, production of management and utilization reports, and adjudication of claims.

5.6.2.3.2 Medicare Buy-In

The purpose of Medicare Buy-in is to ensure that all Medicaid recipients eligible for Medicare coverage are properly enrolled in Medicare, that Medicaid pays the appropriate premiums, and all necessary Medicare information is available and accurately used to process dually Medicaid-Medicare eligibles, including claims payment, and State and federal reporting.

Alaska entered into its buy-in agreement in 1982 as a 209 b, or “alert” State, which indicates that it makes its own buy-in determinations as opposed to “auto accrete” States.

The system must use proven Buy-in functionality that would be applicable for Alaska using the current CMS Buy-in format and daily transaction functionality. The description should also include specific interface design and uses of logically integrated applications of all federal data sources, particularly the EDB.

5.6.2.3.2.1 Functions

- (1) The fiscal agent must create an accurate and streamlined work process using the current federal Buy-in format with daily transaction communication with CMS, to minimize the amount of manual effort involved in reconciling Buy-in files.
- (2) Work processes must include interfaces and procedures to receive, logically integrate, process, and store EDB and other federal data. The fiscal agent must make this data available to DHSS via user-configurable online access and queries.
- (3) All EDB files from SSA must be maintained and made available to State users with search and query capabilities.
- (4) Thoroughly and continuously analyze the Buy-in process to ensure efficient and maximally appropriate buy-in of eligible Medicaid recipients into Medicare.
- (5) When Medicaid terminates eligibility, create appropriate 51 transactions, and generate letter of follow-up to recipient.
- (6) For Medicare eligibility termination, create notification for State case follow-up.
- (7) Create and apply preset MEMOs to the Buy-in History file from CMS Buy-in return data, EDB data and the like (e.g., “Medicare Term 09/2006- Disability Cessation”) in addition to generating any appropriate transactions and activity.
- (8) Prepare the Medicare Buy-in file for both Part A and Part B buy-in using logically integrated federal buy-in data (such as EDB, BENDEX, SDX, etc), data from MMIS, including Buy-in history, to achieve accretion, deletion and change operations according to the State’s priority of these files.

- (9) “Prepared” Medicare Part A and Part B files not only include the historically familiar accretion, deletion and change transactions created from a comparison of Medicaid eligibility to Buy-in status, but must include appropriate actions and responses to State and federal received data together with appropriate notification (e.g., if DOD on EDB or other file such as vital statistics received file, logic should create and send transaction 53 to CMS matching the effective month and year of the DOD, then create a Buy-in history MEMO and notification that the Medicaid case is not closed, etc.). Like activity should occur for all significant data received.
- (10) Medicare effective dates (begin/end) for Part A, Part B, and Part D from EDB and other federal and State sources must be updated to the recipient file, regardless of Buy-in status.
- (11) Medicare effective dates for Part A, Part B, and Part D must be correctly applied to claims processing regardless of Buy-in status.
- (12) Use specific criteria to identify potential Medicare eligibles not appearing to have been applied for Medicare as evidenced by absence from the EDB file and being otherwise eligible (i.e., age or End Stage Renal Disease status, etc.). Create auto generated letter for these recipients.
- (13) Provide ‘in Queue’ file for manual Buy-in transactions scheduled with future transaction dates, and send to CMS no earlier than the month immediately preceding the transaction date. The system must have prioritizing capabilities for transactions waiting in Queue over system generated transactions as defined by the State.
- (14) Provide full user access, including update capabilities, to the Buy-in subsystem for State Buy-in Program Administrator.
- (15) Provide for daily transaction interface with CMS with update to MMIS within 24 hours. The transaction data should be maintained in date order for online reference.
- (16) Process and reconcile CMS responses to the buy-in file and provide processing reports including accretions, deletions, unmatched activity, expected responses not received, items requiring immediate attention such as 1167 and 1728 transactions, and problem transactions to DHSS on-line within one business day of receipt.
- (17) Provide automated error reporting on an ongoing basis per preset protocols for monthly cleanup of problem records and adjudication of CMS responses to attempted accretions, deletions, annuls, and changes.
- (18) Provide to Buy-in Administrator and others at State’s request full, unaltered monthly EDB file online with search and query capabilities together with selected MMIS fields (for example, Medicaid Subtype, Eligibility code, County code, etc.).
- (19) Provide Buy-in Daily History Log by transaction, RID order, Memo activity and other criteria.
- (20) Develop a accurate automated match review processes for the verification of identity of recipient (State) vs. beneficiary (federal) data and maintain in a database.
- (21) Maintain and make available on-line an “alias” database which contains matched recipient/beneficiary data records created from the automated match review process from

MMIS (including Buy-in), EDB, and other sources. Once recipient/beneficiary data is satisfactorily matched to preset tolerances, the data record must be retained and require no additional operator action unless new data is received that triggers another match review. Records found later to be matched in error must be available for manual segregation in the alias database and in Buy-in history.

- (22) The “alias” database will extract to a separate manual match review file, those elements failing the automated match review process, for Buy-in Administrator action. The match review file will contain an indicator for the Buy-in Administrator’s use on the recipient’s Buy-in history which indicates the client has been manually matched and is verified as the same individual.
- (23) Provide on-line access with query capability to Buy-in reports, the EDB, SVES, SDX and BENDEX data.
- (24) Provide on-line update capability to MMIS Recipient file data for DHSS resolution of errors and recipient file update.
- (25) Perform all Buy-in processing in accordance with State and federal requirements.
- (26) Transmit the buy-in file to and from the State data center for transmission between the State and CMS, meeting federal guidelines.
- (27) Design and produce to State specifications all buy-in reports, validate, and distribute, including availability online with query function.
- (28) Maintain historical Buy-in data and reports on-line with query function.
- (29) Provide multiple notice/letter templates for State created letters (e.g., DPA caseworkers, recipients, SSA, etc.) integrated with EDB, MMIS, and State address data. Correspondence must be individual or group executable and customizable from the Buy-in system. Copies must be retained in the Buy-in history of each recipient.
- (30) Create Buy-in transactions for matched recipients using the EDB as primary source, then Buy-in history, SVES, BENDEX, SDX, etc. in preset State prioritized order.
- (31) Provide action alert file with reminder for Buy-in Program Administrator which may be self-set, or triggered by other pre-set criteria.
- (32) Provide editable MEMO capability for individual or grouped recipient Buy-in files with expanded subject line.
- (33) Create statistical data files which capture selected demographic data from EDB, MMIS, Buy-in files, and produce reports by calendar, State fiscal, or federal fiscal years.

5.6.2.3.2.2 Inputs

- (1) Buy-in Transaction Screens
- (2) Buy-in History
- (3) CMS Summary Accounting Statement Billing Notices, Parts A and B
- (4) BENDEX File
- (5) Part A Buy-in Financial Billing Tape
- (6) Part B Buy-in Financial Billing Tape
- (7) Claims Data

- (8) Recipient Update Screens
- (9) Recipient Inquiry Screens
- (10) EDB Files
- (11) SVES
- (12) Vital Statistics
- (13) EIS

5.6.2.3.2.3 Outputs

Currently utilized Buy-in reports are contained in the Procurement Library. It is recognized that the proposed system may have alternative reporting formats. The following outputs and or functionality will be needed with estimated frequency Stated:

- (1) Buy-in Deaths not otherwise appearing or matching EIS updates for open Medicaid Reported Via Buy-in Trans Code 16, Vital Statistics, EDB DOD, or claim data, weekly.
- (2) Buy-in Deletions With 1728 Code – Requested by Other State with address comparison from MMIS and EDB, online menu as received.
- (3) Buy-in Rejected or Delayed Accretion Attempts, online as received.
- (4) Buy-in Rejected or Delayed Deletion Attempts, online as received.
- (5) Buy-in Premium Financial Data reports including Medicare Savings program breakdown by county code, monthly, quarterly, yearly by State fiscal year.
- (6) Buy-in Xxx Cases Not Bought In, Details by Elig code and Elig Group (xxx = QMB, SLMB, MAO) with Medicare data from EDB.
- (7) Medicare Termed including date, reason, location.
- (8) Buy-in Demographic Data reports.
- (9) Buy-in Statistical reports by Category with EDB data by selected fields, e.g., program code, eligibility code, eligibility subtype, BIC, Race Code, CMS eligibility code, and county code.
- (10) Buy-in MMIS/EDB mismatch for Address.
- (11) Buy-in Daily History Log (by Manual or system-generated, Trans Code, Memo, RID# order, Name order.
- (12) Buy-in Retroactive Medicare Eligibility Report per EDB/History, with Medicare coverage dates and EDB enrollment reason codes.
- (13) Buy-in Expected CMS Responses Not Received – This report will contain all transactions (broken down by either system generated or manual) for which an expected response should have been received, but was not (e.g. transaction 51 sent, but no transaction 1751 received, transaction 63 sent but something other than an 1163 was received, such as a wait code).
- (14) Buy-in Transactions Waiting in Queue - This report will reveal all transactions which have been system-generated or manually-generated, with an effective date greater than the following month, monthly.
- (15) Buy-in Current ESRD Start/Stop, with Third Party Payer Code.

- (16) Buy-in Current Medicare Eligibles (from EDB) without Alaska Buy-in.
- (17) Buy-in Uninsured Beneficiaries (M BICs) without Part A and/or Part B Buy-in by Alaska.
- (18) Buy-in Current Medicaid Recipients requested by other State (1728) with EDB/EIS address comparison and third party payer data.
- (19) Buy-in MMIS/EIS MISMATCH per EDB for vital data and HIC# (first, middle, last names, DOB, SSN, sex), mismatch detail.
- (20) Buy-in Part x Medicare Term (per EDB) for Active Medicaid Recipient, no 51/53 sent.
- (21) Buy-in Working Disabled but MCR Term, other State (1728)/ other payer, or deceased per EDB or vital stats.
- (22) Buy-in Miller Trust but MCR Term, other State (1728)/ other payer, or deceased per EDB or vital stats.
- (23) Buy-in Individuals identified as enrolled in a Group Health Plan.
- (24) Buy-in Individuals identified as enrolled in Hospice Coverage.

5.6.2.3.3 Automated Tracking Capability

- (1) Maintain an automated tracking capability to report all recipient interface activities including telephone inquiries, customer service call center activities, written correspondence, in-person encounters, fair hearing activities, recipient reimbursement activities, and publications:
 - (a) Identity of caller, fiscal agent staff involved
 - (b) Recipient, provider, claim, other transaction demographic information to document subject of interface
 - (c) Record of information supplied/questions asked/comments made by the recipient/representative
 - (d) Record of information conveyed in response by fiscal agent staff
- (2) The Department's authorized staff must be able to query and enter information into the above referenced automated tracking system/database.
- (3) Develop or use a COTS Call Center Management system that provides for:
 - (a) Answering calls in sequence
 - (b) Routing calls
 - (c) Recording and printing statistics
 - (d) Call monitoring/mentoring capability with live calls available to fiscal agent management staff and department staff
 - (e) Indicating calls have been placed on hold for a specific time limit
 - (f) Reports generation to the department at least monthly
 - (g) Automatic notification to the department when performance is outside established tolerance limits

- (4) Provide the capability to track and report from automated tracking/database system and Call Center Management system. Some examples of information to be tracked and reported include, but are not limited to the following:
- (a) Number of telephone inquiries by type of inquiry and type of resolution
 - (b) Average length of call by inquiry type and for all calls received
 - (c) Average wait time
 - (d) Number and percentage of busy signals
 - (e) Number and percentage of abandoned calls
 - (f) Number of calls handled by automated system
 - (g) Number of calls handled by human operator
 - (h) Number of calls requiring return call/follow-up and time to return calls/resolve inquiry
 - (i) Number of written inquiries by type of inquiry and type of resolution
 - (j) Average days from receipt of inquiry to response by inquiry type and for all written inquiries
 - (k) Date of oldest pending written inquiry
 - (l) Number of pending inquiries older than five (5) days
 - (m) Number of pending inquiries between six (6) and fourteen (14) days old
 - (n) Number of pending inquiries between fifteen (15) and thirty (30) days old
 - (o) Number of pending inquiries over thirty (30) days old
 - (p) Number of claim reimbursement requests requested
 - (q) Number of claim reimbursement requests completed
 - (r) Number of claim reimbursement requests pending
 - (s) Number of requests for initial production or update to publications by type, date of request, complexity of update, priority level, etc.
 - (t) Number of fair hearing requests received by type and total
 - (u) Number of fair hearing requests resolved by type and resolution totals (upheld vs. overturned, reason(s), appropriate referral (i.e. policy, system, other appropriate department staff for questions/issue resolution, etc)
 - (v) Number of fair hearing requests pending by type, age, and total
 - (w) Number of telephone inquiries monitored
 - (x) Number and percent of monitored calls answered correctly
 - (y) Number and percent of monitored calls answered incorrectly
 - (z) Number of telephonic inquiries received, lost, on-hold, awaiting return call or other follow-up, etc as maintained in Call Center Management system
 - (aa) Corrective actions taken
 - (bb) Compliance with timeline requirements
 - (cc) Recipient file maintenance/update audit activity results
 - (dd) All of the above items query-able by recipient number, eligibility code/subtype, date received, and/or other data elements tracked in database.

5.6.2.3.4 Automated Correspondence Generator

- (1) Maintain an automated correspondence capability for responses to recipient inquiry, correspondence, requests for fair hearing, claim reimbursement requests etc.

- (2) Provide a menu-driven letter generation capability allowing users to choose a standard letter or to develop a customized letter.
- (3) Obtain department approval for content of all letter templates designed for repeated use. Letters that are not designed for repeated use but are rather generated on specific case-by-case basis must be reviewed/approved by Contractor's recipient services supervisory or management staff before mailing.

5.6.2.3.5 Recipient Relations

The Contractor must maintain accurate, professional, and culturally sensitive communications with the recipient community. Recipient inquiries can be received via various modes (e-mail, Web portal's "contact us" link, written correspondence, telephone calls, in-person visits, encounters with various recipient advocacy associations/organizations) either directly to the fiscal agent or through the department. The Contractor will be required to create a continuous quality improvement system that incorporates systematic operating procedures for recipient relations functions to include forms/documentation, interfaces, work flow, MMIS database entry/maintenance/management, identification of stakeholders (internal fiscal agent staff, State/agency staff, external parties) roles and instructions for each, for review and approval by the State. The comprehensive workflow management system will collect data on critical to quality processes and recommend changes to systems based on analysis. Contractor will create a professional culture that embraces refinements to work flow.

- (1) Respond to and document (in automated tracking system) all telephonic and written inquiries from recipients regarding their eligibility, claim payment status, service authorization activities, and other matters. Automatically generate recipient correspondence including form letters and individualized letters. All output must be automatically tracked and retrievable.
- (2) Maintain sufficient staff, telephone lines and toll-free incoming telephone lines for recipient inquiry available to all eligible recipients. Staff operators must be available to answer calls from 7:00 am to 6:00 pm Alaska time Monday through Friday and Saturday and Sunday from 9:00 am to 4:00 pm, except standard holidays. The Contractor may not impose limits on the number of issues raised or the time required to fully resolve inquiries recipients make during a single telephone call.
- (3) Provide four (4) hours of initial and 16 hours annually of training to all staff (call center, publication, other, supervision/management) in billing procedures, MMIS adjudication processes, current Alaska Medicaid program rules/policies, telephone etiquette, customer service training, confidentiality/privacy, use of all internal and external tools/applications available to staff and providers, etc. to ensure that the staff can respond accurately and completely to recipient inquiries and questions
- (4) Provide cross-cultural, and grief, death, and dying communications training specifically geared to the unique recipient population and health care delivery infrastructure in Alaska to all staff having contact with individuals involved in the Alaska medical assistance programs.

- (5) Maintain sufficient office space and staff to accommodate individual recipient relations and assistance in Anchorage, including a conference room with a terminal for inquiry into the recipient's claims history and other information.
- (6) Develop and provide capability for a recipient inquiry via Internet/Web portal, etc with appropriate security to ensure that correspondence between the recipient and the fiscal agent is in compliance within federal and State security standards.
- (7) Ensure that provision of and access to claims data and other information is limited to claims submitted on behalf of the recipient or their authorized representative making the inquiry in accordance with federal and State privacy/confidentiality standards.
- (8) Produce and update publications for recipients with input and approval of DHSS. Produce the publications in camera-ready form and provide the publications to the State in hardcopy or on diskette at the State's discretion. The publications will include a comprehensive Recipient Benefit Guide to include (but not limited to) sections on the following topics:
 - (a) CAMA Benefits Program
 - (b) Denali KidCare Benefits Program
 - (c) Medicaid Benefits Program
 - (d) Other Benefits Programs

Each section will include the following subsections where applicable:

- (e) Children's Services Benefits
 - (f) Pregnant Women's Benefits
 - (g) Family Planning Benefits
 - (h) Breast and Cervical Health Check Benefits
 - (i) Transportation/Accommodation Benefits
 - (j) Disabled Beneficiary Benefits
 - (k) Senior Beneficiary Benefits
 - (l) Home and Community Based Waivers Benefits
 - (m) IHS Beneficiary Benefits
 - (n) TEFRA Benefits
- (9) Maintain a historical library of all recipient publications and updates. The library should be established and maintained on CD-ROM or other DHSS-approved electronic media from the beginning of the new contract period. The archive of publications must meet the following criteria:
 - (a) All versions of publications must be available and easily retrievable in electronic format.
 - (b) All versions and updated pages must be dated.
 - (c) Backup documentation to demonstrate approved changes will be imaged or archived in hardcopy.
 - (d) Backup documentation must be retrievable by the Contractor and delivered to DHSS within one business day of the written request.
 - (e) Historical and current publications must include the ability to search by key words or phrases across all publications in a single search query and produce a report of affected pages within the publication.

- (10) Develop a recipient website that contains information about the Alaska medical assistance programs, includes links to other recipient-related websites and other features including a provider locator function. Obtain DHSS approval of all website material prior to posting the material on the website. Include the following items on the Web site:
 - (a) FAQs
 - (b) How To's
 - (c) Quick reference information
 - (d) What's New
 - (e) Links
 - (f) Recipient publications, bulletins, newsletters and help guides
 - (g) All forms
 - (h) Web portal activities requiring recipient log-in/authorized user
 - (i) Contact us (i.e., receive and respond to inquiries)
 - (ii) Responses to customer satisfaction survey/form for comments
- (11) Produce and/or distribute digital presentations for use by State-designated agencies to explain Medicaid to recipients. These electronic presentations use printed content, still or moving graphics, sound or like media and may be distributed to State agencies and other parties as specified by the department. The presentations must be made available for access by recipients and others via the Contractor's website and on CD-ROM. The Contractor will produce a new presentation or update an existing presentation a maximum of four times per year.
- (12) Ensure that the recipient website is listed on the major search engines.
- (13) Process requests made by recipients related to obtaining reimbursement and claims resolution when the recipient has made payment for their health care services. Receive, track, review, and respond to recipient reimbursement requests in writing.
- (14) Assist DHSS staff with research and resolution of recipient issues and problems brought to the State's attention.

5.6.2.3.6 Recipient Fair Hearing Support

- (1) Develop and maintain a recipient fair hearing review, preparation, and support process through which recipient disagreements are settled. This process must be in compliance with federal guidelines 42 CFR 431.200 through 431.245 and Alaska Administrative Code 7 AAC 49.010 through 49.900 and AS 47.25.180. The fair hearing process must be in place for denial of service authorization, claims denial/reduction disputes, and other areas of disagreement. DHSS must approve the Contractor's fair hearing support process.
 - (a) Document and coordinate recipient fair hearings requests.
 - (b) Participate in recipient pre-hearing conferences during which Contractor staff will assist DHSS in providing the recipient with medical coverage information and respond to questions regarding medical coverage policy. No determinations are made at the pre-hearing conference without prior approval from DHSS.
 - (c) Coordinate fair hearings and provide DHSS with necessary information to review the case.

- (d) In the event travel is required, the Contractor will bill travel cost according to DHSS travel policies.
- (e) Contractor's fair hearing support functions are subject to State and federal rules concerning timely and adequate response during the fair hearing process.
- (2) Process fair hearing requests according to procedures approved by DHSS.
- (3) Provide access to fair hearing data to DHSS staff as requested.
- (4) Track all fair hearing support functions and activities in the automated tracking system.

5.6.2.3.7 Quality Assurance/Improvement – Recipient Eligibility and Relations

Monitor quality and work toward continued quality improvement in all areas related to Recipient Eligibility and Relations. In addition to provisions otherwise included in this section, the following monitoring and reporting requirements must be met:

- (1) Notify the department within one (1) business day of any significant failure (or factor that may otherwise signal impending failure) to properly carry out the business and other required functions contained within this Recipient Eligibility and Relations section.
- (2) All calls will be recorded and archived for retrieval as needed.
- (3) Monitor activities, maintain and review data including statistics showing reasons for calls, claim editing/errors, etc and initiate enhancements to reduce the number, duration, and manual processing time for claims and calls through better automation, better staff training, or other interventions.
- (4) Report on quality in performance reports to department; include comparison quality measures in current and previous reporting periods.
- (5) Initiate, document and implement at the Contractor's own initiative, plans for improvement for any function when quality deteriorates for two (2) consecutive months.
- (6) Document and implement corrective action plans when requested by the department.
- (7) Provide support for survey of customers (recipients and providers), including printing survey forms/web completion support, selection of recipients and/or providers, distribution, data results collection and reporting, analysis and summary of survey results. Customer satisfaction surveys are to be conducted at least quarterly at the direction of the State.

5.6.2.4 Interfacing Systems

- (1) Receipt and processing of eligibility and other data received from the State's Eligibility Information System (EIS).
- (2) SDX (daily Medicare eligibles from SSA).
- (3) BENDEX from SSA.
- (4) EDB from CMS.
- (5) MBD.

- (6) State Online Query (SOLQ) for real-time Medicare inquiry transactions.
- (7) Medicare premium Buy-in files to and from CMS.
- (8) E02 transactions.
- (9) Medicaid eligibility files to CMS and its Contractors.
- (10) Receipt and processing of date of death data from Vital Statistics.
- (11) Receipt and processing of LTC data from the Division of Senior Services or other State-designated agency or Contractor.
- (12) CMS MMA State Response File.

5.6.2.5 Inputs

- (1) EIS
- (2) Prepayment Review Update Date
- (3) Long Term Care Authorization
- (4) Buy-In Transaction
- (5) Medicare Premium files
- (6) Mailing Labels Request Form
- (7) Alaska Bureau of Vital Statistics
- (8) SDX
- (9) MDB
- (10) BENDEX File
- (11) SOLQ
- (12) Paid Claims for Service Limit Data
- (13) Recipient Update Screens
- (14) Recipient Inquiry Screens
- (15) Recipient Telephone Inquiries
- (16) EDB File
- (17) SVES
- (18) On-line Buy-in updates

5.6.2.6 Outputs

Provide for on-line viewing of all MMIS reports except those designated by DHSS to be routinely provided in hard copy. On-line reports will be available on request by DHSS in the media specified by the user (e.g., downloadable file, diskette, optical storage, or hard copy). All MMIS outputs must be archived for permanent storage in electronic media approved by DHSS.

- (1) EIS Interface Update Error Listing Report

- (2) EIS Interface Audit Trail Report
- (3) Recipient Control Report
- (4) Recipient On-line Update Audit Trail Report
- (5) Possible Duplicate Recipient Alpha Report
- (6) Possible Duplicate Recipient SSN Report
- (7) Recipient Eligibility History Database Report
- (8) Active Recipient Summary Report
- (9) File Audit Report of Mismatches
- (10) Inactive Recipient Trending/Aging Summary Report (from previously active recipient data)
- (11) File Audit Report of Mismatches
- (12) Lock-In Exception Report
- (13) Recipient Lock-In Report
- (14) Lock-In Reinstatement Report
- (15) Recipient Numeric Listing (by selected fields, e.g., program code, eligibility code, eligibility subtype, village/district/region)
- (16) Recipient Alphabetic Listing (by selected fields, e.g., program code, eligibility code, eligibility subtype, village/district/region)
- (17) Retroactive Eligibility Report
- (18) HIC Number Change Report
- (19) Billing Match Review in HIC Number Order
- (20) Billing Match Review in Recipient Order
- (21) Billing Match Listing in HIC Number Order
- (22) Billing Match Listing in Recipient Order
- (23) Part A Buy-In HCFA Billing Totals by Transaction Code
- (24) Part A Buy-In HCFA Billing Totals by Category
- (25) Part B Buy-In HCFA Billing Totals by Transaction Code
- (26) Part B Buy-In HCFA Billing Totals by Category
- (27) Part A Buy-In HCFA Billing List Details in HIC # Order
- (28) Part B Buy-In HCFA Billing List Details in HIC # Order
- (29) Part A Billing record with no matching Part B record
- (30) Part B Billing record with no matching Part A record
- (31) Part A Accretion and Deletion Denials

- (32) Part B Accretion and Deletion Denials
- (33) Daily history Log
- (34) Buy-In Details in Alphabetic Order
- (35) Deaths Reported Via Tran Code 16
- (36) Deletions With 1728 Code – Requested By Other State
- (37) Processing Exceptions Accumulated Totals
- (38) HIC # Changes
- (39) Rejected Accretion Attempts
- (40) Rejected Deletion Attempts
- (41) Buy-In Adjustments
- (42) Part A Buy-In HCFA Billing List Details in Recipient ID Order
- (43) Part B Buy-In HCFA Billing List Details in Recipient ID Order
- (44) Buy-In Premium Transactions Sent to HCFA Details by Agency, Tran Code, Recipient
- (45) Buy-In Premium Transactions Sent to HCFA Details in HIC # Order
- (46) Buy-In Premium Transactions Sent to HCFA Details By Transaction Origin and Recipient
- (47) Buy-In Premium Transactions Sent to HCFA Details By Recipient, Agency, Tran Code
- (48) Rolling 3 Months Buy-In (Accretions and Deletions)
- (49) Rolling 3 Months Buy-In Activity
- (50) Buy-In Demographic Data
- (51) Buy-In Statistics By Eligibility Code (xxx = QMB, SLMB, MAO, and Other)
- (52) Buy-In Statistics By Type Old Date = mm/ccyy New Date = mm/ccyy
- (53) Part x Buy-In Statistics By Transaction Code Old Date = mm/ccyy New Date = mm/ccyy
- (54) Part x Buy-In Statistics By Transaction Type Old Date = mm/ccyy New Date = mm/ccyy
- (55) Buy-In Statistics By Origin Code Old Date = mm/ccyy New Date = mm/ccyy
- (56) Buy-In Statistics By Part, Req Type, Response Old Date = mm/ccyy New Date = mm/ccyy
- (57) Cases Not Bought In Details By Elig Code and Elig Group (xxx = QMB, SLMB, MAO)
- (58) Recipients Rejected With 21xx A
- (59) Recipients With Self HIC Out of Sync With SSN
- (60) Buy-In Part x HCFA Billed for mon, ccyy Preliminary Totals By Transaction Code (Part A and B)
- (61) Buy-In Part x HCFA Billed for mon, ccyy Preliminary Totals By Transaction Type (Part A and B)

(62) CMS MMA file

(63) CMS Eligibility file(s) for Medicare to Medicaid Cross-Over claims

Medicare effective dates (begin/end) for part A and Part B should update MMIS including claims from EDB regardless of buy-in.

5.6.2.7 Performance Standards

- (1) Update the recipient eligibility database with electronically received data, and provide DHSS with update and error reports within twenty-four (24) hours of receipt of the update. The update will start within two (2) hours of receipt for a real-time processing environment. For a batch-processing environment, updates must be done prior to daily claims processing.
- (2) Maintain a 99% accuracy rate on electronic eligibility file updates.
- (3) Resolve eligibility transactions that fail the update process within two (2) business days of error detection.
- (4) Refer to the State all eligibility transactions that fail the update process and cannot be resolved by Contractor staff pursuant to edit rules or State approved standards within two (2) business days of attempted error resolution.
- (5) Reconcile the MMIS eligibility data with the EIS reconciliation file monthly by the fifth day of the following month, and provide DHSS with reconciliation reports within 24 hours of receipt of the reconciliation file.
- (6) Perform on-line updates for hardcopy update transactions to recipient data within one (1) business day of receipt.
- (7) Maintain a 98% keying accuracy rate for on-line updates. Strive for a keying accuracy of 99.9%.
- (8) Keying errors in on-line updates must be identified and corrected within one (1) business day of the update.
- (9) Complete the monthly buy-in processing in accordance with federal and State timeliness requirements but no later than the 25th of each month.
- (10) Produce recipient mailing labels within 3 days of receipt of the request.
- (11) Provide access to archived and purged data within three (3) business days of receipt of the request.
- (12) Produce beneficiary guides in print-ready form within sixty (60) calendar days from the date of DHSS's written initial work order requesting the new or updated guide.
- (13) No more than five percent (5%) of incoming calls may ring busy.
- (14) Ninety five percent (95%) of all calls that do not ring busy must be answered on or before the fourth ring.
- (15) Ninety five percent (95%) of calls that are answered must be answered by a live person.
- (16) Hold time must not exceed two (2) minutes for ninety-five percent (95%) of calls.

- (17) The average hold time must not exceed thirty (30) seconds.
- (18) Respond to at least 90% of telephone inquiries during the initial call from the recipient.
- (19) Respond to written, faxed, or e-mailed inquiries within five (5) business days of receipt.
- (20) Prepare and deliver in final form updates to publications to DHSS for review and approval within three (3) working days of the date requested by DHSS or the date changes proposed by the fiscal agent were approved by DHSS.
- (21) Publish updates on the fiscal agent web site within two (2) working days of the date of the DHSS's written approval for publication.
- (22) Produce and distribute new publications and publications with extensive changes in final form no more than sixty (60) calendar days from the date of the DHSS's written request for the new or updated publication or the date changes proposed by the fiscal agent were approved by DHSS.
- (23) Participate in monthly meeting with DHSS counterpart.
- (24) Provide monthly performance reports on call center activity.

5.6.3 Benefit Packages

Benefit Packages encompass those functions necessary to define the services that will be covered by Medicaid, any of Medicaid's programs or other State programs designed for specific recipient populations. These functions include:

- (1) Benefit plan definition including rules.
- (2) Recipient population definition (e.g., all Medicaid recipients, all recipients in a specific program or eligibility category, only recipients within a certain age range).
- (3) Service coverage information (e.g., inpatient hospital, physician, pharmacy; procedures, drugs).
- (4) Service limitations.
- (5) Provider eligibility.

Providing the functional criteria is the responsibility of DHSS and the other State agencies whose claims may be processed in the MMIS. Once the State policy has been defined, DHSS communicates the requirements to the fiscal agent for implementation in the MMIS.

DHSS has identified additional MMIS functionality this is required for compliance with the Deficit Reduction Act of 2005. The MMIS must be capable of full compliance with the Act including the following benefits provisions:

- (6) Processing the purchase of Medicaid coverage by families of disabled children for such children.
- (7) Participating in demonstration project regarding home and community-based alternatives to psychiatric residential treatment facilities for children.
- (8) Sustaining the development and support of family-to-family health information centers.

- (9) Participating in the money follows the person rebalancing demonstration program.
- (10) Participating in the health opportunity accounts demonstration program.
- (11) Supporting an established non-emergency medical transportation brokerage program.

5.6.3.1 Business Needs

The primary objectives of Benefit Packages are to:

- (1) Define the recipient populations to be covered.
- (2) Define the services, their limitations and requirements which are covered.
- (3) Determine the payment methodology.
- (4) Define the providers who can render the services.
- (5) Ensure that the benefit packages are implemented timely in the MMIS to allow correct claim payment.
- (6) Allow for recipient enrollments in multiple programs with overlapping begin and end dates.
- (7) Provide the flexibility to quickly and easily make changes to Benefit Packages/Plans.
- (8) Provide the ability to view Benefit Package history on-line.

5.6.3.2 State Responsibilities

- (1) Define recipient population to be covered.
- (2) Define services to be covered.
- (3) Define providers eligible to provide services.
- (4) Determine payment methodology.
- (5) Prepare approved policy Statement and State Plan amendment as necessary.
- (6) Define system requirements for the addition of a new benefit package or modification of an existing benefit package including:
 - (a) Recipient population
 - (b) Specific services included in the benefit
 - (c) Service limitations
 - (d) Provider criteria
 - (e) Appropriate claim edits and audits
 - (f) Reimbursement methodology
 - (g) Reporting requirements
 - (h) Effective dates
 - (i) State policy changes

5.6.3.3 Contractor Responsibilities

The fiscal agent processes required to implement and support Benefit Packages in the MMIS include the following:

- (1) Prepare a system impact Statement which identifies all system (computer and operations) and user components affected by any change to Benefit Packages.
- (2) Develop and obtain approval of a requirements document when new functionality is requested by DHSS.
- (3) Upon approval of the requirements document and impact Statement, prepare the changes for the MMIS.
- (4) If system programming changes are required, code and test the changes, and provide test results to DHSS and the requesting agency, if other than DHSS.
- (5) Update all documentation including system, user staff and provider resources.
- (6) Conduct training for providers and user staff.
- (7) Upon DHSS approval, implement Benefit Package changes.
- (8) Monitor quality and identify areas for improvement.

5.6.3.4 Interfacing Systems

External interfaces, if any, will be defined during the requirements analysis for implementation of any new benefit packages.

5.6.3.5 Inputs

- (1) Request for New Benefit Package.
- (2) Request for Changes to Existing Benefit Package.

5.6.3.6 Outputs

Reporting requirements include and are not limited to audit trails, recipient notices, enrollment reports, user and provider training reports, system adjudication reports by benefit program, system performance reports, quarterly and annual statistical reports as well as reports identified during the requirements analysis, system documentation, system testing, implementation and certification phases of the MMIS. Additional reports may be specified when a new benefit is requested.

5.6.3.7 Performance Standards

The Contractor must meet the performance standards for system maintenance, operations and enhancements when implementing new Benefit Packages and maintaining existing Benefit Packages.

5.6.4 Provider Enrollment and Relations

The Provider Enrollment and Relations function encompasses those functions necessary to encourage the participation of qualified providers in the Alaska medical assistance programs, enroll and maintain provider data, and provide publications, training and assistance to providers that participate. These functions are primarily the responsibility of the fiscal agent and follow DHSS policies. See also, Provider conversion requirements in 5.5.8.3.

All provider enrollment and relation functions shall be supported using the NPI, taxonomy, and other “State-defined” information to uniquely identify each provider. The system must meet all requirements specified in the National Provider Identifier (NPI) regulation.

5.6.4.1 Business Needs

The primary objectives of the Provider Enrollment and Relations function are to:

- (1) Encourage participation of qualified providers in the Medicaid program through the provision of timely, accurate, up-to-date educational materials/publications, professional response to inquiries, and timely processing of provider application and change information.
- (2) Maintain a timely, accurate, automated, date-sensitive data repository of enrolled providers including current and historical status; eligibility to render services for specific programs; specific categories of service or specific procedures or services; rates of reimbursement, licensure and certification data; various address and contact information; various provider identifiers/enumerators; provider ownership information; provider affiliations with group practices, managed care organizations, multiple business sites, billing services/agents, and other entities.
- (3) Collect, control, and process provider enrollment and status information. The business process of enrolling providers should be automated and must include the provision of efficient tools made available to the provider community and the State for this purpose, including a Web portal.
- (4) Support the data requirements for claims processing, timely information access and decision support, utilization review and quality assurance, TPL, EPSDT, POS, Retrospective DUR, PERM, and managed care.
- (5) Maintain date-specific enrollment and demographic information in the State’s medical assistance programs, including Medicaid and the programs provided other divisions within the Department that may utilize the MMIS in the future.

5.6.4.2 State Responsibilities

- (1) Develop policy and monitor the performance of the Contractor in all areas of the Provider Function.
- (2) Review and approve all inputs (hardcopy forms, electronic formats and content standards, printed and on-line displays, enrollment applications/various agreements, etc.) and all outputs (reports, letters, publications, website, quality assurance/quality improvement content standards, printed and on-line displays) used in the automated and operational provider functions.
- (3) Approve Contractor’s plan, including all procedures and systems used by the Contractor, for managing the provider enrollment function.
 - (a) Approve Contractor’s plan for verification of provider licensure, certifications, permits, ownership, and other items required for provider enrollment.
 - (b) Provide Contractor with guidelines and information regarding licensure, certification, recertification, and decertification.

- (c) Approve or deny certain problematic enrollment applications referred to DHSS by the Contractor.
- (d) Convey policy and approve procedures for use by Contractor to approve providers/trading partners to submit and receive various electronic transactions and to restrict submission of transactions to those approved for each provider, submitter, and transaction.
- (e) Convey policy approve procedures for use by Contractor to authorize EFT capabilities for eligible providers.
- (4) Convey policy and approve procedures/processes for use by Contractor to resolve suspended claims and/or errors related to provider issues.
- (5) Convey policy and approve procedures/process for use by Contractor to authorize the pending of a provider's claims (selected services, selected programs, or all claims) for medical review.
- (6) Approve Contractor's plan for workflow, business processes, automated tracking system, scripts, guidelines for release of information, etc. for use by Contractor staff in the performance of provider customer service in relation to telephonic and written inquiries/correspondence.
- (7) Convey policy and approve procedures/processes for use by Contractor to perform provider appeals process.
- (8) Convey policy and approve procedures/processes for use by Contractor to perform provider training including plan, schedule, materials, and media.
- (9) Convey policy and approve procedures/processes for use by Contractor to obtain State approval of the content of all publications including remittance advice messages and information posted to the website prior to distribution, and approve the process for producing and distributing publications.
- (10) Provide updates and information for the geographic code table.
- (11) Process second and third level provider appeals.
- (12) Respond to external requests for Alaska DHSS program data.

5.6.4.3 Contractor Responsibilities

The business processes required to support the Provider Enrollment and Relations function include:

- (1) Provider Database Maintenance, Update and Edit Function
- (2) Provider Licensure, and Certification, Permit, Grant, Ownership
- (3) Entity Cross-Referencing
- (4) Purging the Provider File
- (5) Rate Change Information
- (6) Maintain Provider Demographic and Other Data
- (7) Maintain Provider Financial Data

- (8) Automated Voice Response (AVR) Capability
- (9) Eligibility Verification System (EVS)
- (10) Automated Tracking Capability
- (11) Automated Correspondence Generator
- (12) Provider Enrollment Function
- (13) Provider Relations Function
- (14) Provider Appeals
- (15) Provider Education Function
- (16) 1099 Function
- (17) Support Applicable HIPAA Transactions

5.6.4.3.1 Provider Maintenance, Update and Edit Function

The system shall provide the following functionality related to maintenance of provider information:

- (1) Maintain current and accurate, date-sensitive information on providers' eligibility to render specific services, at specific locations, to specified categories of eligibles.
- (2) Maintain date-sensitive demographic information including provider type, specialty, and taxonomy for all provider types, and provide for multiple provider types, multiple specialties, multiple taxonomy designations, and multiple office locations on a single provider record.
- (3) The Contractor will be required to eliminate as much as is possible multiple provider numbers, including converting claims history to the single provider number.
- (4) Maintain signed provider contracts/agreements necessary to support the status of the provider as an electronic transaction biller submitter/receiver and/or EFT provider.
- (5) Maintain historic and date-sensitive rate information for providers who have provider-specific rates or rate components, including on-line access to 10 years of provider rates, historical provider information and effective dates.
- (6) Maintain current and historical date sensitive addresses for a provider, including:
 - (a) Pay-to
 - (b) Mail-to
 - (c) Service location(s)
 - (d) Publication distribution addresses and media
 - (e) Other addresses

The Contractor must exert special control on provider address changes.

- (7) Maintain multiple telephone numbers and e-mail addresses for a provider, including business phone, FAX number, and e-mail address for each location.
- (8) Maintain a minimum of five (5) contacts for each provider, including contact type defined by DHSS, contact name, address, e-mail address, and phone number.

- (9) Maintain enrollment information on providers who do not currently submit detail claims for payment, including but not limited to:
 - (a) Providers who are renderers only
 - (b) Providers who are paid by reimbursable service agreements (RSA)
- (10) Maintain indicator(s) on the provider database for use in identifying special pricing or payment processes, and provide the capability to add additional values without extensive programming. Currently this indicator is used to identify:
 - (a) Providers whose services are covered at 100% FFP. These currently include the Indian Health Services providers.
 - (b) Small Hospital Reimbursement. This includes a classification of inpatient hospital providers established by the department which allows payments at greater than billed charges.
 - (c) Outpatient hospital providers paid at a percent of charges rather than the Medicare fee schedule.
 - (d) Critical access hospitals
 - (e) Hospital-based physicians
- (11) Develop and utilize DHSS-approved, and automatically enforce consistent, standard formats for entry of data into the provider database (e.g., name configuration, address data, titles, State, and country). Differentiate between first names, last names, and business or corporate names, and allow flexible searches based on the provider name.
- (12) Provide on-line access to the provider master file with inquiry by:
 - (a) Provider number
 - (b) Provider name
 - (c) License number
 - (d) Group number
 - (e) SSN
 - (f) FEIN
 - (g) DEA number
 - (h) UPIN
 - (i) NPI
 - (j) NCPDP number
 - (k) Medicare number
 - (l) Specialty
 - (m) Taxonomy
 - (n) Business name
 - (o) Provider type
 - (p) Owner name/owner entity name
- (13) Provide on-line inquiry access to other State Contractors (e.g., QIO, TPL, Vision, etc.) using special inquiries with access only to DHSS-specified data.
- (14) Include an indicator/capability on the main provider display screen to identify whether the owner or provider is cross-referenced to other entities, and if so, the type(s) of entity (e.g., group, clinic, managed care organization, etc.), associated dates, and cancellation codes.

- (15) Accept Medicare provider number, NPI, or Medicaid provider number for rendering or billing provider information for various transactions including claims.
- (16) Provide for on-line daily maintenance of provider information, including the following types of transactions:
 - (a) Add a provider and all associated demographic, rate, and date information
 - (b) Change any element in the provider record
 - (c) End-date any date information
 - (d) Change status from active to inactive
 - (e) Reinstate de-activated providers previously placed in inactive status
 - (f) Archive provider records
 - (g) Cancel prior transactions with appropriate levels of authorization
 - (h) Begin and end dates for all cross-referenced entities on both the individual record and the entity record
- (17) Provide for mass updates when requested by DHSS, e.g., rate changes.
- (18) Edit each data field for syntax and paradigmatic validity. Only valid data can update the provider file.
- (19) Maintain audit trail of all file updates, accessible through on-line inquiry. Maintain control totals and provide balance information in response to on-line requests.
- (20) Provide on-line database and provider file updating and inquiry.
- (21) Provide tools to support user-friendly on-line access and query support to provider data.
- (22) Provide for on-line viewing of all MMIS reports except those designated by DHSS to be routinely provided in hard copy. On-line reports will be available on request by DHSS in the media specified by the user (e.g., downloadable file, diskette, optical storage, or hard copy). All MMIS outputs must be archived for permanent storage in electronic media approved by DHSS.

5.6.4.3.2 Provider Licensure and Certification

- (1) Maintain date-sensitive, historical provider license, certification, permit, grant, and ownership status information, including type of license/certification/permit /grant (LCPG), source of LCPG, begin/end date of LCPG, and associated LCPG numbers.
- (2) Identify providers whose licenses, certifications, and permits, and grants are about due to expire ninety (90) days prior to the end date of the current certification, licensing, or permit, or grant period. Notify providers in writing ninety (90) days and thirty (30) days prior to expiration, and suspend all claims for sixty (60) days after expiration if the new license, certification, or permit, or grant is not provided. If the information is not provided within sixty (60) days after expiration, deny the claims.
- (3) Ensure current provider licensing, certification, and permit, grant, and ownership data through automated and manual updates.

5.6.4.3.3 Entity Cross-Referencing

Capability must exist to accurately and efficiently allow for the relationship of providers, provider groups, trading partners/vendors, and persons with ownership or management interest to be recorded, tracked, cross-referenced and available for use in queries and/or reporting.

- (1) Maintain date-sensitive two-way cross-references between an enrolled provider and any of the following entity relationships which apply to the provider:
 - (a) Group practice
 - (b) Billing service vendor ID
 - (c) Hospital-based physician to hospital
 - (d) IHS affiliation
 - (e) Clinic
 - (f) Partnership, ownership, corporation, conglomerate
 - (g) Medical school
 - (h) Emergency room physician group
 - (i) Resident or intern to hospital
 - (j) School-based association
 - (k) Mental health or other case management team
 - (l) Independent laboratories, x-ray facilities, and imaging centers
 - (m) Other associations as needed

“Two-way” cross-reference means that inquiries and linkages for editing and reporting can be made between the individual and the associated entities, and the entities and the individual.

- (2) Cross-reference between any two of the following:
 - (a) National Provider Identifier (NPI)
 - (b) UPIN
 - (c) License numbers
 - (d) DEA numbers
 - (e) Medicare ID
 - (f) Tax ID
- (3) The reporting capability must be able to report on provider Tax identification (FEID or SSN) or an NPI with multiple subparts’ total business or their billings associated with a specified service or cost center based on provider type, specialty, taxonomy, etc. During the re-enrollment process, the Contractor will be required to eliminate, as much as possible, the duplicate provider numbers and convert claims history to merge all claims under a single provider number.
- (4) Associate physician interns, physician assistants, and other practitioners with individual physicians or physician groups, clinics, etc.
- (5) Cross-reference individual physicians, dentists, and other providers to FQHCs, rural health clinics, and other institutional or clinic-based locations.
- (6) Include date spans (i.e., from and through dates) for all affiliations and indicators to identity affiliation types.

- (7) Maintain date sensitive, historical information regarding providers' trading partner relationships including billing agents, POS switch vendors, etc and utilize this information to limit electronic transaction receipt/response to the appropriately identified trading partner as applicable. Include capability to allow providers to have different electronic submission status; add/change trading partners, and ensure that providers/trading partners in the process of testing the submission or receipt of electronic files or who are otherwise in test mode cannot erroneously submit claims into production.

5.6.4.3.4 Purging/Archiving the Provider File

- (1) Upon request of DHSS, the provider file can be purged and archived automatically using criteria specified by DHSS and including length of period of inactivity (e.g., 12 months, 18 months), and provider type (pharmacies, independent labs). Criteria for the purge/archive may be changed by DHSS.
- (2) Process should include automated production of purge/archive report based on the criteria with review by DHSS. The intent of DHSS is to review the purge report and change the provider status to inactive, rather than to purge providers from the database. However, the system must maintain the capability to purge providers in the future should DHSS decide to use this option.
- (3) At any time, on-line, DHSS can change or request fiscal agent to change the status of a provider from active to inactive, inactive to active, and can inquire into only active providers, only inactive providers, or all providers. Appropriate security authorization to change such critical information must be required.
- (4) At any time, on-line, DHSS can inquire into the providers currently meeting specified criteria for potential inactive status.
- (5) Provide authorized users with on-line manual update capabilities to purge providers as needed. Include capability to request purged provider reports as needed.
- (6) Purge process requires separate parameters for in-State, border States, and out-of-State providers.

5.6.4.3.5 Rate Change Information

- (1) Maintain date-sensitive, historical rate information for any provider reimbursed by an individual or provider type (or taxonomy) rate. Providers that may be reimbursed using rate data from the provider database include ICF, SNF, ICF/MR, Inpatient, Outpatient, Home Health, Hospice, FQHC, Rural Health Clinics, RPTCs, IHS Clinics, ESRDs, and Pharmacy providers. The types of rates to be maintained on the provider database include but are not limited to:
 - (a) Institutional per diem rates
 - (b) Revenue code specific rates
 - (c) Clinic encounter rates
 - (d) Percentage of billed charges
 - (e) Dispensing fees
 - (f) Percentage of AWP
 - (g) Case management fees

- (h) Level of care
- (i) Cost center
- (2) Provide the capability to update rate changes on-line.
- (3) With proper security authorization, updated prior rates at DHSS request at any time. Any previous rate and time periods may be selectively changed. The proposed system must be able to reprocess all claims affected by the retroactive change through an automated mass adjustment system. Currently this is a separate process within the MMIS for institutional facilities only.
- (4) All rate change transactions are edited for validity and are subject to on-line audit trail, control totals, balance inquiries, and the Contractor's quality assurance protocols.
- (5) Where the rate change affects a group of providers (e.g., all pharmacies, all SNFs), the Contractor will provide the functionality to make this type of change through a mass update.
- (6) Maintain multiple provider specific reimbursement rates with begin and end dates including:
 - (a) Case mix
 - (b) Preferred provider agreements
 - (c) Volume purchase contracts
 - (d) Other cost containment initiatives

5.6.4.3.6 Maintain Minimum Provider Demographic and Other Data

Maintain any provider data needed to meet MMIS functional requirements, including system certification, data available in the current MMIS (including SURS, DW/DSS, and operational components), and additional data requirements specified by federal and State law, and at the request of DHSS. The Contractor must maintain the record of all relevant provider information including provider enumerations (NPI, Medicaid, and Medicare), service types, specialties/taxonomy, owners, affiliations, billing agents, locations, addresses, (postal/e-mail), contacts, etc. At a minimum, the system will capture, maintain, and provide on-line query to the following data:

- (1) Provider IDs issued by the State or federal NPI enumerator and all related entities associated with and affiliated with the individual provider.
- (2) Provider names, including history of any name changes and "doing business as" (DBA) names if different from the provider name.
- (3) Provider contact information, including names, contact type, addresses, phone numbers, e-mail addresses, and associated date spans.
- (4) Address and ZIP code of each provider location.
- (5) Multiple region associations (e.g., village, election district, region, and ZIP code) for a provider, including region type, associated dates, and region codes with cross-references to the geo code table.
- (6) Provider business office address, telephone number and pay to address and name of billing office.

- (7) Number of beds by type and/or level of care per facility.
- (8) Program participation association, (e.g., Medicaid, CAMA, Mental Health, Developmental Disability, Medicare only, EPSDT, Handicapped children, foster children, and others).
- (9) Submitter ID information for providers and/or their designated trading partners to include extent of electronic transaction submission/response capabilities detailing HIPAA transaction and each Contractor-supplied application with indication of test/production status.
- (10) Mode of payment, (e.g., State warrant, EFT, interagency transaction, electronic remittance advice, non-pay such as DPH nurses).
- (11) Date-sensitive service or payment restrictions placed on the provider including the capability to pend all claims or to pend claims for specific procedure and/or revenue codes for a designated level of review; includes restriction reason code and start and end dates. Produce regular reports listing such providers and payment restrictions to appropriate department staff.
- (12) Geographic relationship codes including ZIP codes of provider locations, election district code, village code, provider EPSDT region code (Position Control Number region and service regions for Public Health nurses), provider pharmacy prior resource (designates pharmacy located near IHS services clinic) with cross references to the geo code table; allow for updates to the geographic codes when changes are made by the State.
- (13) FFP indicator for IHS providers and 638 Compact providers.
- (14) CLIA number and effective dates.
- (15) Lock-in/lock-out relationships.
- (16) User ID numbers assigned for access to EVS/AVR/Web portal/etc; each provider file shall include names and unique ID numbers assigned to providers' designated staff who are responsible for accessing these and other automated systems.

5.6.4.3.7 Maintain Minimum Provider Financial Data

Update and maintain at a minimum automated financial data accessible to on-line inquiry, as follows:

- (1) Reimbursement rate including per diem, percent of charges, case management fee, per capita rate, payment rate for specific procedure/revenue code, prescription dispensing fee, and others.
- (2) Date and amount of past cost settlements and time period associated with the settlement.
- (3) Overall payment percentage based on allowed amounts for claims paid each provider.
- (4) Current cycle:
 - (a) Remittance date
 - (b) Remittance number
 - (c) Warrant number/EFT transaction number
 - (d) Number, billed, and paid amounts for paid claims

- (e) Number and billed amount of pended claims
- (f) Number and billed amount of denied claims
- (5) Month-to-date:
 - (a) Number, billed, and paid amounts for paid claims
 - (b) Number and billed amount of pended claims
 - (c) Number and billed amount of denied claims
- (6) Calendar current year and prior year to date:
 - (a) Number, billed, and paid amounts billed for paid claims
 - (b) Number and billed amount of pended claims
 - (c) Number and billed amount of denied claims
 - (d) Amount returned/recovered
- (7) State fiscal year to date:
 - (a) Number, billed and paid amounts billed for paid claims
 - (b) Number and billed amount of pended claims
 - (c) Number and billed amount of denied claims
 - (d) Amount returned/recovered
- (8) Current negative balance amount:
 - (a) Dollar limit and/or percentage of negative balance to be recovered on next checkwrite
 - (b) Recovery period (i.e., scheduled from and through dates for recovery)
 - (c) Amount of last recovery
 - (d) History of collections (i.e., amount collected and payment date for each payment cycle in which funds were recovered)
 - (e) Source of recovery (e.g., IRS, claim overpayment)
 - (f) Total amount due
 - (g) Current outstanding balance
 - (h) Claim detail records for those claims for which recovery funds were applied
- (9) Current and prior year 1099 amounts

5.6.4.3.8 Automated Voice Response (AVR) Capability

The AVR is a telephone voice and touch-tone response system maintained by the Contractor that provides access to limited data elements from the MMIS. The purpose of the AVR is to provide date-specific information to providers regarding member eligibility, TPL coverage, care management participation, covered procedures, provider payment amounts, etc. Based on the information supplied by the caller, AVR systematically retrieves data, interprets the data, and then communicates the appropriate phrases back to the caller.

- (1) Maintain a state-of-the-art, secure, and user-friendly automated voice response (AVR) capability. Providers will use a Contractor-supplied toll-free telephone number, accessible by touch-tone telephones for all authorized users.
- (2) The AVR product must include a menu-driven design that allows for the use of short-cut key sequences and the ability to support call center integration during call center hours. Monitor provider feedback to menus and options and make continuous improvements based on State and provider feedback.

- (3) Support call center integration minimally as follows:
 - (a) Provide up-front message in the IVR to inform users when the system is down or experiencing difficulties including an indication of when the system is expected to be operational.
 - (b) Roll incoming calls to the fiscal agent call center staff during those instances when the system is unavailable during the hours that the call center/help desk is staffed.
 - (c) Provide straightforward menu option to allow callers to select an option to reach live call center staff/operator during hours that call center/help desk is staffed.
- (4) Provide capability to make changes to/reprogram AVR recorded voice messages/responses/prompts at any time upon request from DHSS.
- (5) Provide sufficient in-bound access lines.

5.6.4.3.9 Eligibility Verification System (EVS)

The Contractor must develop and operate effective means for Medicaid providers, State-designated staff and State-designated Contractors to verify recipients' eligibility status. In addition to responding to fax, secure e-mail, and call-center activities, eligibility inquiries may be made by HIPAA electronic transaction, by pharmacy POS networks/systems, via the Web portal that the Contractor will establish, and through the Contractor's AVR system. Electronic responses to HIPAA transactions must be in HIPAA formats. Responses on the Web portal must meet HIPAA standards.

- (1) Maintain automated, secure, eligibility verification system (EVS) capabilities that meet ANSI and EDI standards as applicable and accessible via various modes, including POS terminal device and the Internet.
- (2) Display on-line in real time and allow for users to print when requested, the results of the EVS inquiry when the provider accesses EVS via PC/modem, Web portal. Display the results of the EVS inquiry when the provider uses a terminal device with display capability on LCD or print roll.

Common Requirements for both AVR and EVS

The Contractor must apply appropriate security in responding to eligibility inquiries, regardless of their source and/or mode of request. The requestor must be or represent an authorized Medicaid provider or other entity at the time the inquiry is made. The request must be for a specific provider's or recipient's data and must be based on positive identification of provider and/or recipient (i.e., by knowledge of the recipient's name and Medicaid ID number; the recipient's name and date of birth; or the recipient's name and social security number). The response must be in formats approved by the State. Responses through AVR and call centers must meet standards approved by the State.

- (1) Provide the capability to restrict access to AVR/EVS information to specific provider queries and according to minimum federal and State-defined security protocols including requirement that a valid provider ID number and pass code to be provided before responding to any queries.
 - (a) Verify requestor identity and determine requestor's permission to receive data (is an authorized user) according to State criteria

- (b) Assign and track login parameters for authorized users, including login ID, password, PIN, etc in compliance with federal and departmental security standards
- (2) Provide appropriate safeguards to protect confidentiality of all information in compliance with federal, State, and department confidentiality laws, including HIPAA and State data security standards.
- (3) Allow all providers to verify eligibility through AVR/EVS, including Public Health Nurses, school-based service providers, mental health grantees, Contractors, and others as designated by the department.
- (4) Provide for automated logging of all transactions, maintain an audit trail of all inquiries and responses, and produce reports as required by DHSS.
- (5) Ensure that the AVR/EVS uses (access/extract data) current, updated, accurate information from eligibility files and other MMIS data files.
- (6) Provide access to eighteen (18) months of data based on the following:
 - (a) Recipient eligibility and benefit information
 - i) verification of recipient/client via name and date of birth, social security number and date of birth, and/or Medicaid ID number
 - ii) health benefit package/program eligibility inquiry and status for multiple programs for the date queried
 - iii) benefits available, current utilization information (used and remaining) on limited benefits
 - iv) current patient liability/cost of care/spend-down/premium information status in managed care, lock-in, case management, disease management, and/or other programs
 - v) prior resource information (third-party liability)
 - (b) Provider enrollment and coverage information
 - i) verification of provider enrollment status in various health benefit programs
 - ii) benefit coverage inquiry (procedure coverage)
 - iii) claim inquiry and status; number of and amount billed associated with in-process and/or suspended claims
 - iv) remittance advice inquiry and status information, warrant and EFT status, amounts, dates, warrant numbers
 - v) prior authorization inquiry and status
 - (c) Miscellaneous capability
 - i) resetting, ending, adding user password/PIN
 - ii) requesting AVR and EVS user guide(s)
- (7) Contractor will train providers in the use of EVSAVR and EVS options and will respond to questions via a toll-free line. Contractor will provide special training to providers serving remote populations, FQHC, IHS clinics, and other safety-net providers or providers with special needs.
- (8) Produce and distribute timely and accurate provider AVR and EVS user manuals.

5.6.4.3.10 Automated Tracking Capability

- (1) Maintain an automated tracking capability to report all provider interface activities including telephone inquiries with separate categories for EVS and AVR inquiries, customer service call center activities, written correspondence, field encounters, provider enrollment, provider training, first level appeals, and publications. The automated tracking database must contain the following information:
 - (a) Identity of caller, fiscal agent staff involved
 - (b) Provider, recipient, claim, other transaction demographic information to document subject of interface
 - (c) Record of information supplied/questions asked/comments made by the provider/representative
 - (d) Record of information conveyed in response by fiscal agent staff
- (2) The Department's authorized staff must be able to query and enter information into the above referenced automated tracking system/database.
- (3) Develop or use a COTS Call Center Management system that provides for:
 - (a) Answering calls in sequence
 - (b) Routing calls
 - (c) Recording and printing statistics
 - (d) Call monitoring/mentoring capability with live calls available to fiscal agent management staff and department staff
 - (e) Indicating calls have been placed on hold for a specific time limit
 - (f) Reports generation to the department at least monthly
 - (g) Automatic notification to the department when performance is outside established tolerance limits
- (4) Provide the capability to track and report from automated tracking/database system and Call Center Management system. Some examples of information to be tracked and reported include, but are not limited to the following:
 - (a) Number of telephone inquiries by type of inquiry and type of resolution
 - (b) Average length of call by inquiry type and for all calls received
 - (c) Average wait time
 - (d) Number and percentage of busy signals
 - (e) Number and percentage of abandoned calls
 - (f) Number of calls handled by automated system
 - (g) Number of calls handled by human operator
 - (h) Number of calls requiring return call/follow-up and time to return calls/resolve inquiry
 - (i) Number of written inquiries by type of inquiry and type of resolution
 - (j) Average days from receipt of inquiry to response by inquiry type and for all written inquiries
 - (k) Date of oldest pending written inquiry
 - (l) Number of pending inquiries older than five (5) days
 - (m) Number of pending inquiries between six (6) and fourteen (14) days old
 - (n) Number of pending inquiries between fifteen (15) and thirty (30) days old

- (o) Number of pending inquiries over thirty (30) days old
- (p) Number of field visits requested
- (q) Number of field visits completed
- (r) Number of field visits pending
- (s) Number of enrollment requests received
- (t) Number of enrollment requests approved
- (u) Number of enrollment requests denied
- (v) Number of enrollment requests pending and/or in-process at each step in the workflow process
- (w) Number of providers enrolled, re-enrolled, or potentially due to end enrollment (i.e. license, certification, permit, grant, due to expire)
- (x) Number of training sessions held, including number of people in attendance and number of providers represented
- (y) Training evaluation statistics
- (z) Number of requests for initial production or update to publications by type, date of request, complexity of update, priority level, etc.
- (aa) Number of first level appeals received by type and total
- (bb) Number of first level appeals resolved by type and resolution totals (upheld vs. overturned, reason(s), appropriate referral (i.e. policy, system, other appropriate department staff for questions/issue resolution, etc)
- (cc) Number of first level appeals pending by type, age, and total
- (dd) Number of telephone inquiries monitored
- (ee) Number and percent of monitored calls answered correctly
- (ff) Number and percent of monitored calls answered incorrectly
- (gg) Number of telephonic inquiries received, lost, on-hold, awaiting return call or other follow-up, etc as maintained in Call Center Management system
- (hh) Corrective actions taken
- (ii) Compliance with timeline requirements
- (jj) Provider file maintenance/update audit activity results
- (kk) All of the above items can be queried by provider number, provider type, date received, and/or other data elements tracked in database.

5.6.4.3.11 Automated Correspondence Generator

- (1) Maintain an automated correspondence capability for responses to provider inquiry and appeals.
- (2) Provide a menu-driven letter generation capability allowing users to choose a standard letter or to develop a customized letter.
- (3) Obtain department approval for content of all letter templates designed for repeated use; letters that are not designed for repeated use but are rather generated on specific case-by-case basis must be reviewed/approved by Contractor's provider services supervisory or management staff before mailing.

5.6.4.3.12 Provider Enrollment Function

- (1) Provide a provider enrollment function incorporating federal and State provider enrollment and certification requirements and establish detailed procedures covering the

enrollment of all provider types. Conduct provider enrollment activities including verification of eligibility for both in-State and out-of-State providers. Create detailed systematic and operating procedures for provider enrollment functions to include enrollment requirements and other rules, steps, forms/documentation, interfaces, work flow, MMIS database entry/maintenance/management, identification of stakeholders (internal fiscal agent staff, State/agency staff, external providers) roles and instructions for each, for review and approval by the State. The comprehensive workflow management system and processes must be easily modifiable by the department as program or processing rules change.

- (2) Screen providers requesting enrollment for OIG/Medicare/Medicaid/other entity sanctions prior to approving the enrollment and deny enrollment to sanctioned providers according to State guidelines. In addition to screening prior to initial enrollment, provide a method for similar screening on an on-going, periodic basis for all enrolled providers.
- (3) Provide a complete enrollment package to DHSS for review and approval of enrollment of DHSS-specified providers with a checklist showing that all documents, verifications, and other required material were obtained. On occasion, DHSS may specify providers who must be reviewed by DHSS prior to enrollment.
- (4) Design, print, and distribute provider enrollment applications.
- (5) Develop and obtain DHSS approval of an electronic enrollment process, including providing enrollment forms which can be completed and submitted on-line via the Internet, authentication of electronic signatures, and capability to accept imaged copies of supporting documents as well as capability to match paper copies submitted as supporting documentation for an electronically submitted enrollment.
- (6) Respond to and document (in an automated tracking/database system) provider inquiries regarding the enrollment process.
- (7) Assist providers as necessary in completing enrollment applications.
- (8) Design, print, and distribute Alaska-specific paper forms for provider use in communication as required by the Alaska medical assistance programs. These forms include but are not limited to requests for authorization, appeals, certification of medical necessity, and limited claim billing for transportation/accommodation services. Design, print, and distribute changes to these forms as required by DHSS for Alaska-specific forms only.
- (9) Support use of standard forms and HIPAA electronic transactions; however, continue to support use of the State's Transportation and EPSDT Forms. Return items submitted on old Alaska-specific forms/formats with a letter of explanation to resubmit using updated forms/format and/or follow national paper form and/or electronic format standards.
- (10) Conduct monthly verification of licensure with an automated interface with the Division of Occupational Corporations, Business, and Professional Licensing and other licensing agencies for in-State providers who are required to have occupational licenses, and automated monthly verification for out-of-State providers, if practical. For other providers and other credentialing authorities, verify current provider licensing, certification, permit, grant, and/or ownership information through automated and manual

updates. Development or enhancement of automated, electronic interface capability with other entities is encouraged.

- (11) Produce and send to providers an annual verification notice to verify enrollment and affiliation data maintained on the provider database (e.g., addresses, specialty, etc.).
- (12) Update the provider database with information returned by the provider.
- (13) Include in the provider enrollment packet and the annual verification notice a request for contact information, including contact type, contact name, address, e-mail address, and phone number.
- (14) Acquire any documentation needed for verification of provider credentials.
- (15) Obtain the Medicare sanction/reinstatement report monthly via electronic interface with CMS.
- (16) Identify on the provider database/master file sanctioned providers and those with service restrictions. Produce and provide to DHSS a monthly report of sanctioned providers, including the reason for the sanction and the sanction period.
- (17) Contractor must verify that CLIA-certified laboratories are certified for the specific procedure billed. All federal CLIA requirements must be met.
- (18) Contractor must verify Medicare information for providers supplying Medicare provider numbers.
- (19) Reconfigure, reassign, and/or maintain cross-walk functionality between old and new provider numbers at the request of DHSS (includes NPI).
- (20) Use imaging equipment to capture, store, and retrieve provider applications and associated documents.
- (21) Be prepared to enroll other new provider types and/or taxonomy codes during the term of the contract with minimum system modification (e.g., assume that MMIS design facilitates addition of new provider types, their mode and rate of reimbursement, their associations with multiple provider entities, authorized categories of service or specified procedures, and other data elements).
- (22) Maintain files of provider enrollment, file maintenance/update, and related documents.
 - (a) Hard-copy files labeled and located in a secure area and provide a system for checking out files so that all files can be located and controlled; keep all files current and file all items within two (2) business days
 - (b) Electronic files in a manner that allows easy navigation directly to images of source documents including enrollment documents

5.6.4.3.13 Provider Relations Function

The Contractor must maintain efficient communications with the provider community. Provider inquiries can be received via various modes (e-mail, Web portal's "contact us" link, written correspondence, telephone calls, training sessions, field visits to provider offices and/or with providers at fiscal agent offices, encounters with professional provider associations/organizations) either directly to the fiscal agent or through the Department.

- (1) Design, produce, and distribute provider policy and billing procedure manuals and updates. There are separate manuals for each provider type, although some provider types are combined in a single manual and some sections within the manual are universal based on claim form type, remittance advice, and other similar sections. At implementation there will be a maximum of 60 manuals, and during the operations phase there will be a maximum of 70 manuals. Examples of the current provider manuals are in the Bidders Library. Maintain manuals in updateable format in three-ring binders in which replacement pages are inserted, and also provide the manuals on the website and on diskette or CD-ROM.
- (2) Distribute manuals and manual updates according to the provider's media preference (i.e., via the Website, in hardcopy, on diskette, or on CD). The preference should be identified on the Provider Database. If provided in hardcopy, distribute up to two sets of hardcopy manuals and updates to each provider's location(s) per year and a maximum of four sets to clinics and institutions. The Contractor may charge the provider a nominal fee for reproduction and handling of additional copies requested by providers in excess of these numbers.
- (3) Produce and provide the following Help Guides including but not limited to the following:
 - (a) Companion Guide for all HIPAA Electronic Transactions
 - (b) User Guides for AVR, EVS, Web portal, and other Contractor-supplied applications, processes, workflow tools, etc.
 - (c) User Guides in support of various State/program specific processes, procedures, etc.
 - (d) User Guide in support of provider enrollment process
- (4) Produce and distribute digital tutorials, which are electronic presentations using printed content, still or moving graphics, sound or like media and which may be distributed to providers, recipients, State agencies, and DHSS specified customers for the purpose of understanding and using Alaska Medical Assistance programs. The tutorials must be made available for access via the Contractor's web site and on CD-ROM.
- (5) Provide a Web site/Web portal accessible to providers that includes provider manuals, bulletins, newsletters and other informational materials regarding the Medicaid program. Include the following items on the Web site:
 - (a) FAQs
 - (b) How To's
 - (c) Quick reference information
 - (d) What's New
 - (e) Training schedules
 - (f) RA messages
 - (g) Edits, descriptions, and strategies for resolution
 - (h) Tutorials
 - (i) Links
 - (j) Provider manuals, bulletins, newsletters and help guides
 - (k) All forms
 - (l) Web portal activities requiring provider log-in/authorized user

- i) Contact us (i.e., receive and respond to inquiries)
 - ii) Responses to customer satisfaction survey/form for comments
 - iii) Capability to sign-up for alert messages/receive e-mail
 - iv) Form order requests
 - v) Completion/submission of forms on-line and ability to associate completed forms to recipient and service claim
 - vi) Submission of provider file updates such as address change
 - vii) EVS capabilities
- (m) Ensure that the provider website is listed on the major search engines.
- (6) Produce and distribute monthly provider bulletins (offerors should be prepared to issue bulletins monthly and State must review prior to distribution).
- (7) Produce Remittance Advice messages and flyers to be mailed with remittance advices, e-mailed, or otherwise distributed on request. Provide the capability to use bold, underline, capital and lower case letters, apply graphics, and selection of font and type style on the RA/other messages/flyers/bulletins/letters. Provide the capability to target and distribute information to specific provider types, specialties, regions, affiliations, and other criteria.
- (8) Develop and provide to DHSS a provider marketing and outreach strategy with high-level plan outline to include the following components:
 - (a) Transition to new fiscal agent
 - (b) Periodic Provider re-enrollment
 - (c) Encourage provider participation in the Alaska Medicaid program
 - (d) Encourage training attendance
 - (e) Encourage use of electronic transactions and interfaces
 - i) HIPAA EDI transactions
 - ii) Contractor-supplied tools/applications
 - iii) Efficient control of attachments
 - (f) Evaluation of data to identify and prioritize components of plan based on such information as volume of claims, providers, specific edits/errors, electronic vs. manual, or other relevant data parameters
 - (g) Obtain provider feedback about/take necessary action regarding provision of improved customer service being offered to the provider/submitter community
- (9) Maintain an on-line historical library available at the user's desktop of all provider manuals, other provider/recipient publications, and updates for use in provider investigations to determine which policies and procedures were in effect at the time a service was rendered or a bill was submitted and processed. The library should be established and maintained on CD-ROM or other DHSS-approved electronic media from the beginning of the new contract period. The archive of publications must meet the following criteria:
 - (a) All versions of publications must be available and easily retrievable in electronic format.
 - (b) All versions and updated pages must be dated.

- (c) Backup documentation to demonstrate approved changes will be imaged or archived in hardcopy
 - (d) Backup documentation must be retrievable by the Contractor and delivered to DHSS within one business day of the written request.
 - (e) Historical and current publications must include the ability to search by key words or phrases across all publications in a single search query and produce a report of affected pages within the publication.
- (10) Maintain sufficient staff, telephone lines and toll-free incoming telephone lines for provider inquiry available to all enrolled providers. Customer service staff must be available to answer calls from 7:00 AM to 6:00 PM Alaska time Monday through Friday, except on State holidays. The Contractor may not impose limits on the number of issues raised or the time required to fully resolve inquiries providers make during a single telephone call.
- (11) In addition to required HIPAA EDI transactions, develop and provide capability for a provider inquiry and claims status checking capability via AVR/EVS, the Internet/Web portal, etc with appropriate security to ensure that only enrolled providers have access, and that access to claims data is limited to claims submitted by the provider making the inquiry.
- (12) Respond to and document (in automated tracking system) all telephonic and written inquiries from providers regarding their enrollment, recipient's eligibility, claim payment status, and other matters. Automatically generate provider correspondence including form letters and individualized letters. All output must be automatically tracked and retrievable.
- (13) Provide proactive provider support. Proactive provider support is a systematic standardized process whereby provider services not only responds to routine inquiries of providers, but proactively identifies, centralizes contacts, coordinates resolutions, and assists providers to correct pended, denied, appealed, and other non-paid claims or authorization requests. Additionally, the centralized contact provides individualized training and referral to additional sources of training or information. Problem areas such as providers or provider types with high denial/pend rates or extended time periods to obtain claim payment are examples of areas that will be identified by the fiscal agent for appropriate intervention. Analysis of claims activity and targeting of specific areas is required. The fiscal agent and DHSS will work together to determine the priority of targeted areas.
- (14) Reconcile provider outstanding balances on request. This includes identifying pended and denied claims that are potentially payable, and eliminating duplicate billings.
- (15) Produce written reports on all field visit encounters with any provider.
- (16) Provide initial and ongoing training to all staff (call center, training, publication, other, supervision/management) in billing procedures, MMIS adjudication processes, current Alaska Medicaid program rules/policies, telephone etiquette, confidentiality/privacy, use of all internal and external tools/applications available to staff and providers, etc. to ensure that the staff can respond accurately and completely to provider and trading partner inquiries and questions.

- (17) Provide cross-cultural communications training specifically geared to the unique provider population and health care delivery infrastructure in Alaska to all staff having contact with individuals involved in the Alaska medical assistance programs.
- (18) Maintain sufficient office space and staff to accommodate individual provider relations and billing assistance in Anchorage, including provider trainer(s) and a conference room with a terminal for inquiry into the provider's claims history.
- (19) Within fifteen (15) days of the termination of a provider due to State or federal action, notify recipients who have received services within the last twelve (12) months from the provider who has been terminated.
- (20) Interface with provider associations, including providing staff to attend association meetings on request, and working with associations to encourage inclusion of medical assistance programs information in their newsletters.

5.6.4.3.14 Provider Appeals

- (1) Develop and maintain a provider appeals process through which provider disagreements are settled. This process must be in compliance with federal guidelines 42 CFR 431.105, Alaska Administrative Code 7 AAC 43.083 and 43.085, and Alaska Statutes AS 47.77.010, 070. Appeals processes must be in place for denial of enrollment applications, claims disputes, provider terminations, denials of prior authorization requests, and other areas of disagreement. DHSS must approve the Contractor's appeals process.
- (2) Provide a pre-appeals process for providers to submit claims for services which may be exceptions to current Medical Assistance policies or editing which would normally be applied and result in denial or reduction of payment. To utilize this process, providers will submit the claim with documentation that supports the exceptional circumstances with a cover sheet clearly marked as a pre-appeal review. The Contractor will review the claim and documentation to determine whether the exception is appropriate according to guidelines specified by DHSS, and processes the claim accordingly.
- (3) Process first level appeals according to procedures approved by DHSS. First level appeals include claim disputes such as appeal of a claim denial or appeal of the amount paid on a claim.
- (4) Notify the provider in writing of the results of the appeal, and when a first level appeal has been denied, include the reason for the denial and notification of the provider's right to further appeals.
- (5) Provide access to first level appeal data to DHSS staff for second and third level appeals.
- (6) Provide staff to testify in court when requested by DHSS or the MPFCU regarding claims processing, claims payment, or other fiscal agent activities.
- (7) Implement and operate an automated appeals tracking system to include provider, recipient, and claims appeals processes.
- (8) Track all appeals in the tracking system.

5.6.4.3.15 Provider Education Function

- (1) Develop and obtain DHSS approval of a provider training plan and update as necessary. The plan will include basic and advanced training for all provider types in each of the locations specified below. For paired cities (identified by “or” between the two cities), DHSS will designate which city should be included:
 - (a) Monthly and on-request training in the Anchorage area. The Anchorage area is defined as the city of Anchorage and north to Eklutna and south to Girdwood.
 - (b) Biannual training in Juneau, Fairbanks, Kenai, and Palmer or Wasilla.
 - (c) Annual training in Seattle, Washington or Portland, Oregon for out-of-State providers enrolled in the Alaska Medicaid Program.
 - (d) Annual training in Nome or Kodiak, Sitka or Ketchikan, Valdez or Cordova, Homer or Seward, Bethel or Dillingham, Barrow or Kotzebue, Wrangell or Petersburg.
 - (e) Special training as needed when major changes are made which affect the providers (e.g., changes in billing requirements, addition of new programs and/or provider types, regulation changes, etc.)
 - (f) Use of State-of-the art technology as alternative and supplement to in-person training session offerings. Such technology may include use of scheduled teleconferencing, video conferencing, satellite, and web casting, as well as web-based tutorials accessible at the provider’s convenience, and/or other modes of conveying information
 - i) Provide for initial training of newly enrolled providers and/or newly hired billing staff to be performed via web-based tutorial with follow-up by telephone contact by provider training representative after completion or after specified timeframe.
 - ii) Provide for automatic tracking to report when providers access tutorials, including new providers completing initial training tutorial
 - (g) Focused training efforts for major subject areas/unique circumstances affecting large groups of providers Statewide, such as:
 - i) Fiscal agent transition, during new MMIS implementation and any period of similar change
 - ii) National Provider Identifier
 - iii) Future federally mandated initiatives
- (2) Provide advanced training a minimum of 4 times and maximum of 8 times per year. This training may be done jointly with the training described above.
- (3) Provide multi-agency training a minimum of twice and maximum of four times per year.
- (4) Provide individual training to providers upon request in the fiscal agent’s Anchorage facility or via the telephone.
- (5) Notify providers of training sessions and schedule via letter, via RA message, and on the Web site. Encourage participation in the training via marketing and outreach efforts.
- (6) Develop training materials and obtain State approval for use. Training will be:

- (a) Problem focused
 - (b) Audience tailored
 - (c) Professionally presented using presentation software and handouts
 - (d) Participatory
 - (e) Well attended as a result of outreach efforts
 - (f) Evaluated for effectiveness and satisfaction
 - (g) Continuously improved as a result of evaluations and quality assurance efforts
- (7) Maintain (in an automated tracking system/database) information on provider training activities, including training sessions provided, dates, times, locations, list of attendees, providers represented, evaluation statistics, and questions/concerns that arose during training.
- (8) Develop and obtain approval from DHSS for digital training presentations and provide the digital presentations on the Web site, on a CD, and on videotape. Suggested topics for such presentations include:
- (a) A presentation for potential and/or new providers that includes provider enrollment and participation requirements; instructions to submit billings, service authorization requests, inquiries, etc; instructions for accessing the tools (AVR, EVS, web site) and staff offered by the fiscal agent available to assist providers; department program management structure and contacts; claims payment reconciliation; etc.
 - (b) A presentation for existing providers that includes instructions for resolution of common problems and more detailed explanations of claims submission requirements
- (9) Track provider access to the Web site and provide reports to DHSS on the number of providers accessing the site and provider comments regarding the materials presented on the site, accessibility, and other comments.

5.6.4.3.16 1099 Function

- (1) Calculate 1099s based on Federal Employee Identification Number (FEIN), Social Security number or other tax identification number; accumulate all payments to the same tax ID on a single 1099.
- (2) Update the cumulative total 1099 payment field including all payments, cost settlements made via manual checks, and recoupments for the calendar year.
- (3) Prepare and mail the 1099-MISC Form at the close of the calendar year to each unique provider who received payments in that year.
- (4) Mail the forms to the providers and supply the information to the Internal Revenue Service (IRS) using electronic media on or before January 31 of each year for the prior year payments. The 1099s must comply with IRS requirements that total payments to providers of medical services be reported for tax purposes.
- (5) Maintain on-line 1099 history for three years for query and reporting purposes.
- (6) Prepare additional copies of 1099s upon provider or DHSS request.

- (7) Research, resolve problems and issue/send amended/corrected 1099s if research indicates inaccuracies whether created by the State or Contractor when notified of errors by providers, IRS, or the State:
 - (a) Respond to all provider inquiries regarding 1099s including incorrect FEINs
 - (b) Resolve 1099 issues regarding correct reporting of tax information based on federal 1099 policies and as required by the IRS to avoid penalties
 - (c) Assume all responsibility and accountability for any damages caused by inaccurate information under the Contractor's responsibility
- (8) Balance data to be used in 1099 generation monthly and provide a monthly report demonstrating that 1099 production is in balance.

5.6.4.4 Interfacing Systems

The Contractor must develop and/or enhance interfaces with State and federal agencies, Contractors, and entities including but not limited to the following:

- (1) Department of Commerce and Economic Development, Division of Occupational Licensing for various medical professional licenses and business licenses.
- (2) Department of Commerce and Economic Development, Division of Corporations for verification of ownership information.
- (3) Various divisions within the department for verification of grant information or other program information such as background check status.
- (4) CMS/Office of Inspector General for provider sanction data.
- (5) National Provider Identifier (NPI) enumerator agency to verify NPI of applicants; details concerning this interface are not yet available.
- (6) Establish and provide data exchange and data validation through electronic interfaces with other entities, including but not limited to the following. Interface criteria will be defined during the Design and Development Phase of the contract:
 - (a) Drug Enforcement Agency
 - (b) Oscar (CLIA information)
 - (c) Bureau of Vital Statistics
 - (d) Provider credentialing agencies
 - (e) National Practitioner Database (NPDB)

5.6.4.5 Inputs

- (1) Provider Enrollment Applications and supporting documentation supplied by the provider and/or through automated interfaces and/or manual processes.
- (2) Provider Database Updates.
- (3) AVRS Transactions.
- (4) EVS Transactions.

- (5) Provider inquiries and correspondence received by various modes conveying issues, questions, concerns requiring appropriate response by fiscal agent.
- (6) Provider Appeals.
- (7) Program/Policies/Regulations and other program information as currently defined and subject to change for use in educational materials, publications, inquiry responses, etc.

5.6.4.6 Outputs

- (1) Provider enrollment notifications (approval, denial).
- (2) Hard-copy and electronic records of all applicant information including images of all paper documents received and letters generated as part of the enrollment process.
- (3) Communications to providers in various modes (telephone, written correspondence, in person, etc.).
- (4) Publications including information within web portal, posted on web site, in provider manuals, billing guides, forms, training materials, and other printed and electronically published materials.
- (5) Notifications to Recipients Regarding Terminated Providers.
- (6) Provider information files/database containing all related information necessary to administer provider enrollment, claims processing, payment, and reporting such as but not limited to the following:
 - (a) Provider Update Audit Trail including provider name, provider number, and status changes
 - (b) Provider Audit Trail Control Totals Report
 - (c) Provider Applications Pending
 - (d) Provider File Inquiry (standard inquiry screens)
 - (e) Provider File Queries (user defined sorts of providers by one or more data element; with individual and summary totals; may be supported by Decision Support database)
 - (f) Provider Name Cross-Reference
 - (g) Provider ID (NPI) Cross-Reference to Other Entities (e.g., provider group practice, clinic, managed care organization, and others as specified by DHSS user)
 - (h) Medicare/Medicaid ID Cross-Reference
 - (i) Provider Entity Cross-Reference to Individual Providers
 - (j) Aged Provider Update Errors
 - (k) Provider Numeric Listing by selected fields, (e.g., provider type, specialty, taxonomy code, category of service, location)
 - (l) Provider Alphabetic Listing by selected fields, (e.g., provider type, specialty, taxonomy code, category of service, location)

- (m) Provider Enrollment Summary by selected fields, (e.g., provider type, specialty, taxonomy code, category of service, location)
- (n) Providers with License and/or Certification Due to Expire Within Specified Number of Days
- (o) Provider Address Labels by selected fields, (e.g., provider type, specialty, taxonomy code, category of service, location, status)
- (p) Provider Rate Table
- (q) Number and Type of Beds
- (r) Report of Providers Paid
- (s) 1099 Forms
- (t) 1099 Tape
- (u) Totals for Net Payment
- (v) Adjustment Report and Proof List of Adjustments
- (w) Year End Provider Totals
- (x) Inactive Providers/Active Providers
- (y) Purged Providers
- (z) Providers with License Dates Updated
- (aa) Annual Provider Participation Report
- (bb) Provider Inquiry Statistical Report

5.6.4.7 Performance Standards

The performance standards for the provider enrollment and relations functions are provided below.

5.6.4.7.1 Provider Database Maintenance, Update and Edit

- (1) Update provider data received electronically within one (1) business day of receipt of file.
- (2) Perform on-line updates to provider data within one (1) business day of receipt of the update.
- (3) Maintain a 98% accuracy rate for on-line update transactions.
- (4) Identify and correct errors within one (1) business day of error detection.
- (5) Provide backup documentation for provider database updates to DHSS within one (1) business day of the written request for the documentation.

5.6.4.7.2 Provider Licensure and Certification

- (1) Update the Provider database with Occupational Licensing updates at least twice a month.

- (2) Validate the licensing update process within two (2) business days of application of the update transmission.
- (3) Resolve licensing transactions that fail the update process within two (2) business days of error detection.
- (4) Refer to the State all licensing transactions that fail the update process and cannot be resolved by Contractor staff pursuant to edit update rules or State-approved procedures within two (2) business days of attempted error resolution.

5.6.4.7.3 Eligibility Verification System (EVS)

- (1) Provide sufficient in-bound access lines so that AVR users:
 - (a) Are connected with the AVR system within three (3) rings at least ninety-nine percent (99%) of the time
 - (b) Receive AVR response within ten (10) seconds of entry of required information (provider ID, member ID, etc.) at least ninety-nine (99%) of the time
 - (c) Receive a busy signal less than five percent (5%) of the time they call
 - (d) Are not dropped and do not receive a busy signal in excess of one percent (1%) of the total daily call volume
 - (e) Are successfully transferred to live assistance at the customer service call center in less than one-hundred-twenty (120) seconds of the request to transfer
- (2) The AVR must be available twenty-three (23) hours a day, seven (7) days a week.
- (3) Resolve all AVR system downtimes caused by the AVR hardware, software, or other components under the Contractor's control, within thirty (30) minutes of initial notification of system failure. If the system is not in service within that time frame, the Contractor shall provide an alternative AVR system to ensure that system downtime is limited to a maximum of thirty (30) consecutive minutes.
- (4) Alert appropriate department systems unit staff in the event of AVR system failure
- (5) Maintain and retain for twenty-four (24) months electronic records of all AVR inquiries made, information requested, and information conveyed.
- (6) Make updates to the AVR recorded messages/prompts/responses within two (2) business days of receiving a request from the department, unless otherwise directed by the department.

5.6.4.7.4 Provider Enrollment

- (1) Send enrollment application packets to provider within two (2) business days of receipt of request by provider.
- (2) Screen and review enrollment applications for accuracy, validity, and completeness within two (2) business days of receipt from provider.
- (3) Contact provider within two (2) business days of receipt of incomplete enrollment application explaining additional information required.
- (4) Process completed provider enrollment applications and send notification information to providers within two (2) weeks from date of receipt of a completed application.

5.6.4.7.5 Provider Relations

- (1) Screen and resolve pended and denied claims within eighteen (18) working days from identification of a provider requiring proactive support.
- (2) No more than five percent (5%) of incoming calls may ring busy.
- (3) Ninety five percent (95%) of all calls that do not ring busy must be answered on or before the fourth ring.
- (4) Ninety five percent (95%) of calls that are answered must be answered by a live person.
- (5) Hold time must not exceed two (2) minutes for ninety-five percent (95%) of calls.
- (6) The average hold time must not exceed thirty (30) seconds.
- (7) Respond to at least 90% of telephone inquiries during the initial call from the provider.
- (8) Respond in writing to written, faxed, or e-mailed inquiries within five (5) business days of receipt.
- (9) Announce, make available via web site with print upon request for all new or updated provider manuals; and make them available for mailing within fourteen (14) calendar days of written approval by the State.
- (10) Print and mail newsletters, bulletins, inserts or other special mailings within five (5) calendar days of written approval by the State.
- (11) Prepare and deliver in final form updates to publications to DHSS for review and approval within three (3) working days of the date requested by DHSS or the date changes proposed by the fiscal agent were approved by DHSS.
- (12) Publish updates on the fiscal agent web site within two (2) working days of the date of the DHSS's written approval for publication.
- (13) Publish remittance advice messages within one (1) payment cycle from the date of DHSS approval of the message.
- (14) Produce and distribute new publications and publications with extensive changes in final form no more then sixty (60) calendar days from the date of the DHSS's written request for the new or updated publication or the date changes proposed by the fiscal agent were approved by DHSS.

5.6.4.7.6 Provider Education

- (1) Provide the annual training plan to DHSS by January 15 of each calendar year of the contract.
- (2) Develop and update professional training materials for use in seminar and web-based delivery and provide appropriate department staff with hard and electronic copies of all training materials for review and approval at least annually (by January 15 for annually planned sessions and with no less than 30 days prior to unplanned training sessions unless change implementation necessitates faster implementation).

- (3) Provide a monthly report on provider education and provider relations activity by the 5th working day of the month for the previous month's activity using the automated tracking capability.

5.6.4.7.7 Provider Appeals

- (1) Screen claims appeals and reviewed for accuracy, validity, and completeness within two (2) business days of receipt from provider.
- (2) Notify the provider within three (3) work days of receipt of a claims appeal of incomplete or missing information.
- (3) Send the final determination letter on a claims appeal to the provider within ten (10) work days of receipt of complete documentation.

5.6.4.7.8 Provider 1099 Production

- (1) Produce and mail provider 1099s by January 31 of each calendar year.

5.6.4.8 Quality Assurance/Improvement – Provider Enrollment and Relations

Monitor quality and work toward continued quality improvement in all areas related to Provider Enrollment and Relations. In addition to provisions otherwise included in this section, the following monitoring and reporting requirements must be met:

- (1) Notify the department within one (1) business day of any significant failure (or factor that may otherwise signal impending failure) to properly carry out the business and other required functions contained within this Provider Enrollment and Relations section.
- (2) Provide information from reviewers independent of the staff performing the provider services functions including provider enrollment, file maintenance and update including rate changes, appeals resolution, and provide capability to monitor or record communication with providers via operator calls and training sessions for quality assurance purposes.
- (3) Monitor activities, maintain and review data including statistics showing reasons for calls, claim editing/errors, and initiate enhancements to reduce the number, duration, and manual processing time for claims and calls through better automation, better provider and/or staff training, or other interventions.
- (4) Report on quality in performance reports to department; include comparison quality measures in current and previous reporting periods.
- (5) Initiate, document and implement at the Contractor's own initiative, plans for improvement for any function when quality deteriorates for two (2) consecutive months.
- (6) Document and implement corrective action plans when requested by the Department.
- (7) Provide support for survey of customers (providers, trading partners, other), including printing survey forms/web completion support, selection of providers, distribution, data results collection and reporting, analysis and summary of survey results. Customer satisfaction surveys are to be conducted at least quarterly at the direction of the State.

5.6.5 Reference Databases

The Reference Databases include those functions necessary to provide accurate coding and pricing information for use by the claims processing system.

The process of maintaining the reference databases is primarily that of the fiscal agent, and follows policy decisions made by DHSS and State and federal requirements for the use of coding schemes in the MMIS.

5.6.5.1 Business Needs

The primary objectives of the Reference Databases are to:

- (1) Provide accurate coding, pricing verification, edits and audits during claims processing for all approved claim types, programs, and reimbursement methodologies.
- (2) Maintain flexibility in reference parameters and database capacity to make the MMIS capable of easily accommodating changes in the programs.
- (3) Support the data requirements of other MMIS applications including: claims processing, information access and decision support, utilization review and quality assurance, pharmacy point-of-sale (POS), prospective and retrospective DUR, management and reporting (MAR) functions, Benefit Packages, and special reports.
- (4) On-line accessibility, updatability, and reporting capability available based on system security standards.

5.6.5.2 State Responsibilities

- (1) Set policy guidelines and monitor the performance of the Contractor in all areas of the Reference function.
- (2) Establish and approve policies governing procedure code and procedure code modifier reimbursement, new medical procedures, procedure codes and modifiers that have duplicate or conflicting information, State unique procedure code modifiers, service limits and restrictions.
- (3) Establish rates, fees, and other pricing instructions, and authorize pricing updates.
- (4) Identify those procedures and diagnoses that require prior authorization.
- (5) Identify services not covered under the Alaska medical assistance programs (Medicaid, CAMA, Mental Health, Developmental Disabilities, and others).
- (6) Establish policies concerning drug reimbursement formulas and interim rates.
- (7) Approve any additions, changes, or deletions to all reference data elements.
- (8) Provide policy guidelines, and identify any restrictions or service limitations.
- (9) Authorize on-line updates to reference databases.
- (10) Establish and/or approve all error messages to ensure clarity in interpretation.
- (11) Set policy guidelines and approve updates to the edit/audit criteria database.

- (12) Define alternative pricing methodologies to be implemented in the future (e.g., DRG, APG).
- (13) Review and approve changes to format and content of standard reference reports, both printed output and on-line displays and download capability.

5.6.5.3 Contractor Responsibilities

The reference databases include:

- (1) Procedure/Revenue Code Database.
- (2) Formulary Database.
- (3) Diagnosis Database.
- (4) Resource-Based Relative Value Scale (RBRVS) Database.
- (5) Error Text Database.
- (6) Edit/Audit Criteria Database.
- (7) Certified Laboratory Improvement Amendments and Mammography Provider Database.
- (8) Patient Status Codes.
- (9) Type of Bill Codes.
- (10) Condition Codes.
- (11) All current HIPAA standard code sets.
- (12) Fiscal Agent Functions Applicable to All Reference Databases.

5.6.5.3.1 Procedure/Revenue Code Database

- (1) The procedure/revenue codes and procedure code database shall be designed to minimize the impacts of future HIPAA adopted code sets such as the ICD-10-PCS, surgical procedure codes. This requires that all data files, database tables, and programs be defined with sufficient space to support the number and size of the modifiers associated with the ICD-10-PCS, surgical procedure codes, and other HIPAA adopted code sets as required.
- (2) Maintain current and historical procedure and diagnosis codes (including modifiers) using the CMS HCPCS, CPT, ABC, and ICD-9-CM, procedure codes, or the current version as defined by National standards and DHSS. Maintain a process to identify, collect, analyze, and update/use within the MMIS, current National standard code sets in a time period specified by the State.
- (3) Maintain all procedure codes and data contained in the current Alaska MMIS procedure code database including, but not limited to:
 - (a) Allowed prices (e.g., both modified and unmodified procedures, variations among claim types, variations across provider types and programs)
 - (b) Geographical differentials
 - (c) Restrictions (e.g., age, sex, number of occurrences, benefit plans, programs)

- (d) Prior authorization
 - (e) Pre-procedure review indicator
 - (f) Service limitations
 - (g) Family planning indicator
 - (h) Automatic error codes
 - (i) Ambulatory surgery center pricing
 - (j) Approved for assistant surgeon services indicator
 - (k) Date specific ambulatory surgical group data
 - (l) Provider types
 - (m) Provider specialties
 - (n) Funding program indicators
 - (o) Modifier restrictions
 - (p) CLIA category and certificate type
 - (q) Anesthesia base rate and time unit rate
 - (r) FFP values
 - (s) IHS identifier
 - (t) Procedure code and procedure code modifier descriptions
 - (u) Pricing Action Codes
 - (v) Place of Service
 - (w) Disease management indicator
 - (x) Case management indicator
 - (y) Provider taxonomy
 - (z) Encounter rate indicator
 - (aa) Effective (begin and end) dates for all data values
- (4) Obtain and update procedure codes with HCPCS data and ICD-9-CM procedure code data as changes are approved and published), and data from approved data publishing sources for CPT, ABC, DSM codes.
- (5) Acquire and update the State of Washington Medicaid Fee Schedule biannually for Physicians for pricing claims from Washington State physicians. Obtain other state pricing information as determined by the State to price Alaska Medical Assistance claims.
- (6) Maintain current and historical revenue codes in a revenue code database with on-line update, inquiry and reporting capability including:
- (a) Coverage information by provider type, provider specialty and programs
 - (b) Restrictions (e.g., age, gender, benefit plan, programs, providers, provider specialties, taxonomy, etc.)
 - (c) Service limitations
 - (d) Automatic error codes
 - (e) Pricing data
 - (f) Revenue code descriptions
 - (g) Effective (begin and end) dates for all items
- (7) Obtain and update revenue codes from the National Uniform Billing Committee and the National Standard Maintenance Organization as approved by DHSS.
- (8) Provide a surgery indicator to be used in claims editing.

- (9) Maintain current and 10 years of historical date-sensitive payment information.
- (10) Provide for mass updates when requested by DHSS.
- (11) Acquire the Medicare Fee Schedule including the lab fee schedule and update the Reference Database at least annually to ensure conformance with federal requirements regarding Medicare pricing.
- (12) Maintain the ASA codes and related values on the procedure code data set, and use them for pricing anesthesia services provided by surgeons, anesthesiologists, and other provider specialties.

5.6.5.3.2 Formulary Database

- (1) Maintain current and historical coverage status and pricing information on legend drugs, selected (State-approved) OTC items, and injection codes (when available from First Databank) on the Alaska MMIS formulary database(s).
- (2) Maintain all data contained in the current Alaska MMIS formulary database as well as additional features including:
 - (a) U&C
 - (b) MAC
 - (c) EAC
 - (d) AWP data
 - (e) AMP
 - (f) WAC
 - (g) Medicare indicator
- (3) Maintain and provide on-line access to an archive for NDCs that have had a change to a different name.
- (4) Contract with First Databank for weekly updates of the drug database, and assume all costs for the weekly update process.
- (5) Update the formulary database on a weekly basis using data received from First Databank.
- (6) Notify the State of any newly approved drug products identified during the First Databank updates.
- (7) Notify the State of any DESI or newly recalled drugs identified during periodic CMS Rebate updates.
- (8) Edit all transactions to allow only valid data to update formulary database information.
- (9) Provide on-line inquiry capability by:
 - (a) Partial NDC
 - (b) Generic name
 - (c) Brand name.
- (10) Provide the capability to request reports on-line using as selectable data elements:
 - (a) Nine or eleven digit NDC

- (b) NDC ranges
 - (c) Therapeutic class
 - (d) GC3
 - (e) DEA schedule
 - (f) Generic name and generic code number (GCN)
 - (g) Trade (brand) name
 - (h) Family planning indicator
 - (i) Medicare Part B
 - (j) Medicare Part D
 - (k) Effective dates for all items
 - (l) Other data elements on the formulary database
- (11) Maintain an indicator on the formulary database for family planning and use this indicator to bypass co-payment requirements in the payment methodology and establish family planning collocation code assignment.
- (12) Maintain the First Databank GC3 classification indicator in addition to the therapeutic class indicator on the formulary database.

5.6.5.3.3 Diagnosis Database

- (1) The diagnosis database shall be designed to minimize the impacts of future HIPAA adopted code sets such as the ICD-10-CM. All data files, database tables, and programs must be defined to support the full set of available ICD-10-CM diagnosis codes.
- (2) Maintain current and historical diagnosis codes using the International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) or the current version as defined by DHSS or as mandated by updated HIPAA regulations.
- (3) Maintain current and up to 10 years historical data contained in the current Alaska MMIS diagnosis code database including:
 - (a) Age and sex restrictions
 - (b) Review or prior authorization requirements
 - (c) Service limitations
 - (d) LOS data by age and weight for 25th, 50th, 75th, and 90th percentile for PAS western regions (single, multiple and operated, non-operated)
 - (e) Automatic error codes
 - (f) Family planning indicator
 - (g) Major diagnostic category indicator
 - (h) Effective dates for all items
- (4) Maintain other LOS modifying data including birth weight criteria, and benchmark LOS applicable to defined diagnoses.
- (5) Demonstrate the capability to maintain and use DRG methodology for processing institutional claims. Although Alaska does not currently use a DRG methodology, the Alaska MMIS will be required to have the capability to perform analysis using DRGs and use DRG methodology in the future for pricing inpatient claims.
- (6) Obtain and update PAS/LOS data for the Western United States with data from CPHA.

- (7) Obtain and update the diagnosis database with the annual ICD-9-CM/ICD-10-CM and ICD-10-PCS updates from CPHA as approved by the State.

5.6.5.3.4 RBRVS Database

RBRVS payment methodology must offer the flexibility to apply payments based on facility or non-facility RVUs.

- (1) Maintain selected Medicare Fee Schedule (MFS) data and the Resource-Based Relative Value Scale (RBRVS) data set for claims pricing.
- (2) Maintain pricing data based on RBRVS or other Relative Value Unit (RVU) pricing methodology as well as other pricing methods, such as flat fees.
- (3) Maintain current and historical RVU data with special pricing indicators, geographical pricing, and effective dates.
- (4) Maintain multiple conversion factors, and select the appropriate conversion factor based on procedure range, procedure grouping, recipient age, diagnosis code, provider type, specialty, and region.
- (5) Maintain on-line access to all RBRVS data elements, including:
 - (a) Category of Service
 - (b) Conversion factors
 - (c) Relative value units
 - (d) Relative value unit components
 - (e) Procedure code
 - (f) Modifiers
 - (g) Procedure code description
 - (h) Procedure modifier description
 - (i) Pricing indicators
 - (j) Geographical differentials
 - (k) Information found on the MFS
 - (l) Effective dates for all items.
- (6) Convert and make available to DHSS for research purposes the data contained on the Usual and Customary/Prevailing Fee database. Claims are no longer priced using this file, but the data will be needed for researching claims prior to conversion to RBRVS in 1997. The Contractor may provide access to the data via a file or reports that are available on line and indexed for ease of research.

5.6.5.3.5 Error Text Database

- (1) Maintain on-line date-sensitive data on error codes, error code descriptions, and status by claim type, provider type, program, FFP indicator, region code, recipient eligibility code (including eligibility subtype, and cash indicator), media, and original claim vs. adjustment on the error text database.
- (2) Provide the capability to access the error text file by claim type, provider type, provider specialty, program, FFP indicator, region code, recipient eligibility code (including

eligibility subtype, and cash indicator) and other data that limits application of error codes (e.g., original or adjustment claim, hard copy or electronic claim).

5.6.5.3.6 Edit Audit Criteria Database

- (1) Maintain on-line date-sensitive criteria to edit claims against all historical claims for the same recipient on the edit/audit criteria database.
- (2) Maintain McKesson HBOC ClaimCheck[♥] and ClaimReview[→] including SmartSuspense or a functionally equivalent audit capability including on-line access and customization capability.

5.6.5.3.7 Certified Laboratory Improvement amendments and Mammography Provider Database

- (1) Maintain date-sensitive CLIA and mammography certification data.
- (2) Provide capability to capture, maintain, and utilize certification data for additional provider types as required by CMS.
- (3) Provide tape update capability for CLIA and mammography information using CMS supplied data.
- (4) Provide on-line inquiry capability to CLIA and mammography certification data.
- (5) Maintain effective dates for all items.

5.6.5.3.8 Fiscal Agent Functions Applicable to All Reference Databases

- (1) Operate and maintain all automated and manual Reference Function processes.
- (2) Provide current and historical reference database information to be used during claims processing.
- (3) Maintain all reference databases and ensure that the most applicable, up-to-date, accurate information is used in claims processing.
- (4) On all automated update processes, provide update reports to DHSS according to State-supplied specifications for review and approval prior to applying the updates to the database.
- (5) Accommodate retroactive rate changes and Medicaid policy changes as they relate to medical procedures and limitations.
- (6) Provide the State and authorized State Contractors with on-line inquiry access to all reference databases except during update processing.
- (7) Edit all transactions to allow only valid data to update reference databases.
- (8) Maintain the reference data that supports claims edits, audits, and pricing logic in accordance with State policy.
- (9) Develop and maintain security procedures to ensure that only authorized personnel have access to the reference databases functions (additions, changes, deletions, inquiries, and updates).

- (10) Enter all batch and on-line updates within the time frames specified by DHSS.
- (11) Serve as the expert in researching and resolving reference database discrepancies.
- (12) Provide the capability to request procedure/revenue code reports on-line using procedure/revenue code or procedure/revenue code ranges, including or excluding modifiers, and other data elements on the procedure code database as selectable data elements. Allow user specified sorts and sub sorts.
- (13) Maintain audit trail of all database updates, accessible through on-line inquiry. Maintain control totals and provide balance information in response to on-line request.
- (14) Provide on-line update capability to all reference databases to authorized fiscal agent and State users. Update authorization may be to a single reference database, selected reference databases, or all reference databases for a single user.

5.6.5.4 Interfacing Systems

- (1) First Databank Blue Book for drug pricing and other formulary data.
- (2) Commission on Professional and Hospital Activities (CPHA) for ICD-9-CM diagnosis and procedure code updates.
- (3) CMS for HCPCS procedure code updates.
- (4) National Uniform Billing Committee for revenue codes.
- (5) Commission on Professional and Hospital Activities (CPHA) for PAS LOS for the Western Region of the United States.
- (6) CMS for Medicare Fee Schedule/RBRVS.
- (7) Washington State Medicaid Fee Schedule for Physicians.
- (8) CMS Clinical Laboratory Improvement Amendments (CLIA) database for information regarding laboratory certifications (OSCAR).
- (9) American Society of Anesthesiologists for Anesthesia Relative Values.

5.6.5.5 Inputs

- (1) HCPCS Update
- (2) Revenue Code Updates
- (3) First Databank Update
- (4) ICD-9-CM Update (Diagnosis and Surgical Procedure Codes)
- (5) PAS for Western United States Update (Length of Stay)
- (6) Medicare Fee Schedule
- (7) RBRVS Updates
- (8) CLIA/Mammography Certification Data
- (9) Procedures Authorized for Assistant Surgeon Services

- (10) On-Line Updates
- (11) Procedures authorized as rentals
- (12) Procedures authorized for professional or technical components
- (13) ClaimCheck® and ClaimReview® updates
- (14) Washington State Medicaid Fee Schedule for Physicians
- (15) ASA RVUs

5.6.5.6 Outputs

- (1) Procedure, Diagnosis, and Formulary Error List
- (2) Procedure/Formulary Database Audit Trail
- (3) Procedure/Formulary Database Inquiry
- (4) Procedure/Formulary Database Listing
- (5) Diagnosis Database Update Report
- (6) Diagnosis Database Error Report
- (7) Diagnosis Database Update Control Report
- (8) Diagnosis Database Audit Trail
- (9) Diagnosis Database Inquiry
- (10) Diagnosis Database Listing (with or without length-of-stay data)
- (11) First Databank Drug Update Comparison Report
- (12) First Databank Drug Error Report
- (13) First Databank Drug Add Report
- (14) First Databank Drug Update Report by NDC
- (15) First Databank Drug Update Report by Trade Name
- (16) Drug Listing by Trade Name
- (17) Drug Listing by Therapeutic Class/Trade Name
- (18) Drug Listing by Generic Drug Name
- (19) Drug Listing by Generic Drug Code
- (20) Drug Name Cross-Reference Build Control Report
- (21) Generic Drug Name Cross-Reference Build Control Report
- (22) Group Number Length-of-Stay Update Report
- (23) Diagnosis Database CPHA LOS Update Control Report
- (24) Error Text Database Inquiry
- (25) Error Text Database Listing

- (26) Error Text Database Audit Trail
- (27) Edit/Audit Criteria Database Listing
- (28) Edit/Audit Criteria Database Inquiry
- (29) Edit/Audit Criteria Database Audit Trail
- (30) Alpha Diagnosis Database Listing
- (31) Reference Function Audit Trail Summary
- (32) RBRVS Update Reports
- (33) RBRVS Audit Trail
- (34) RBRVS Listing
- (35) RBRVS Inquiry
- (36) CLIA Database Inquiry
- (37) CLIA Audit Trail
- (38) CLIA Listing
- (39) Revenue Code Inquiry
- (40) Revenue Code Audit Trail
- (41) Revenue Code Database Listing
- (42) Mammography Certification Inquiry
- (43) Mammography Certification Audit Trail
- (44) Mammography Certification Listing

5.6.5.7 Performance Standards

- (1) Update pricing changes to the drug formulary file within one (1) business day from receipt of update from pricing authority.
- (2) Update the CLIA laboratory designations within one (1) business day of receipt of file.
- (3) Perform on-line updates to reference data within twenty-four (24) hours of receipt.
- (4) Process procedure, diagnosis, and other electronic file updates to the reference databases within five (5) business days of receipt or upon a schedule approved by the State.
- (5) Provide update error reports and audit trails to the State within 24 hours of completion of the update.
- (6) Update edits adjudication documentation within three (3) days of the request from DHSS.
- (7) Update error text file documentation within three (3) days of DHSS approval of the requested change.
- (8) Maintain a 98% accuracy rate for all reference file updates.
- (9) Identify and correct errors within one (1) business day of error detection.

- (10) Inform the State and reprocess any claims adversely impacted due to errors.

5.6.6 Prior Authorization

The Prior Authorization (PA) function encompasses those functions necessary to process and approve or deny requests for prior authorization for services specified by DHSS. The responsibility for processing prior authorization requests is shared among several entities. The fiscal agent authorizes the services based on policy provided by and procedures approved by DHSS. The fiscal agent is also responsible for maintaining the interface with the authorizing agencies and Contractors when programs use the MMIS for claims processing purposes.

Qualis Health, a quality improvement organization (QIO) authorizes medical inpatient hospital stays under a contract with DHSS, and First Health Services/Health Care Management authorizes Alaska inpatient and residential psychiatric services under a separate contract. The Division of Senior and Disabilities Services authorizes all home and community based waiver services, personal care attendant services and all long term care facility services. The Division of Behavioral Health authorizes some outpatient behavioral health services. All other prior authorization requests are evaluated by the fiscal agent.

5.6.6.1 Business Needs

The primary objective of the Prior Authorization function is to verify the medical necessity of specified services prior to provision of those services.

5.6.6.2 State Responsibilities

- (1) Identify and provide to the Contractor a list of services requiring prior authorization.
- (2) Provide written prior authorization and plan of care guidelines for processing and adjudication of prior authorization requests.
- (3) Specify and approve edits and/or audits and other service authorization rules/guidelines to be used in prior authorization review, processing, notification, etc.
- (4) Provide written guidelines for claim and prior authorization appeals processing.
- (5) Serve as authorizing entity for and provide prior authorization data to the MMIS for home and community based waiver services programs, long term care services, personal care services, and certain outpatient behavioral health services.
 - (a) Receive plans of care from service providers including care coordinators via electronic and paper request formats
 - (b) Review plans of care, LTC documentation, other information submitted with service authorization request and determine appropriate level of care, the amount and duration of services to be approved or denied, and include approved rate information, as applicable.
 - (c) Send authorization decision information to the fiscal agent for input to the MMIS PA system.
 - (d) Notify the applicable providers of authorization decision information.

5.6.6.3 Contractor Responsibilities

The table below identifies the authorizing agencies and the services that are authorized by the agency.

Authorizing Agency	Services Authorized
Fiscal Agent	Transportation and Accommodation Vision Durable Medical Equipment Emergency Transportation Radiology (MRI, PET, SPECT) Dental Specified Physician Services Home Health Pharmacy (through the POS system described in Section 5.6.15) Outpatient mental health and substance abuse rehabilitation services beyond regulation limits
Quality Improvement Organization (QIO)	Inpatient Acute Care beyond 3 day LOS Selected Diagnoses and Procedures requiring Preadmission/Precertification Case Management
Quality Improvement Organization (QIO-like)	Inpatient Psychiatric Residential Psychiatric
Division of Senior and Disabilities Services (DSDS)	Home & Community Based Waiver Programs Services Long Term Care Services Personal Care Attendant (PCA) Services
Division of Behavioral Health (DBH)	Some outpatient behavioral health services beyond regulation limits.

The fiscal agent is responsible for authorizing the services identified under “Fiscal Agent” on the above chart, and for maintaining the interfaces with other Contractors and authorizing agencies.

The business processes required to support the prior authorization function include:

- (1) General Prior Authorization Functions
- (2) Processing Requests Authorized by the Fiscal Agent
- (3) Processing Requests Authorized by Other Agencies and Contractors

5.6.6.3.1 General Prior Authorization Functions

- (1) Provide an automated prior authorization system to enter prior authorization information, edit claims against prior authorization data, and track activity against approved prior authorizations.

- (2) Receive and process (approve, pend, route, or deny) all requests for prior authorization of services in accordance with federal and State and medical guidelines, procedures, and standards.
 - (a) Image all service authorization request forms and make available for viewing in the MMIS; imaged files must be easily accessible by hypertext link from view of recipient, claims, or service authorization screens.
 - (b) Accept web-based, direct online entry, batch entry, paper, fax, and telephone Service Authorization Requests, or other methods as directed by the department. Make full use of HIPAA 278 request/response transactions and, when available, HIPAA 275 transactions.
 - (c) Provide automated process to link hard-copy Service Authorization attachments received by fax or mail with the corresponding Service Authorization requests that have been submitted electronically.
 - (d) Provide a mechanism to receive and process Service Authorizations based on the National Provider Identifier (NPI).
 - (e) Process Service Authorization requests and amendments according to department-approved guidelines, time constraints, and provide responses to clients and providers of their approved, denied, or pending status.
 - (f) Provide the means to perform mass updates of Service Authorization records; for example; provide capability to globally change provider ID numbers or procedure codes/modifiers for pending or approved but unutilized services.
 - (g) Identify service categories that are subject to the same limitation and accumulate the like services.
- (3) Provide an automated tracking system for receiving, collecting, transmitting and routing prior authorization requests. Designated supervisory personnel must be able to route PAs to the appropriate staff or authorizing agency. Provide the capability to maintain the following data, produce reports and inquire on PAs to track the following:
 - (a) Who submitted the request (both the representative and the name of the local/attending health care provider)
 - (b) When the request was received
 - (c) Where the request was routed and when
 - (d) Who processed the request
 - (e) Who will render the services (rendering provider, service category)
 - (f) What type of authorization
 - (g) When the request was returned (date of decision, date PA data entered on authorizing entity file, date of submission to/receipt by the department or fiscal agent Contractor)
 - (h) When the provider and recipient were notified of the disposition (date of notification)
 - (i) Comments and other information
 - (j) All required and specified situational data elements necessary for receipt, processing, and response of HIPAA 278 electronic transaction
- (4) Ensure the capability to appropriately and adequately track pending authorizations.

- (5) Assign system-generated unique PA numbers to approved, pending, and denied PA requests, and maintain all PA data on the PA file. Identify the status of prior authorizations, including pending, approved, denied, or amended, and display the appropriate status on-line.
- (6) Edit to ensure that only valid data is entered on the PA file, and deny duplicate requests or requests that contain invalid data.
- (7) Capture and maintain both the requested service amounts (units and/or dollars) and authorized service amounts (units and/or dollars) on the PA file.
- (8) Provide the capability to authorize services for a specific recipient by procedure codes and modifiers, revenue codes, tooth and surface codes, drug codes, diagnosis codes, types of service, units, dollars, origin, destination, provider number, provider types. This includes the following types of prior authorization data:
 - (a) PAs which are client-specific but not necessarily provider-specific
 - (b) PAs which span multiple provider types, time periods, and number and intensity of services.
- (9) Provide the capability to reserve authorized services to a specific provider pending receipt of the claim.
- (10) Maintain all data element fields associated with the authorization request/response and claims adjudication rules necessary to enforce Service Authorization requirements including the following:
 - (a) Requestor
 - (b) Authorizing agency
 - (c) Reserved for provider
 - (d) Rendering provider
 - (e) Date received
 - (f) Date entered on PA file
 - (g) Date of notification
 - (h) Type of authorization
 - (i) Comments field
 - (j) Line Number
 - (k) From/Thru service dates
 - (l) Clinical indicator type and acuity
 - (m) Travel origin/destination/purpose
 - (n) Provider type
 - (o) Provider specialty
 - (p) Provider taxonomy
 - (q) Procedure code/procedure code modifiers
 - (r) Revenue codes
 - (s) Tooth number/surface codes
 - (t) Benefit program/plan eligibility
 - (u) Status of request at line level
 - (v) Reason code for denial/cutback
 - (w) Number of units requested/approved/denied

- (x) Number of units used/remaining/reserved/available/transferred/suspended
 - (y) Multiple diagnosis codes
 - (z) Frequency of service
 - (aa) Intensity of service
 - (bb) Recipient eligibility
 - (cc) Recipient DOB
 - (dd) Recipient calculated age
 - (ee) Date of last claim that used PA
 - (ff) PA routing: location and date
 - (gg) 278 request/response elements
- (11) Maintain electronic copies of the notification letters and provide a hyperlink from the PA file/record in MMIS to the associated letters.
- (12) Provide the capability to capture and maintain data for denied prior authorizations and deny claims for which prior authorization was denied.
- (13) Provide the capability to track modifications to authorization records (i.e., partial approval and partial denial on the same authorization, appealed authorization decision reversed resulting in modified authorization) and pay claims at the appropriate rate or units of service.
- (14) Provide the capability to change the services authorized and to extend or limit the effective dates of the authorization. Maintain the original and the change data in the PA file available through on-line inquiry.
- (15) Update Service Authorization records based upon claims processing results indicating that the authorization has been partially used or completely used. These activities include processing of original claims, adjustments, and voids that “draw down” (decrement) and/or “add back” authorized services (units, dollars, authorized dollar amount per unit, etc.).
- (16) Track and make available on-line, the number of authorized services (units, dollars, authorized dollar amount per unit, etc) used based on claims payment activities and show how many services remain. This includes the capability to associate claim CCN/ICN data of all claim activities affecting PA record (original, adjustment, and void transactions) and the resulting affect on PA record data (increment/decrement units, dollars, etc.).
- (17) Provide on-line inquiry access to the prior authorization file information using requesting and/or rendering provider name, requesting and/or rendering provider number, recipient name, recipient ID number, prior authorization number, type of authorization/category of service, procedure code (with/without modifiers) or other data elements as parameters to access only specific prior authorizations or only authorizations for a particular service (e.g., transportation, inpatient hospital, or home health).
- (18) Provide the capability for providers to check the status of PA requests on-line via the Contractor’s Internet Web portal. Both the requestor (if the request was submitted by a provider) and the provider to whom services have been assigned should have inquiry access to the authorization records for their patients.

- (19) Maintain audit trail of file updates, accessible through on-line inquiry. Maintain control totals and provide balance information in response to on-line requests.

5.6.6.3.2 Processing Requests Authorized by the Fiscal Agent

- (1) Receive requests from providers and authorize the following services based on State-defined criteria:
 - (a) Transportation and Accommodation
 - (b) Vision
 - (c) Durable Medical Equipment
 - (d) Emergency Transportation
 - (e) Radiology (MRI, PET, SPECT)
 - (f) Dental
 - (g) Specified Physician/ANP Services
 - (h) Home Health Services
 - (i) Outpatient Behavioral Health Services
 - (j) Pharmacy Services
- (2) Use imaging equipment to capture, store, and retrieve hard copy prior authorization requests and associated documents.
- (3) Provide on-line entry of hard copy requests to the prior authorization file.
- (4) Approve or deny prior authorization requests according to DHSS approved procedures.
- (5) Provide for the system to apply different PA start, check, and deny criteria based upon program eligibility. Under each program, check the recipient eligibility for the current date or the start date of the service(s) being requested in the PA. If there is no eligibility for the recipient, suspend the request for the period specified by the program and re-check for eligibility. Continue to suspend the request and recheck or deny the request based on individual program specifications. This applies to retroactive requests as well.
- (6) Provide necessary staff to perform PA and claims resolution activities requiring professional review. Recommended minimal staffing includes:
 - (a) 1 FTE who is a currently licensed R.N. available during Alaska business hours
 - (b) A currently licensed M.D. or D.O. for a minimum of 4 hours per week
 - (c) A currently licensed D.D.S or D.M.D. for a minimum of 4 hours per week
- (7) Maintain a prior authorization manual that includes procedures, policies, and protocols for PA processing as approved by DHSS. Perform continuous review and update of the manual, and obtain DHSS approval of all changes and updates identified by the fiscal agent and provide verification notice to DHSS for changes requested by DHSS.
- (8) Produce control and balancing reports for all prior authorization requests, and provide the reports to DHSS accessible on-line and in hardcopy upon DHSS request.
- (9) Generate automatic approval and denial notices to requesting and assigned providers, and case managers, and recipients for prior authorization review activities. Denial notices to recipients must include the reason for the denial and notification of the recipient's right to a fair hearing. Maintain electronic versions of the notification letters.

- (10) Enter and accept all prior authorization requests in the on-line prior authorization file, regardless of final decision/status (approved, pending, and denied).
- (11) Print/distribute in hardcopy and make available for download via Contractor's internet Web site prior authorization request forms.
- (12) Receive travel and radiology authorization requests by telephone and FAX, and authorize or deny services based on State-defined criteria. Enter the reason for travel on the PA file and include this data in the on-line display for travel PAs. Track busy signals on the telephone and FAX line(s) to ensure that providers have access to these capabilities.
- (13) Provide a toll free call center telephone and fax numbers for providers to request prior authorizations.
- (14) Provide on-line entry of telephone requests to the prior authorization file.
- (15) Provide a prior authorization number to the provider for all requests received via telephone, hard copy and fax.
- (16) Provide the capability to identify clients who abuse travel services and restrict prior authorizations for travel for these clients according to State guidelines.
- (17) Provide 24-hour pharmacy PA processing through the POS system. (See 5.6.15.3.3)
- (18) Develop an electronic submission process via the Contractor's Internet Web portal for receipt of and response to prior authorization requests.
- (19) Provide the capability to accept, process, and respond to prior authorization requests in the HIPAA format.
- (20) Review and approve prior authorization requests received electronically according to DHSS approved procedures.

5.6.6.3.3 Processing Requests Authorized by Other Agencies and Contractors

- (1) Accept hardcopy as directed by the department and develop electronic interchange process to accept electronic prior authorization requests that may be provided by Contractors and other agencies for the following services:
 - (a) Quality Improvement Organization (QIO) Contractor/Authorizing Entity
 - i) Inpatient Acute Care continued stay beyond 3 day benchmark LOS
 - ii) Selected Diagnoses and Procedures requiring Preadmission/Precertification
 - iii) Case Management
 - (b) Quality Improvement Organization (QIO)-like Contractor/Authorizing Entity
 - i) Inpatient Psychiatric
 - ii) Residential Psychiatric
 - (c) Division of Senior and Disabilities Services (DSDS)
 - i) Home & Community Based Waiver Programs Services
 - ii) Long Term Care Facility Services
 - iii) Personal Care Attendant (PCA) Services
 - (d) Division of Behavioral Health (DBH)

- i) Some outpatient behavioral health services beyond regulatory service limitations
- (e) Other Department programs such as OCS and DJJ
- (2) Produce control and balancing reports for prior authorization requests received from Contractors and other agencies, and provide the reports to DHSS accessible on-line and in hardcopy upon DHSS request.
- (3) Interface with the Contractors and other agencies to resolve any problems regarding authorizations submitted by the Contractors or other agencies. For PAs which are incomplete or which contain invalid data, add the PA to the database in a suspended status and return the request to the Contractor or authorizing agency for correction.
- (4) Notify Contractors and other agencies of the format and range of numbers to be used as the PA number on their authorizations.
- (5) Provide the capability to adjust prior authorizations for modifications to the number of certified days/length of stay authorized based on assessment reviews by the quality improvement organization (QIO/QIO-like) Contractor(s) (i.e., medical necessity/acute level of care evaluation of hospital stays).
- (6) Add prior authorization requests received through the batch process to the on-line prior authorization file.
- (7) If a provider submits a PA request that should be processed by another Contractor, accept and route the PA to the other Contractor.
- (8) If a provider submits a PA request that should be processed by another State agency or program, add the request to the PA database in a suspense status and notify the agency or program that the suspense transaction is on the file for the agency/program to review and approve or deny.
- (9) Provide on-line access to prior authorization data to authorized personnel from the Contractors, agencies and programs for review and resolution of PA requests.

5.6.6.4 Interfacing Systems

- (1) QIO Contractor:
 - (a) Inpatient Acute Care (continued stay beyond 3 day benchmark LOS)
 - (b) Select Diagnoses and Procedures requiring Preadmission/PreCertification
 - (c) Case Management
- (2) QIO-like Contractor:
 - (a) Inpatient Psychiatric
 - (b) Residential Psychiatric
- (3) Division of Senior and Disability Services (DSDS):
 - (a) Home and Community Based Waiver Programs Services
 - (b) Long Term Care Services
 - (c) Personal Care Attendant (PCA) Services

- (4) Division of Behavioral Health (DBH)
 - (a) some outpatient behavioral health services beyond regulatory service limitations

5.6.6.5 Inputs

- (1) Service Authorization/Prior Authorization requests
 - (a) Hardcopy Prior Authorization Requests
 - (b) Telephone Prior Authorization Requests
 - (c) FAX Prior Authorization Requests
 - (d) Individual and Batch Electronic Requests via the Contractor's Internet Web portal
 - (e) HIPAA 278 Service Authorization Request Transactions
- (2) Electronic Interface/PA Record Information from Other Contractors and/or Agencies

5.6.6.6 Outputs

- (1) Service Authorization/Prior Authorization Responses
 - (a) Hardcopy Prior Authorization Responses
 - (b) Telephone Prior Authorization Responses
 - (c) FAX Prior Authorization Responses
 - (d) Individual and Batch Electronic Responses via the Contractor's Internet Web portal
 - (e) HIPAA 278 Service Authorization Responses Transactions
- (2) Prior Authorization Audit Trail
- (3) Batch Prior Authorization Update Error Reports
- (4) Electronic Prior Authorization Submission Audit Trail
- (5) Electronic Interface/PA Record Information Submission Error Reports
- (6) HIPAA 278 Service Authorization Response Transaction
- (7) Routing PA Requests
- (8) Prior Authorization control and balancing reports

5.6.6.7 Performance Standards

- (1) Enter all hard copy PA requests that have been approved or denied into the MMIS within one business day of receipt.
- (2) Enter approved or denied PAs received from other agencies and Contractors that contain no critical errors into the MMIS within one business day of receipt.
- (3) Return one hundred percent (100%) of PA requests with critical errors (i.e., the PA does not contain enough information to process the request) to the submitter within one business day of identification of the critical error.
- (4) Deny or approve all non-emergency travel and radiology PA requests that do not require medical review or technical review by the State within one (1) business day of receipt.

- (5) Generate and mail or electronically transmit ninety-five percent (95%) of prior authorization decisions to the requesting provider and the recipient (for denials) within one (1) business day of the adjudication of the prior authorization request. Generate and mail the remaining five (5%) within three (3) business days of adjudication of the request.
- (6) Complete all Contractor PAs that require clinical review within ten (10) days of receipt.
- (7) Deny or approve all Contractor PAs that do not require medical review or technical review by the State other than non-emergency transportation or radiology within three (3) business days of receipt.
- (8) Complete all PA interface updates within one (1) business day of receipt of a file if there are no critical errors.
- (9) Generate all error reports within one (1) business day of the interface or file update.
- (10) Resolve ninety-five percent (95%) of all Contractor errors (as identified on error reports) within five (5) business days of generation of the error report and the remaining five percent (5%) within ten (10) business days.
- (11) Update the prior authorization manual within three (3) business days of State approval of a change or State request for a change.

5.6.7 Reimbursement

The Reimbursement Function encompasses those activities necessary to define the methodology for payment, and level of payment for services covered by Medicaid or one of the other State programs. The Alaska MMIS requires the capability to match reimbursement methodologies by recipient, by service, by program for multiple programs, and use geographic differentials for some services.

Current reimbursement methodology is by service, with some variation between Medicaid and State funded programs. The current reimbursement methodologies are described in Section 4.4.6 of the RFP and are in the Alaska Pricing Manual included in the Bidders Library.

The DHSS will require the fiscal agent to demonstrate the capability to support new reimbursement methodologies that may be adopted by the DHSS. The DHSS is currently evaluating the following reimbursement systems for possible application to DHSS program payments: a Diagnosis Related Grouper (DRG) system for inpatient hospital services, outpatient groupers for outpatient hospital services, Ambulatory Payment Groupers (APG) for Ambulatory Surgical Centers, nursing home resource utilization groups (RUGs), State maximum per service per visit basis or case mix reimbursement for home health services, unique base unit rate plus unique time unit rate pricing from a single claim line for anesthesia services, and procedures for pharmacy disease management program. These reimbursement methodologies are not currently part of the Alaska Medicaid reimbursement methodology, but will be incorporated through future policy changes or under study for future inclusion. System design and development must be structured so that these reimbursement methods can be easily accommodated with minimal change and cost when implementation decisions are made.

Activities within the Reimbursement function include:

- (1) Defining the universe (e.g., all Medicaid recipients, all recipients in a specific program or eligibility category, all recipients within a specific level of care/intensity of service, only recipients within a certain age range, or recipients in a geographic area) for the specific reimbursement methodology.
- (2) Defining the reimbursement methodology by provider, by program, by service, by location or geographic region, and by recipient (e.g., all providers participating in Denali KidCare could receive a fee-for-service reimbursement for office visits based on Alaska usual and customary, rather than the RBRVS in place for physician office visits for adults, or differing Ambulatory Surgery rates based on rural or urban locations.)
- (3) Defining the requirements for new reimbursement methodologies not currently in use by the DHSS (Inpatient hospital DRGs, APGs).
- (4) Determining the cost impact of any reimbursement change, including geographic differentials and cost settlements.
- (5) Defining the system requirements for reimbursement changes.

The Reimbursement function is primarily the responsibility of DHSS and the other payer agencies, with technical support from outside reimbursement experts. Once the policies have been defined, DHSS communicates the requirements to the fiscal agent for implementation in the MMIS. The fiscal agent may be required to provide technical assistance with cost benefit analyses in support of development of new reimbursement methodologies.

5.6.7.1 Business Needs

The primary objectives of the Reimbursement function are to:

- (1) Define appropriate reimbursement methodology for all services.
- (2) Evaluate new reimbursement methodologies, based on population served, provider services and cost benefit.
- (3) Balance cost, administrative ease and provider support in evaluating the impact of existing reimbursement methodologies versus changes.

5.6.7.2 State Responsibilities

- (1) Define reimbursement methodology for each service, for each defined benefit package.
- (2) Identify new reimbursement methodology for existing services: inpatient DRGs, outpatient grouper, Ambulatory Surgical Center grouper, home health case mix, nursing home resource utilization group (RUG) at such time as DHSS decides to proceed with new reimbursement system.
- (3) Define reimbursement methodology for new services as these services are developed: Behavioral Rehabilitation Services and Pharmacy Disease Management are recent examples.
- (4) Analyze impact of new reimbursement on service delivery, program cost, and provider participation.
- (5) Select desirable new reimbursement methodologies.

- (6) Develop program and define rules for system requirements for new reimbursement methodologies.
- (7) Provide fiscal agent with requirements for design and implementation of reimbursement methodology.

5.6.7.3 Contractor Responsibilities

- (1) Install, test and confirm reimbursement methodology with program data.
- (2) Assist the State in performing impact analyses of new reimbursement methodologies on service delivery, program cost, and provider participation.
- (3) At the State's direction, define the system requirements for new reimbursement methodologies.
- (4) Provide flexibility in pricing design to support ease of implementing changes to existing and new reimbursement methodologies.
- (5) Provide accurate and timely delivery of system solutions for new and modified reimbursement methodologies.
- (6) Monitor new and modified reimbursement methodologies post-implementation to assure quality outcomes. Report problems, including a corrective action plan, to the State immediately.
- (7) Accommodate variable date-sensitive pricing methodologies for identical procedure codes based on benefit plans, recipient data, provider types and specialties, and provider specific data.
- (8) Accommodate pricing rule changes with ability to perform online changes to methodologies.
- (9) Provide strict security of online change abilities and provide a testing process to test the impact of an online change to a methodology before impact to production environment.

5.6.7.4 Interfacing Systems

External interfaces, if any, will be defined during the requirements analysis for implementation of any new reimbursement methodologies.

5.6.7.5 Inputs

- (1) Reimbursement Methodology for Services (From State to Fiscal Agent)
- (2) Changes to reimbursement methodology (From State to Fiscal Agent)
- (3) Test data on changes to Reimbursement methodology (From Fiscal Agent to State)
- (4) RBRVS data updates
- (5) Medicare Fee Schedule for laboratory services data updates
- (6) Ambulatory Surgery Center grouper data updates
- (7) State rate updates

- (8) Hospital rate data updates
- (9) Other external update sources for existing and new methodologies

5.6.7.6 Outputs

- (1) Test validation from Fiscal Agent of reimbursement methodology
- (2) Cost comparison of existing reimbursement system with proposed alternative
- (3) Updated DSD payment methodology manual (i.e., pricing manual)
- (4) Quality control reports that monitor the accuracy and impacts of newly implemented methodologies

5.6.7.7 Performance Standards

The Contractor must meet the performance standards for system maintenance and enhancement when implementing new reimbursement methodologies.

5.6.8 Claims Processing

The Claims Processing function encompasses both automated and manual functions necessary to process all claims submitted to the Alaska medical assistance programs. These functions are primarily the responsibility of the fiscal agent and follow policy decisions made by DHSS.

5.6.8.1 Business Needs

The primary objectives of the Claims Processing function are to:

- (1) Ensure claims and related input is captured at the earliest possible time in an accurate manner.
- (2) Monitor the movement and distribution of claims once they are entered into the system to ensure control and provide an accurate audit trail from receipt of claims through data entry to final disposition.
- (3) Accept claims and other transactions via hard copy and electronic media to include tape, diskette, modem-to-modem, FTP transmission and Internet transmission. These methods will evolve with the progression of electronic technologies. The State determines the types of acceptable magnetic or electronic media.
- (4) Establish and maintain control over all transactions during their entire processing cycle.
- (5) Maintain accurate and complete audit trails and registers of all processing and regularly monitor and evaluate these as part of the quality control process.
- (6) Verify that providers submitting input are properly enrolled and eligible to bill for the type of service at the time of service.
- (7) Ensure that recipients for whom claims are submitted were eligible for the type of service at the time the service was rendered.
- (8) Ensure input submitted is processed completely, accurately, and timely.

- (9) Process all claim data against defined service, policy, and payment parameters and make appropriate claim adjudication in accordance with the Alaska MMIS plan and established federal and State guidelines.
- (10) Ensure that payments are accurate and in accordance with State and federal policy.
Ensure that interfacing systems receive accurate payment information in a timely manner.
- (11) Process voids and adjustments.

5.6.8.2 State Responsibilities

- (1) Develop policy and monitor the performance of the Contractor in all areas of the Claims Processing Function.
- (2) Provide written approval of all accepted internal and external claims processing procedures used to adjudicate claims and monitor the location within the claims processing system for all claims (i.e., edits and audits, medical policy resolution, manual pricing, etc.).
- (3) Monitor the Contractor through review of claims processing cycle balancing and control reports.
- (4) Establish hardcopy and imaging, disc, and electronic claim retention and retrieval standards.
- (5) Define standard claim forms such as CMS-1500, UB-92, ADA, and NCPDP as well as unique State claim forms such as screening and transportation forms.
- (6) Define data requirements for standard claim forms and State-unique claim forms.
- (7) Provide written criteria and procedures for adjudication of late billing claims, retroactive eligibility claims, out-of-State emergency claims, payment of claims under court order, result of an appeal/fair hearing, and any other State-defined situation.
- (8) Review inventory management and other operational claims reports.
- (9) Establish financial processing and adjustment processing policies and procedures.
- (10) Approve hardcopy claim forms.
- (11) Approve EMC formats.
- (12) Define and provide written approval of accepted pricing methodologies and any modifications to those methodologies.
- (13) Determine State location assignments and error hierarchy and communicate these to the Contractor.
- (14) Approve changes to error message texts, error locations, and edit/audit dispositions.
- (15) Perform pended claims review and resolution error codes designated for State disposition.
- (16) Assist the Contractor in determining edit and audit criteria, and provide approval of all criteria used.
- (17) Specify error override and force policy and procedures for use by the Contractor in claims correction.

- (18) Determine and provide to the Contractor prepayment and medical review criteria.
- (19) Provide requirements and procedures for the manual pricing of certain claims.
- (20) Provide the Contractor with policy clarifications, as necessary, for the resolution of claims.
- (21) Review and approve changes to format and content of standard claims processing reports, both printed output and on-line displays.

5.6.8.3 Contractor Responsibilities

The business processes required to support the Claims Processing function include:

- (1) Claims Control and Entry
- (2) Electronic Media Claims
- (3) Claims Adjudication and Pricing
- (4) Pend Resolution
- (5) Information Access

5.6.8.3.1 Claims Control and Entry

- (1) Provide a batch control system to control, track, and reconcile claims input to ensure all claims received by the Contractor are processed.
- (2) Produce control and balancing reports for all claims input (hardcopy and electronic media), perform daily balancing, and provide the reports and daily balancing results to DHSS accessible on-line and in hardcopy upon DHSS request. The frequency, quantity, format, and distribution of the reports may be changed without additional cost to the State.
- (3) Provide 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 provider number, recipient ID number, procedure codes, and diagnosis codes.
- (4) Provide for capture and processing of UB-92 and UB-04 data elements as defined by the State, including all diagnosis, procedure, procedure modifiers and revenue codes and other UB-92 and UB-04 elements not processed by the current Alaska MMIS. Maintain and adapt capabilities as revisions are made to this claim form.
- (5) Provide for capture and process of CMS 1500 data elements as defined by the State; maintain and adapt capabilities as revisions are made to this claim form.
- (6) Provide for capture and process of ADA dental form data elements as defined by the State; maintain and adapt capabilities as revisions are made to this claim form.
- (7) Provide for capture and process of NCPDP UCF form data elements as defined by the State; maintain and adapt capabilities as revisions are made to this claim form.
- (8) Provide for capture and process of data elements from the State-unique EPSDT services form as defined by the State. The Contractor will reassess and recommend an alternate

solution which captures requisite claim data and clinical data elements required for EPSDT program functions.

- (9) Provide for capture and process of data elements from the State-unique Transportation services form as defined by the State. The Contractor will reassess and recommend an alternate solution for the transportation and accommodation prior authorization process which enables capture of requisite claim data on a standard industry claim form while supporting the transportation and accommodation program functions.
- (10) Capture and process the 2-digit Medicare place of service codes.
- (11) Provide the capability to capture and process rendering provider information at the line-item level.
- (12) Provide the capability to capture and process third-party payment information at the claim line level.
- (13) Provide the capability to capture and process prescribing provider information on various claim forms.
- (14) Provide the capability to capture and process prior authorization information at the line-item level.
- (15) Provide the capability to capture and process NPI and provider taxonomy information at the claim line level.
- (16) Capture all claims data necessary for processing according to State and federal guidelines, including third party resources (including Medicare) at the line level.
- (17) Prepare and control incoming and outgoing Alaska Medicaid and State program mail to ensure claims and other correspondence are picked up and delivered to sites designated by DHSS in the most effective and efficient means available.
- (18) Deliver to and pick up from DHSS Contractor mail, reports and other deliveries. Pickups and deliveries shall be made once in the morning and once in the afternoon each workday, and at the request of the State.
- (19) Sort incoming mail and, date/time stamp, image, and deliver provider correspondence, administrative mail, and other non-claims mail to the appropriate functional areas.
- (20) Maintain a returned mail process to track mail sent by the Contractor and returned by the post office as undeliverable.
 - (a) For returned mail that was sent to a recipient (e.g., REOMBs) forward the returned mail to DHSS for handling.
 - (b) For returned mail that was sent to a provider, check the provider database to determine if the address has been changed. If so, re-send the document to the correct address.
 - (c) If the address on the provider database has not been changed, attempt to contact the provider by telephone and/or e-mail to determine the problem with the address. If the provider cannot be contacted by telephone or does not respond to the e-mail, notify DHSS that the provider cannot be located.

- (21) Establish control over source documents to ensure documents are not misplaced after receipt by the Contractor.
- (22) Prescreen hardcopy claims and return those not meeting State-defined criteria to the provider with a cover letter identifying the reason for the return. Currently claims are returned for a missing provider ID number or claim submitted on the wrong invoice form. Track these returned claims to evaluate for ongoing billing problems and activate provider education outreach efforts to resolve ongoing issues.
- (23) Log and electronically image returned claims on a daily basis prior to returning the claims to the provider. Provide access to returned claims by date of service, provider name, client name, and date of receipt.
- (24) Screen, capture electronic image, date-stamp, assign unique control numbers and batch hardcopy claim forms and attachments, adjustment/void forms, and resubmittal turnaround documents.
- (25) Log each batch into an automated batch control system.
- (26) Produce machine-readable records using data entry equipment with the capability of performing gross edits (i.e., field edits for validity and data completeness).
- (27) Produce electronic image of hardcopy claims and claim-related documents, and perform quality control procedures to ensure that the electronic image is legible and meets quality standards. Routinely measure the quality of the imaging process and include findings in quality control reports to the State.
- (28) Establish and maintain balancing and control procedures to ensure that all claims received are processed.
- (29) Produce claims entry statistics reports, in a format conducive to assessing performance compliance, and deliver to the State.
- (30) Make available to approved State users all imaged documents, including but not limited to claims and claim attachments, attachments to electronic claims, adjustment/void forms, resubmittal turnaround documents, and prior authorization forms at the user's desktop.

5.6.8.3.2 Electronic Media Claims

- (1) Accept and process electronic claims in batch mode via tape, diskette, modem-to-modem transmission, transmission via FTP, or Internet transmission, and on a claim-by-claim basis via Internet transmission. All electronic claims from HIPAA covered entities must be in the HIPAA compliant format. Electronic claims from HIPAA non-covered entities must be in the most recent National Standard format or in the HIPAA compliant format.
- (2) Provide a plan and maintain the process for HIPAA-compliant EDI transaction processing. This plan and process must include the assumptions, features, capabilities and limitations of the HIPAA-compliant process and must be written with non-technical nomenclature to support understanding of the process by non-technical personnel. It must include balancing and control procedures, reporting, testing, privacy, security and recovery standards and processes. All transactions must be fully accounted for at all times. Design must support timely submission of appropriate transactions to the MMIS while preventing duplicate submission of transactions to the MMIS.

- (3) Prescreen electronic media claims prior to control number assignment to ensure the validity of the entire transmission, tape, or diskette. Validation of HIPAA compliant transactions must meet X12N and CMS standards. Validations will be performed to ensure the validity of the transaction as well as to ensure valid data content within every segment of the transaction. The State will approve the HIPAA validation level.
- (4) With the exception of fatal errors within the electronic envelope, the HIPAA solution must have the capability to process valid transactions within a transmission and reject incorrect or invalid transactions within the same transmission. Accept HIPAA transactions that contain multiple transaction types in the same electronic envelope.
- (5) Error(s) in the interchange envelope (ISA/ISE) will result in a negative TA1 or other HIPAA compliant acknowledgement transaction response approved by the State. This must be generated to the sender within 2.5 seconds of receipt.
- (6) Both positive and negative responses are required to acknowledge receipt of and status for each segment within the HIPAA transaction. The HIPAA compliant acknowledgement transaction response used to meet this requirement must be approved by the State. These positive and negative acknowledgements must be generated to the sender within 60 seconds of receipt.
- (7) Accept and store all fields on the HIPAA claims transactions. The Contractor will present for State approval mapping documents identifying HIPAA fields needed to process claims. The intent is to maximize use of the claim related information available within HIPAA transactions.
- (8) Make all fields on inbound HIPAA claims transactions available for viewing in a useable format at the users' desktops.
- (9) For claims from HIPAA non-covered entities, evaluate the transaction for balancing purposes and presence of minimum data requirements. If the transaction is out-of-balance or missing critical data elements defined by the State, prevent the entire electronic submission from being entered into the system, and notify the provider of the errors. For claims submitted on tape or diskette, notify the provider within 24 hours of receipt that the claims could not be processed and the reason for the rejection. For claims submitted via modem-to-modem transmission or via the Internet, return an electronic receipt and/or notification that the transmission could not be processed within 60 seconds of transmission receipt.
- (10) Provide regular balancing and processing reports of the HIPAA-compliant processing solution on a schedule subject to State approval. Said reporting must include details of all rejected transactions as well as details of all transactions accepted by the EDI solution and details of all MMIS-received transactions from the EDI solution.
- (11) Receive and process multi-line CMS 1500 or HIPAA 837 P claims with the ability to capture and process up to 50 lines within a single claim.
- (12) Receive and process UB 92 and UB 04 or HIPAA 837I claims with the ability to capture and process up to 999 service/revenue code lines within a single claim.
- (13) Receive and process ADA or and HIPAA 837D claims with the ability to capture and process up to 50 lines within a single claim.

- (14) Receive and process Pharmacy UCF and NCPDP batch and POS standard formats.
- (15) Enter and assign a unique control number to each electronically submitted claim.
- (16) Produce electronic facsimiles of all electronically submitted claims that provide an image of the claim and all data submitted at the point of input. Archive and make available the imaged documents at the users desktop.
- (17) Provide a unique submitter number for each billing service or submitter who submits claims to the MMIS for a single provider or for multiple providers.
- (18) Provide and maintain a process subject to State approval that addresses standards for electronic claims submitters and providers, including appropriate trading partner agreements, an authorized electronic submitter file that links submitters to the providers they represent, and testing methods for electronic submitters. Testing must include reports to submitters and providers of their transmission success or failure, HIPAA compliance, adjudication results and recommendations to correct billing errors.
- (19) Test provider electronic claims submissions for new EMC providers and changes in provider software or billing agencies, including testing the transmission and processing test claims through a complete processing and payment cycle in a test mode prior to authorizing the provider for live submissions.
- (20) Provide attachment indicator values for all National Standard format electronic media claims to be used by the submitter to identify claims for which attachments are being submitted separately. Accommodate all HIPAA-mandated transaction sets including all standard electronic claims formats (e.g., EDI, NCPDP, ANSI, etc.). Assure that providers are authorized for the transaction types they submit and that current, valid and appropriate trading partner agreements exist for those providers and submission dates. Screen and verify that a valid claims transmittal form has been submitted with any electronic media claims for which the transmittal form is required.
- (21) Provide an electronic, HIPAA compliant solution for receipt, tracking and use of claim attachments.
- (22) Provide an automated tracking process that logs tapes and diskettes upon receipt and assigns batch numbers.
- (23) Enter and process electronic media claims.
- (24) Log, image, enumerate and forward claim attachments associated with electronic media claims to appropriate operational area for processing.
- (25) Produce electronic facsimiles of electronic media claims at the point of input and perform quality control procedures to ensure that electronic image is legible and meets quality standards.
- (26) Match attachments received for electronic media claims to the claim and process attachments according to State-defined guidelines.

5.6.8.3.3 Claims Adjudication and Pricing

- (1) Perform, at a minimum, a daily adjudication cycle and adjudicate all claims received through Contractor data entry, electronic media submission, and suspended claims released since the last adjudication cycle. Real time processing is preferred.
- (2) Capture, format and process all new claims submitted for the adjudication cycle.
- (3) Include as part of the claim activity and history record all data elements needed for processing, federal reporting requirements and analyses. The scope of these data elements is subject to State approval but will include NDC on the CMS 1500 format and NPI and provider taxonomy on all formats.
- (4) Edit all State required data elements of the claim record for required presence, format, consistency, reasonableness, and/or allowable values.
- (5) Assure the integrity of the claim record information throughout the receipt, adjudication and history storage process to prevent corrupting claim information.
- (6) Where multiple like data elements exist on a claim record, edit all occurrences of those data elements (e.g., multiple diagnoses or multiple procedure code modifiers on a single record).
- (7) Edit data elements of the claim record that are national code sets for national code set validity.
- (8) Edit code sets and code set relationships based on State-defined criteria including the ability to determine inappropriate values based on code set relationships (e.g., type of bill and patient status relationships), and ability to restrict code sets to specific provider or client groupings.
- (9) Edit all UB 92 and UB 04 claims at the revenue code/service code level for date of service requirements, and appropriateness and conformity to Alaska's formulary and policy standards.
- (10) Edit provider ID numbers and recipient ID numbers for validity and for eligibility for the services provided on the dates of service.
- (11) Edit procedure codes, diagnosis codes, and revenue codes for validity and coverage by the Alaska medical assistance programs on the date of service.
- (12) Edit place of service and provide ability to restrict payment for services for specific provider groupings based on place of service.
- (13) Edit claims against applicable third party resources, including private insurance and Medicare eligibility for cost avoidance by insurance coverage type, claim form/invoice type, claim type, provider type, category of service, specific procedure codes, combinations of procedure and diagnosis codes, eligibility code, other program indicators, and court order indicator.
- (14) Create a date-specific matrix which allows for federally-waived "pay and chase" for certain services by insurance coverage type, claim form/invoice type, claim type, provider type, category of service, specific procedure codes, combinations of procedure and diagnosis codes, eligibility code, other program indicators, and court order indicator.

- (15) Provide claim editing flexibility to recognize and avoid third party rules for known third party non-covered items or services by insurance coverage type, invoice type, claim type, provider type, category of service, specific procedure codes, combinations of procedure and diagnosis codes, eligibility code, client/recipient identification number, other program indicators, and court order indicator. Provide single transaction update and mass update ability to these avoidance rules.
- (16) Edit claims where applicable against prior authorization requirements and either approve or deny depending on State policy for each PA element (provider, date of service, diagnosis, procedure, length of stay, units, tooth code, tooth surface, revenue code, etc.).
- (17) Provide the capability to apply edits based on provider type, provider specialty, category of service, recipient eligibility code (including subtype and cash indicator), program, benefit plan (and subparts), FFP indicator, region code or other data to provide more flexibility in application of the error codes. Provide on-line access to the edit table for research and update of the edit criteria.
- (18) Provide a flexible solution for editing procedure code modifiers on claim records with the ability to restrict procedures, providers, provider specialties, provider types, categories of service, claim types or other criteria as valid for specific modifiers, when required by the State, as well as the ability to recognize when certain modifiers are informational and should not impact editing rules.
- (19) Provide the flexibility to edit claims for durable medical equipment and medical supplies on measurement and quality duration criteria. These field values are in addition to the unit field.
- (20) Provide the capability to pend or deny claims for recipients assigned to the recipient lock-in program based on State guidelines.
- (21) As an alternative to denying claims that fail certain State specified edits, provide edit capability to suspend claims and generate claim correction forms, also called resubmission turnaround documents (RTDs), so that providers may correct claim information. Failure to respond to the claim correction form within State-specified time frames will result in subsequent automatic denial of the claim.
- (22) Provide the capability to monitor services for suspected abusers at the request of the State, using a “pay and report” lock-in or some equivalent system function that will provide weekly reports of the claim activity for these recipients.
- (23) Provide the capability to edit claims for recipients in long term care facilities to ensure that services included in the LTC payment rate are not separately paid to individual practitioners or other providers.
- (24) Provide the capability to edit claims for other concurrent care situations to ensure denial of claims for services that are mutually exclusive to other already paid services, for example, mutually exclusive relationships between home infusion therapy and home health services.
- (25) Provide the capability to apply service limitations (units and monetary amounts) based on specified time periods which may differ based on the service (e.g., daily, monthly, yearly or other service limitations).

- (26) Provide the ability to track and report remaining/available units or dollars for service limitations or for other maximum unit or dollar limitations for a defined benefit.
- (27) Provide the ability to cutback to remaining available units or dollars and pay claims that exhaust the defined benefit.
- (28) Provide the capability to exceed service limits based on the presence of valid authorization or other State-specified criteria.
- (29) Provide the capability to edit and report travel claims for recipients who travel but do not have medical services during the period of approved travel.
- (30) Identify applicable error codes for claims that fail edits.
- (31) Audit claims against defined service, policy, and payment parameters in accordance with the Alaska MMIS plan and established State and federal guidelines.
- (32) Audit claims against historical data from claims history, claims in the current processing cycle, and claims in the Budget Funding File for duplicate checking.
- (33) Audit claims against State-defined service limitations including once-in-a-lifetime procedures and other frequency, periodicity, and dollar limitations.
- (34) Provide for and process claims against all components of the McKesson HBOC ClaimCheck[♥] and ClaimReview[→] audits including SmartSuspense or a functionally equivalent audit system, including the capability to modify audits according to State standards, customize audits as defined by DHSS, capability to automatically void paid claims, and capability to generate new claims. Examples of the types of editing to be included are:
 - (a) New visit frequency
 - (b) Incidental procedures for surgical procedures
 - (c) Pricing of multiple surgeries and multiple modifiers
 - (d) Add on codes from multiple surgery editing
 - (e) Mutually exclusive procedures
 - (f) Diagnosis to procedure editing
 - (g) Cross provider editing for surgeons and assistant surgeons
 - (h) Rebundling of procedures where procedure codes have been billed separately
 - (i) Pre-operative and post-operative services which should be included in the global surgery procedure
 - (j) Application of AMA guidelines as defined in the CPT for asterisked (*) procedures
- (35) Provide support from a physician for ongoing review of clinical audits, and provide recommendations to DHSS for additions, changes and deletions of clinical audits. Upon DHSS approval, implement changes to clinical audits.
- (36) Provide a test edit capability to allow processing of test edits during live production runs and provide reports to DHSS of all test edits.
- (37) Assign claim status (i.e., approved, denied, pending, rejected) based on criteria approved by the State.
- (38) For pending claims, assign the location of the State unit, other State programs, or Contractor unit that will resolve the pending claim based on criteria determined by the

State. Expand the number of State pend locations from the current number of State locations to multiple State locations that specify the State program manager to which the pend should be assigned. Provide queues with on-line access to pending claims in each location, and the capability to re-assign claims to queues as needed.

- (39) For claims failing recipient eligibility edits, recycle the claims on a schedule to be approved by DHSS before denying the claims.
- (40) For claims failing provider certification or licensing requirement edits, recycle the claims on a schedule to be approved by DHSS before denying the claims.
- (41) Deny claims that are received past the applicable filing limits according to State specifications. The current filing limit for original claims is twelve months from the date of service or if beyond the 12-month limit, 60 days from the Remittance Advice date.
- (42) Maintain the former claim control number (CCN) and former paid date on any claim that denies or pends against another claim, (i.e., duplicates, once-in-a-lifetime services, early refill, rebundle, incidental, mutually exclusive, pre/post-operative visit, or medical visit).
- (43) Assign collocation codes to each claim using State-specified criteria, including but not limited to provider type, category of service, recipient's eligibility code, eligibility sub-type, recipient age, procedure indicator, family planning indicator, FFP, funding source, plan, and program. Provide the capability to manually assign collocation codes at the direction of DHSS.
- (44) Pend claims for review that cannot be assigned a collocation code during the adjudication cycle.
- (45) Provide an on-line claims resolution and claims correction process.
- (46) Generate an allowed amount and payment amount for each approved claim after reasonableness edits on billed charges are performed using current payment criteria and methodologies defined by Alaska MMIS policy, including the capability to apply cutbacks to the authorized price, units, and/or service limits. The current pricing methodologies are included in the Alaska Pricing Manual.
- (47) Provide the capability to process recipient cost sharing (e.g., copayments, cost of care (patient liability) for Nursing Home/LTC and Home and Community Based Care services) on any service or client group specified by the State using a fixed amount or percent of charges.
- (48) Demonstrate the capability to price claims using the following methodologies at a future date as determined by the State:
 - (a) DRG methodology for inpatient hospital claims
 - (b) Unit-based and/or fee-for-service payments to assisted living facilities
 - (c) Outpatient grouper methodology for outpatient hospital services
 - (d) Home health visit rate for home health services
 - (e) Per capita, and encounter rates for school-based services
 - (f) ASC grouper methodology for Ambulatory Surgical Centers
 - (g) Encounter or client-based contract payments
 - (h) RBRVS, including use of modifiers for allied health professionals

- (49) Provide the capability to process and pay administrative fees for primary care case managers.
- (50) Demonstrate the capability to easily accommodate processing and paying claims for new service programs that are not included in DDI scope of work. System design and development must be structured to accommodate these programs with minimal change and cost. These programs are administered by the following organizations:
 - (a) Division of Behavioral Health
 - (b) Division of Juvenile Justice
 - (c) The Section of Women's, Children's, and Family Health of the Division of Public Health
 - (d) DPA Temporary Assistance Program – Work Services
- (51) Provide the capability to process and pay claims for school-based services using per capita, encounter, and/or fee-for-service methodology.
- (52) Provide the capability to pay claims submitted by enrolled Canadian providers and automate this process, if feasible.
- (53) Provide the capability to process and pay special claims when requested by DHSS, on an exception basis, out of State-specified collocation codes, and provide the capability to identify these claims in the system. This will include procedures to handle exceptions due to court orders, appeals, and other special cases at the request of the State.
- (54) Process adjustment and void claims according to State-approved procedures, including financial adjustments in which the adjustment is linked to a financial transaction such as a provider refund or a returned warrant. Provide ability to identify claims associated with a returned warrant.
- (55) Provide the capability to price claims manually or in an automated fashion.
- (56) Provide the capability to capture encounter claim service data for all services associated with an encounter payment or all-inclusive payment. Claim service data may be multiple lines within a single claim document or may be across multiple documents. Deny the claim line if it is an exact duplicate to a prior approved line but approve the line without payment if it is not a duplicate but is part of the already-paid encounter service.
- (57) Provide the capability to apply date specific restrictions to new claims submissions, adjustments, and/or voids for specific providers and date ranges as a result of cost settlements or other settlements.
- (58) Provide claims pricing functionality that will price all claims in accordance with Alaska Medicaid and State program policy, benefits and limitations.
- (59) Provide the capability to price at a reduced percentage or value of an established rate for unique services or groups of services for specified groups of providers based on procedure code modifiers or other defined criteria.
- (60) Provide the capability to perform exception pricing for EPSDT screening services (e.g., recognize and price EPSDT screening services at 100% of the physician RBRVS rate regardless of the provider's assigned pricing methodology).

- (61) Provide the capability to price at different rates for various revenue codes or procedure codes on a UB92 or UB04 claim.
- (62) Provide the capability to re-bill or adjust claims automatically based on pre-defined criteria supplied by the State (for example, retroactive change in eligibility category, payment rates or funding source may require adjustments to existing claims).
- (63) Provide the capability to price claims for which Medicare was the prior payer (Medicare-to-Medicaid crossover claims) at the lesser of the amount Medicaid would have allowed for the same service as a non-crossover claim or the sum of the Medicare allowed amount plus the coinsurance and deductible.
- (64) Provide the flexibility to perform exception pricing for other specific services regardless of the provider's assigned pricing methodology.
- (65) Provide flexibility in the pricing methodology to price certain services based on a comparison of the lesser of established rates and billed charges at the direction of the State; e.g., pricing professional services at the lesser of billed charges or the established rate per unit of service times the units billed.
- (66) Provide the flexibility to perform hierarchical pricing for specific services and or provider groupings.
- (67) Provide the capability to perform unique base unit rate plus unique time unit rate pricing from a single claim line for anesthesia services.
- (68) Provide the flexibility to price at variable rates for the same service based on place of service, provider's home State or other specified provider criteria; e.g., unique Washington physician fee schedule, facility vs. non-facility RBRVS, etc.
- (69) Provide an electronic adjustment/void receipt, tracking, and processing capability.
- (70) Provide on-line request capability to receive and enter mass adjustment information and process mass adjustments when requested by the State, including institutional rate changes, procedure-based pricing changes, and other retroactive changes in pricing.
- (71) Maintain adjustment reason codes that indicate the reasons for adjustments and the dispositions of the claim (additional payment, recovery, third party payment, third party recovery, history only, etc.) for use in reporting adjustments. Adjustment reason codes should identify the source for the adjustment as well as the positive or negative financial action the adjustment will create.
- (72) Maintain the original claim with the original date of payment and the results of adjustment transactions in claims history, and link all claims and subsequent adjustments by control number.
- (73) Maintain the financial control number in the claim adjustment record for adjustments that were processed against financial transactions.
- (74) Price all claims requiring manual pricing according to State approved procedures.
- (75) Provide the flexibility to price claims at the prior authorization per unit rate.

- (76) Price out-of-State claims at the local State Medicaid rate using either an automated or manual process in accordance with DHSS regulations. Determine the local (i.e., home State) Medicaid rate by contacting the home State.
- (77) Provide for the capability to accept NDC on the CMS 1500 and 837P in addition to the corresponding HCPCS codes. Provide the flexibility to price according to the NDC pricing structure. Capture these professional claims in the Drug Rebate Program and include them in the retrospective and prospective Drug Utilization Review processes for pharmacy claims.
- (78) Receive information from the EPSDT MMIS component and generate non-payment encounter records from that information.
- (79) Send paid EPSDT screening claim information from the Claims Processor to the EPSDT component to support timely and accurate EPSDT data updates.
- (80) Provide State-approved processes to measure, monitor and report on claims processing functions for all claims and related input to assure claims are captured and processed accurately and timely. Claims throughput processing measurements for electronic claims will be based on the time claims arrive at the FTP server or other electronic site of provider/biller submission.

5.6.8.3.4 Pend Resolution

- (1) Manually review and resolve suspended claims in Contractor locations according to State-approved procedures.
- (2) Provide at a minimum the following professional staff to perform claims resolution activities: 1 FTE licensed registered nurse, 1 FTE certified coder.
- (3) Provide on-line access and resolution capability to claims suspended to State and Contractor locations, sorted by location program manager or other State-defined criteria, with on-line access to the corresponding imaged copies of the claims.
- (4) Provide the capability to electronically route claims within locations, and to route claims to other locations when necessary.
- (5) Provide a system to track all suspended claims in the routing process so that location of all claims is known at all times, provide aging reports of all suspended claims by location and by totals, and account for all suspended claims in the balancing and control process.
- (6) Review claim attachments, where applicable, as part of the resolution process for suspended claims, including matching and reviewing attachments submitted separately for electronic media claims.
- (7) Enter adjustment/void data and resolve any errors causing the adjustment to suspend according to State-approved procedures.
- (8) Perform quality control monitoring of claims resolution, claim correction, and adjustment/void processing to ensure the accuracy of resolution activities, including the accuracy of manual pricing and the appropriate use of override codes. This is intended to be a complete quality control process by work area, including technical controls. The process must include regular reporting to the State with corrective action plans for

identified problems. Include special focus on high risk areas such as new employees, high dollar claims, and unique provider or service groupings. This quality control process is subject to State approval.

5.6.8.3.5 Information Access

- (1) Produce required claims operations reports and provide them to DHSS accessible on-line which can be printed at the request of DHSS. This online tool must include an export capability to easily transfer reports to other software applications for data analysis and manipulation.
- (2) Maintain 60 months of adjudicated claims history and all claims for other procedures exempt from regular purge criteria (e.g., lifetime procedures), as defined by the State, on a current, active claims history database for use in audit processing, on-line inquiry and update, and printed claims inquiries.
- (3) Maintain claims purged from the on-line claims history indefinitely on a permanent history archive and easily accessible in electronic or hardcopy format on request of the State. Provide access to claims history back to 1980.
- (4) Provide on-line inquiry to a minimum of 60 months of claims history and the capability to generate provider and recipient histories, accessible by all elements on the claim record with multiple select and sort options. This on-line inquiry will include claims in current activity as well as those in history. The claims history on-line inquiry must include the ability to group providers by National Provider Identifier and other classifications. The claims history must show all claims and claim adjustments for the time period selected. Include the detail line-item data for UB92/UB04 claims in the on-line history display (i.e., procedure or revenue code, units, billed charges, and payment amount for claims paid at the line item level). For pharmacy claims, show all fields including days supply, prescriber, family planning indicator, specific therapeutic class (GC3), therapeutic class, and any third party payments made after the claim reimbursement was made to the provider. This will include the capability to access and generate reports of claims history with user-defined parameters such as the capability to request all claims paid for a specific procedure code or procedure code range for recipients with a specific eligibility category for a specified period of time.
- (5) Provide on-line inquiry access to the pending and in process claims file, accessible by all elements on the claim record. Flexibility in accessing data and rapid system performance in responding to inquiries are required.
- (6) Provide on-line access to the financial transaction file, including the capability to access transactions by financial control number, provider number, warrant number, reason code, program, collocation code, and/or funding source and the capability to select transactions using a date range. Provide the capability to limit the request to show only gross-level transactions or to include both gross-level and claim-specific transactions.
- (7) Provide for the distribution of claims data and reporting to other divisions of DHSS, other State agencies, and outside entities as defined and approved by DHSS.

- (8) Provide accurate and current information to other MMIS components that utilize claims information to respond to provider inquiries, and produce management and utilization reports.

5.6.8.4 Interfacing Systems

- (1) Division of Senior and Disability Services, Division of Behavioral Health, Division of Public Health, Office of Children's Services, Office of Rate Review, QIO/UM and TPL Contractors, providers, clearinghouses, and billing agencies for claims submissions.
- (2) Division of Senior and Disability Services, Division of Behavioral Health, Division of Public Health, Office of Children's Services, Office of Rate Review for resolution of pending claims.
- (3) CMS Coordination of Benefits Contractor.
- (4) Batch updates to code, code sets, rules and reference files.
- (5) Batch updates to fees and rate tables.
- (6) File Transfer Protocol (FTP).
- (7) HIPAA translator and database solutions.
- (8) Web portals.
- (9) Pharmacy Point of Sale (POS) System.
- (10) Other MMIS components including but not limited to Recipient, Provider, Reference, EPSDT, Prior Authorization, DSS, MAR, SUR.

5.6.8.5 Inputs

- (1) Hardcopy Claims and Adjustments, all industry standard forms as well as the State-unique transportation and EPSDT forms.
- (2) EMC Claims and Adjustments, all industry standard and CMS-required forms as they currently exist and as they are periodically updated.
- (3) Pending Resolution Instructions.

5.6.8.6 Outputs

- (1) Input Summary Report
- (2) On-Line Pending Resolution Audit Trail
- (3) Pending List
- (4) Pending Location Totals Report
- (5) Deceased Recipient Listing
- (6) Disposition of Claims
- (7) Disposition of Claims Totals By Claim Type
- (8) Adjustment/Void Control List

- (9) Recipient History Profile Report
- (10) Provider Claims Detail Request
- (11) Daily Processing Control Report
- (12) Recipient Explanation of Medical Benefits (REOMB)
- (13) Batch Inventory Control Reports
- (14) Claim Type Summary Totals
- (15) Direct Biller Proof List
- (16) Data Entry Input Summary
- (17) Data Entry Error Report
- (18) EMC Professional Crossover Provider Mismatch
- (19) Detail/Summary Client Record Update Audit Trail
- (20) Claims Input Analysis
- (21) Electronic Media Claims Facsimiles
- (22) EMC Month-To-Date Billing Report
- (23) EMC Claims Volume Report
- (24) Monthly Claim Totals by Claim Type, Format, and Media
- (25) Aged Pend List
- (26) Pend Report
- (27) Deny Report
- (28) Sample Paid and Denied Claims Report
- (29) Requested Pend Sheet Summary Report
- (30) Claims Tracking Report
- (31) Aged Study of Original Pended Claims
- (32) Aged Study of Adjustment/Void Pended Claims
- (33) Weekly/Monthly Claim Control Totals
- (34) Deny Error Analysis Report
- (35) Pend Error Analysis Report
- (36) Pended Resubmittal Error Analysis Report
- (37) Test Error Analysis Report
- (38) Pended Claims Error Analysis Report
- (39) Rejected Claims Error Analysis Report
- (40) Month-To-Date Billing Summary
- (41) Claims Input Summary Totals

- (42) Adjustment/Void Processing Audit Report
- (43) Billable Claim Totals Report
- (44) Work-In-Process Summary Totals
- (45) Weekly Claims Processing Performance Report
- (46) Contractor Pended Claims
- (47) Pended Adjustment/Voids
- (48) Batch Transaction Queue Input Error Listing and Control Report
- (49) ClaimCheck[®] and ClaimReview[®] Reports or functionally equivalent reports on clinical audits

5.6.8.7 Performance Standards

- (1) Ninety percent (90%) of all clean claims must be adjudicated for payment, denial or budget relief within twenty (20) calendar days of receipt.
- (2) Ninety-nine percent (99%) of all clean claims must be adjudicated for payment, denial or budget relief within sixty (60) calendar days of receipt.
- (3) One hundred percent (100%) of all claims must be adjudicated for payment, denial or budget relief within one hundred twenty (120) calendar days of receipt.
- (4) One hundred percent (100%) of all clean provider-initiated adjustment requests must be adjudicated within ten (10) business days of receipt.
- (5) All EMC claims, including Medicare crossover claims, must be processed in the next daily cycle after receipt.
- (6) For claims submitted on tape or diskette, notify the provider within twenty-four (24) hours of receipt when claims cannot be processed and include the reason for the rejections in the notice.
- (7) For claims submitted via modem-to-modem transmission or via the Internet, return an electronic receipt and/or notification within four (4) business hours of receipt.
- (8) Return hard copy claims which fail the prescreening process within one (1) business day of receipt.
- (9) Log, image and assign a unique control number to every claim, attachment, adjustment/void, prior authorization and other documents submitted by providers within one (1) business day of receipt.
- (10) Produce facsimiles of electronic claims within twenty-four (24) hours of receipt.
- (11) Data enter all hard copy claims and adjustment/void requests within three (3) business days of receipt.
- (12) Resolve all rejected batches within three (3) business days of the rejection.
- (13) Produce and provide to DHSS all daily, weekly and monthly claims entry statistics reports within one (1) business day of production of the reports.

- (14) Provide access to imaged documents to all users within one (1) business day of completion of the imaging. Response time for accessing imaged documents at the desk top must not exceed ten (10) seconds.
- (15) Claims processed in error must be reprocessed within ten (10) business days of identification of the error or upon a schedule approved by the State.
- (16) Produce and submit to the State balancing and control reports that reconcile all claims input to the processing cycle to the output of the cycle by the next business day following the cycle.
- (17) Maintain at least a 95% keying accuracy rate for data entered documents.
- (18) Maintain a 99% accuracy rate for electronic claims receipt and transmission.
- (19) Respond within 2.5 seconds of receipt with a TA1 or other HIPAA-compliant acknowledgement transaction response approved by the State when errors occur in the interchange envelope (ISA/ISE) of HIPAA-compliant electronic transaction batch transmissions.
- (20) Respond within 60 seconds of receipt of HIPAA-compliant electronic transaction set batch transmissions to provide positive and negative acknowledgement response for each segment within the HIPAA transaction.
- (21) Respond within 60 seconds of receipt of all other electronic batch transmissions to provide positive or negative acknowledgement response.

5.6.9 Claims Payment

The Claims Payment function includes those functions necessary to ensure that payments to providers are accurately and appropriately rendered. This includes monitoring payments to ensure that expenditures do not exceed budget appropriations, monitoring accounts receivable to ensure that funds are recovered when necessary, and producing and distributing remittance advices and payment instruments. The Claims Payment function will produce payments that reduce the claims processing-determined allowed amount based on reductions for third party payments, co-pays, patient liabilities/cost of care, and other State-defined reductions. These functions are primarily the responsibility of the fiscal agent and follow policy decisions made by DHSS.

The Contractor is responsible for ensuring that appropriate internal controls and segregation of duties in accordance with Generally Accepted Accounting Principles (GAAP), are adhered to in all aspects of claims payment services.

5.6.9.1 Business Needs

The primary objectives of the Claims Payment Function are:

- (1) Ensure that reimbursements using EFT transactions and hardcopy warrants to providers are rendered in accordance with State and federal policy.
- (2) Ensure that expenditures do not exceed budget appropriations.

- (3) Ensure that funds owed to the program by providers are collected and appropriately accounted for.
- (4) Ensure that remittance advices and payment instruments are produced and distributed on the schedule specified by DHSS.

5.6.9.2 State Responsibilities

- (1) Provide accounting code table and budget appropriation data to fiscal agent annually. Provide adjustments to the accounting code table and budget appropriation data as needed.
- (2) Provide the rules to be used in the assignment of accounting (collocation) codes to claims approved for payment.
- (3) Enter budget appropriation, collocation code, and criteria cross-reference data to the collocation code table.
- (4) Provide adjustments to budget appropriations and instructions for payment of specific claims when total claims expenditures exceed appropriations. Instructions for releasing claims for payment may include an automated release of claims using a “first in, first out” release by status date, or specific criteria for release of certain claims based on provider, dollar amount, or other claims-related criteria.
- (5) Review and approve checkwrite reports. State approval is required before funds disbursement.
- (6) Notify fiscal agent when warrants and remittance advices can be released to providers.
- (7) Review balancing of checkwrite cycles to ensure accuracy of payments.
- (8) Define hierarchy for processing outstanding receivables against current payments.
- (9) Define time frames for review of overdue receivables.
- (10) Provide disposition instructions for overdue receivables.

5.6.9.3 Contractor Responsibilities

The business processes required to support the Claims Payment function include:

- (1) Budget Monitoring
- (2) Accounts Receivable Processing
- (3) Weekly Checkwrite Balancing and Processing and Distribution of remittance advices
- (4) EFT Processing

5.6.9.3.1 Budget Monitoring

- (1) Ensure that claims and adjustment payments, and financial transaction payouts are monitored by the payment system for budget appropriations by collocation code. Applying State-specified criteria, match each payment to the collocation code to reduce the balance in the collocation code as payments are made. Every claim payment must be linked to a collocation code. Provide the ability to manually assign a collocation code to

a claim or financial transaction. Every financial transaction must be linked to a collocation code. There will be no 'zero' collocation codes for claims payments, adjustments, voids or financial transactions. Adjustments and voids to prior paid claims must be linked to the original claim collocation code or to the prior claim collocation code in the case of multiple adjustments.

- (2) When year-to-date expenditures exceed budget appropriations, automatically suspend claims payments if the appropriation amount is insufficient to cover the payment amount. Establish a hierarchy in the batch accounting controls to allow financial transactions to process against available funds before claims payment processing. Release of claims for payment from this budget suspense will be based on accounting FIFO (first in, first out) standards by claim status date. Release of financial transactions from this budget suspense will be based on FIFO (first in, first out) standards by status date of the financial transaction. Provide the ability to flag claims or financial transactions for exceptions to this FIFO rule.
- (3) Provide the capability to enter budget data by appropriation, account and collocation code and adjust the data as necessary during the fiscal year.
- (4) Provide the capability to enter and utilize in claims processing a cross-reference between the collocation codes and the criteria to be used for matching claims to the appropriate collocation code, including but not limited to provider type, category of service, client benefit plan, client/recipient's eligibility code, eligibility sub-type, recipient age, client/recipient race, client/recipient eligibility for PHS/IHS coverage, provider specialty, procedure indicator, family planning indicator, FFP, funding source, plan, and program. Provide the capability to update the cross-reference on-line, and update the cross-reference as authorized by DHSS.
- (5) Provide the capability to add collocation codes and criteria to the collocation code table on-line upon State request. These additions must be coordinated with the State.
- (6) Receive and enter budget data by collocation code prior to the beginning of the State fiscal year and adjust the budget appropriations as necessary upon request of DHSS.
- (7) Provide the capability for authorized DHSS staff to enter the adjustments to the budget appropriations on-line. The fiscal agent shall staff with the expectation that the State will delegate this data entry task to them.
- (8) Track and maintain State fiscal year-to-date expenditure and budget data by appropriation, account and collocation code.
- (9) Produce and provide to DHSS a week-to-date summary of expenditures against collocation codes so that adjustments to the budget appropriations can be made prior to the weekly payment cycle.
- (10) Produce and provide to DHSS a Funds Availability Report by appropriation account and collocation code number and description with each processing cycle illustrating expenditures vs. budgets for current year-to-date, prior year, and encumbrances.
- (11) Produce and provide to DHSS a weekly report of all suspended activity on the Budget Funds File after payment processing. Suspended activity must be viewable, at a

minimum, by collocation code, billing provider id number and name, and by each State budget area.

- (12) Notify DHSS before year-to-date budget expenditures exceed budget appropriations. Sufficient advance notification must be provided to allow the State adequate time to analyze the budget and determine re-appropriation actions. Enter budget adjustment data from DHSS and release suspended claims after appropriation data has been entered.

5.6.9.3.2 Weekly Checkwrite Processing

- (1) Generate payment amounts and process payments made through reimbursable service agreements (RSAs). Make payments to other programs without issuing EFT transactions or hard copy warrants.
- (2) Process a payment cycle no less than weekly that includes processing of all claims and financial transactions. Apply claim and appropriate financial transactions to the provider's past balance to determine the current financial balance and warrant amount.
- (3) Produce provider payments in hardcopy warrant format as defined by the State.
- (4) Ensure that warrant stock and signature plates are stored in separate, secure locations (i.e., safes or separately lockable rooms with both key and combination lock requiring two individuals to open) that is accessible only to personnel authorized to access warrant stock and apply signatures. Provide flexibility to accommodate and use an electronic signature file in place of signature plates at the State's discretion.
- (5) Produce check registers and balancing reports for payment processing and provide payment data together with payment cycle balancing reports to DHSS for authorization. Timely availability of these reports is required. Review and approval by DHSS is required before transmission of all bank, warrant, accounting and electronic funds transfer files and before the printing of remittance advice documents and warrants/checks. Electronic remittance advice documents (the 835 transaction set and all future HIPAA related transaction sets) may not be generated until this State approval has been granted.
- (6) Produce and balance payment cycle reports and financial transaction audit trails, and submit reports and all balancing results to DHSS for approval.
- (7) Produce provider remittance advices (RAs) in hardcopy and in HIPAA-compliant electronic media (currently, the 835 transaction set) for those providers requesting electronic RAs using the sort sequence selected by the provider. Provide the flexibility to perform and report on the remittance advice cost settlement activities against a provider's account which prevent check issuance to the provider when appropriate. Hard copy remittance advice documents will include a financial summary in addition to the claims transactions. This financial summary will include details on provider refunds and be structured in a manner that provides the ability to associate a specific refund with specific claim(s) adjustment(s). The electronic 835 transaction set will be structured in a manner that fully utilizes the intent and scope of the transaction set. The Contractor will fully maintain and update this transaction set as relevant national code sets are revised and updated. The Contractor will notify the State and seek approval for these revisions.

- (8) Provide the capability for the provider to specify the sort sequence on the remittance advice utilizing multiple sort options, including but not limited to recipient name, recipient ID number, date of service, claim status, patient account number, and program.
- (9) Provide the capability to print informational messages on the remittance advices with multiple messages available on a user-maintainable message text file, with selectable print parameters such as provider ID number, provider type, claim type, and payment cycle date(s). Provide flexibility in remittance advice message format, type style, use of symbols, etc.
- (10) Include claims which have been denied or voided due to conflicts with previously paid claims (e.g., duplicates, clinical audits) in a separate section of the remittance advice and provide the reason for the denial, the ICN of the historical claim, the ICN of the current claim, and/or the ICNs of the void and rebundled claims as appropriate. Provide the ability to prevent/suppress printing of CCNs billed by a rendering or billing provider from appearing on a different provider's remittance advice.
- (11) Include adjustment/void transactions that are processed against provider refunds in a separate section of the remittance advice and include the financial control number of the refund on each adjustment/void transaction.
- (12) Update claim history and on-line financial files with the check number, date of payment, and amount paid after the claims payment cycle. Online financial history per provider will report warrant/check history and also capture and display reissued warrant information. (Reissued warrants typically occur when initial warrants are lost or damaged.)
- (13) Update claims history and other appropriate files (e.g., prior authorization, service limit, lifetime services) with the results of claims processing activities.
- (14) Provide the capability to make payments to providers by remitting only the federal portion of the payment amount.
- (15) The Contractor will provide the warrant stock. The State will issue a range of allowable warrant/check numbers. Print provider warrants in the format defined by the State.
- (16) Maintain warrant stock and signature plates in secure areas on-site in the State of Alaska and provide inventory control procedures to ensure that only authorized personnel remove warrants from the secure area. The Contractor must develop and maintain appropriate records regarding removal of warrant stock and ensure auditable records are maintained on the number of warrants removed, printed and mailed.
- (17) Produce and mail provider remittance advices with the associated warrants. The Contractor must develop and implement, upon State approval, a quality control process to assure hard copy warrants are matched to the appropriate remittance advices.
- (18) Enter remittance advice messages to the message text file upon the request and/or approval of the State.
- (19) Produce electronic warrant files and adjusting journal entry files reflecting weekly payment cycle data for transmission to the Alaska State Accounting System. Note the MMIS will use two separate State bank account numbers to generate payments depending upon the method of payment (warrant versus electronic funds transfer).

5.6.9.3.3 Accounts Receivable Processing

- (1) Maintain all accounts receivable (gross level and claim-generated transactions) and process payments against the accounts receivable according to State-approved procedures. This may include cost settlement actions (specific transactions not tied to claims), but the majority will be associated to claims and will cause claim adjustment actions. These may result from actions generated by the State or by providers.
- (2) Provide on-line inquiry access to the accounts receivable database. This database must retain all key data fields including but not limited to financial control numbers, provider id and name, type of receivable (created by a claim transaction or by a financial transaction), collocation code, original balance, prior balance, current activity, balance forward, the claim control number that generated the receivable (if the receivable was generated as a result of a claim action), the reason code, cycle date, schedule of future receivables, age of receivable in days, and dates. Search criteria (the key inquiry data elements) for access to this database will be defined by the State.
- (3) Provide the capability to identify the fiscal year in which an account receivable was created.
- (4) Notify DHSS of overdue receivables according to the time frames defined by DHSS. Overdue receivables tracking will include an aged receivables report as well as tracking by individual provider account to identify all instances when the provider fails to meet collection agreements.
- (5) Process overdue accounts receivables according to the instructions provided by DHSS.
- (6) Identify and report for inclusion on the CMS-64 the amount of recoveries of provider overpayments.

5.6.9.3.4 EFT Processing

- (1) Produce electronic funds transfer provider payments for those providers requesting EFT.
- (2) Provide EFT authorization forms to providers requesting EFT. The Contractor will provide the State with recommendations for rules and processes relating to provider EFT agreements. These will be implemented upon State approval.
- (3) Send EFT authorizations to the State Department of Treasury for set up of EFT payments.
- (4) Send via FTP EFT transaction file to Treasury for weekly checkwrite.
- (5) Accept the file of EFT transaction IDs from Treasury and update claims history and the provider's remittance advice with the EFT transaction number.
- (6) Provide security for EFT account numbers to restrict access to numbers to specified users only.
- (7) Produce all EFT audit trail activity reports as well as summary and detailed transaction reports with each EFT action.

5.6.9.4 Interfacing Systems

- (1) Treasury for EFT transaction data
- (2) Budget interface file
- (3) Providers for electronic remittance advices

5.6.9.5 Inputs

- (1) Budget Appropriations
- (2) Overdue Accounts Receivable Instructions
- (3) EFT Requests
- (4) Bank account reconciliation file (report detailing warrants/checks and their redeemed/unredeemed status)

5.6.9.6 Outputs

- (1) Provider Warrants
- (2) Warrant files
- (3) Adjusting Journal Entry files
- (4) Remittance Advices
- (5) Check Register Report
- (6) Remittance Activity Control Totals
- (7) Year-To-Date Claim Payment Summary
- (8) Negative Balance Report
- (9) Provider Payment Analysis Report
- (10) Summary Page (Check Register)
- (11) EFT Transaction Summary
- (12) Intergovernmental Transfer Reports
- (13) Payment cycle balancing report

5.6.9.7 Performance Standards

- (1) Provide payment cycle reports to DHSS by 8:00 a.m. on the day following the payment processing cycle.
- (2) Transmit the warrant file and accounting interface file to DOA by close of business on the day following the payment processing cycle.
- (3) Transmit EFT transaction file to Treasury by close of business on the day following the payment cycle processing.
- (4) Mail and/or electronically transmit warrants and remittance advices within forty-eight (48) hours of notification from DHSS of the release of funds.

5.6.10 Financial Services

The Financial Services Function includes those functions necessary to ensure that expenditures processed in the MMIS are appropriately accounted for in the Alaska State Accounting System (AKSAS), and that non-claims financial transactions, refunds, and returned warrants are processed according to procedures approved by DHSS. These functions are primarily the responsibility of the fiscal agent and follow policy decisions made by DHSS.

5.6.10.1 Business Needs

The primary objectives of the Financial Services function are to:

- (1) Ensure that expenditures and receipts made through the MMIS are accurately reported and accounted for in the AKSAS system.
- (2) Accept and process non-claim financial transactions according to State and federal guidelines.
- (3) Ensure that refund checks and returned warrants are controlled and processed according to procedures approved by DHSS.

5.6.10.2 State Responsibilities

- (1) Review and approve fiscal agent procedures for financial services processes.
- (2) Monitor fiscal agent processing of financial services activities.
- (3) Provide specifications for warrant/EFT file and accounting interface (agency journal entry) file to fiscal agent.
- (4) Provide requests for lump sum financial transactions and manual warrants.
- (5) Provide lien requests to process liens against providers.
- (6) Approve fiscal agent procedures for processing refund checks and release of excess funds.
- (7) Review deposit receipts and control logs of refunds received by the fiscal agent.
- (8) Define the limit for fiscal agent release of excess funds received from providers, and review and approve release of funds in excess of the limit. Review released funds reports.
- (9) Monitor fiscal agent processing of refunds and release of excess funds.
- (10) Provide the redeemed warrant file to the fiscal agent each month.
- (11) Prepare and submit stop-payment transactions and provide authorizations for fiscal agent to reissue lost or destroyed warrants.
- (12) Approve the format and content of the letters generated to providers for unredeemed warrants, provider overpayment recoveries and other miscellaneous provider communications.

5.6.10.3 Contractor Responsibilities

The business processes required to support the Financial Services function include:

- (1) General Contractor Functions
- (2) Accounting Interface
- (3) Financial Transaction Processing
- (4) Processing Refund Checks
- (5) Processing Returned Warrants
- (6) Bank Account Reconciliation

5.6.10.3.1 General Contractor Functions

- (1) Provide an automated financial transaction system to enter and process non-claim-specific financial transactions, including payouts, accounts receivable, refund checks, returned warrants, unredeemed warrants, liens and levies.
- (2) Automate the process of issuing a manual check (outside the weekly payment cycle) or a separate check to a payee or pay-to address that is different from the pay-to address and provider name on the provider file. This could occur when a cost settlement needs to be issued to a provider's attorney as a result of a court settlement, or when a lien or levy needs to be processed against a provider. In these cases, the fiscal agent will need to be able to enter the financial transaction using the provider's ID number and include in the transaction entry the name and address of the payee for the transaction. Provide for the ability to make the manual check 1099 reportable.
- (3) Assign a financial control number (FCN) and FCN type to all financial transactions, refund checks, and returned warrants and enter all transactions to the on-line financial transaction database. An online financial transaction data entry system is required which minimally provides the capacity to enter warrant numbers and respond with the date of payment, amount and provider id/name associated with the specific warrant numbers.
- (4) Receive, control, and enter non-claim-specific financial transactions, refund checks, and returned warrants. The system must provide the capacity to identify all claims and financial transactions associated with a returned warrant and automatically create appropriate void actions.
- (5) Provide on-line entry and inquiry to the financial transaction file by financial control number, provider number, provider name, financial transaction type, reason code, date range, and check number. Provide the drilldown ability to link financial control numbers to their corresponding claim control numbers, when applicable.
- (6) Edit all financial transactions for validity and include editing to prevent duplicate transactions from being entered. One unique financial control number is required per financial transaction. No override to this rule is permitted. Edit for duplicate check numbers and allow override ability subject to State approval.
- (7) Edit the collocation code provided on the financial transaction against the agency requesting the transaction to ensure that the agency is authorized to submit transactions for the collocation code on the transactions.

- (8) Produce and balance audit trails for financial transaction processing. The Contractor has the obligation to balance audit trails to input documents daily and post the balancing documents with all notations for State review.
- (9) Adjust provider 1099 amounts for provider refunds and other financial transactions. Provide capacity to create a financial adjustment for the purpose of adjusting a 1099, as needed, throughout the tax year.
- (10) Provide the capability to delete, reverse, or change any financial transaction, including adjusting the provider 1099 amount when appropriate. The Contractor must provide a process to resolve all 1099 mismatches. Reports of 1099 correction and re-issuance must be provided to the State.
- (11) Produce required financial reports and provide them to DHSS accessible on-line which can be printed at the request of DHSS.

5.6.10.3.2 Accounting Interface

- (1) Produce and transmit to the Department of Administration (DOA) a warrant/EFT file and an accounting interface (agency journal entry) file in the format specified by DOA after each payment cycle for processing in the State accounting system (AKSAS) in formats specified by DOA. The format specified by DOA for the accounting interface and warrant files shall be that established by the Department of Administration, Division of Finance for systems submitting transactions to AKSAS. The State requires that the Contractor modify its financial processing and reporting to include the terminology and definitions utilized by the State of Alaska. This accounting interface must be bidirectional to allow for receipt of information regarding the status of warrants which supports the bank account reconciliation process.
- (2) In addition to the aforementioned warrant file, a list of any warrants that were spoiled or voided during the printing process shall be produced.

5.6.10.3.3 Financial Transaction Processing

- (1) Process State requests for lump sum payouts to providers, e.g., cost settlements.
- (2) Process State requests to establish accounts receivables.
- (3) Process State requests for manual warrants with the capability to set a start date for recoupment and a rate of recoupment (e.g., total, specified amount per payment cycle, or specified percentage per payment cycle).
- (4) Maintain lien and assignment information to be used in directing or splitting payments to the provider and lien holder.
- (5) Provide the capability to split payments between the provider and a third party (e.g., a lienholder) and produce separate checks for the provider and the third party.
- (6) Automate the processing of State and/or federal share of funds transfer for State facilities, including the capability to change the percentage when requested by the State.

5.6.10.3.4 Processing Refund Checks

- (1) As checks are opened, endorse and log all refund checks on a daily check receipt log. Image all checks received on the day of receipt.
- (2) Deposit refund checks to the State bank account within 24 hours of receipt. Deliver to DHSS the deposit receipt with a control log showing the financial control numbers of the checks, copies of the checks, the original deposit ticket, audit trails and balancing to the amount of the deposit. DHSS will review and authorize the Contractor to input the deposit activity to the financial transaction file.
- (3) Process provider refunds including the capability to draw down the refunds through claim-specific transactions, payouts or through gross level transactions. Edit transactions to prevent the utilization of completed transactions (i.e., prevent claims from processing against refunds when the refund balance is zero). If unable to match a refund check to a provider, create a suspense file and process, subject to State approval, for resolving the transaction.
- (4) Prepare and process claim adjustment/voids to utilize refund checks with the ability to identify the claims associated with a refund. Claims batched for refund action shall be separate from other claim batches.
- (5) Release funds received in excess of the associated claim adjustments to providers and provide reports of the released funds to DHSS. Obtain DHSS approval prior to release of excess funds for those cases in which the excess funds exceed the State-specified limit.
- (6) Ensure that funds released to providers for overpayments on refunds are processed against any outstanding accounts receivable for the provider.
- (7) Process refunds from third parties including the capability to draw down the refunds through claim-specific transactions or through gross level transactions without affecting the provider's 1099 amount and without printing these transactions on the provider remittance advice.

5.6.10.3.5 Processing Returned Warrants

- (1) Log all returned warrants on a daily returned warrant receipt log, image the returned warrants, and forward original warrant and control log to the financial area for processing.
- (2) Determine reason for return and take appropriate action, including obtaining correct addresses for returned warrants providers. Warrants must be kept in a secure setting during this research. Mail returned warrants to the new address when provided. If unable to determine new address, void returned warrant per detailed State instructions.
- (3) Void returned warrant when provider cannot be located or when provider notifies fiscal agent that claims are not for provider's patients.
- (4) Provide returned warrant research documentation to the State for approval. Prepare and process claim adjustment/voids against returned warrants.
- (5) Send cancel transaction for the warrant to AKSAS on the warrant file.

5.6.10.3.6 Bank Account Reconciliation (follow-up on unredeemed warrants)

- (1) Provide an automated system for performing the monthly bank account reconciliation.
- (2) Reconcile the bank account each month using input from the redeemed warrant interface file.
- (3) Provide balance reports and outstanding warrant reports to DHSS after completion of the monthly reconciliation; make accessible on-line and in hardcopy upon request of DHSS.
- (4) Provide an automated system for follow-up on outstanding warrants, including receipt and processing of the redeemed warrant tape from DOA, capability to delete, adjust, and correct transactions entered in error, and automatic production of letters to providers for warrants which have not been redeemed after 30 and 60 days. Follow up via telephone when no response is received.
- (5) Produce, mail notification letters, and provide follow up with providers for unredeemed warrants.
- (6) Provide affidavits of lost or destroyed warrants (warrant status form) to DHSS for processing of stop payments. These affidavits must be completed by the provider.
- (7) Prior to reissuing warrants, verify that the warrant has not been cashed.
- (8) Upon authorization from DHSS, process reissued and voided warrants including reversal of all claim and financial transactions associated with voided warrants that are not reissued.

5.6.10.4 Interfacing Systems

- (1) AKSAS for accounting interface file (Agency Journal Entry) and warrant/EFT file
- (2) DOA for redeemed warrant file

5.6.10.5 Inputs

- (1) Requests for Lump Sum Payouts
- (2) Request to Establish Accounts Receivable
- (3) Requests to Process Lien
- (4) Requests for Manual Warrant Reissue or Payout
- (5) Refund Checks
- (6) Returned and Outstanding Warrants
- (7) Redeemed Warrant Tape

5.6.10.6 Outputs

- (1) Bank Account Reconciliation
- (2) TPL Cash Receipts and Dispositions
- (3) TPL Claims Adjustments

- (4) Bank Tape File
- (5) Accounting Interface Transaction File↓Claims
- (6) Accounting Interface Transaction File↓Financial
- (7) Financial Claims Listing
- (8) Budget Funds Report
- (9) Financial Transaction Control Report
- (10) Financial Transaction Report
- (11) Financial Transaction By Transaction Type
- (12) Outstanding Receivables Report
- (13) Receivables By Transaction Type
- (14) Recovery Suspense Report
- (15) Refund Deposit and Void Check Summary
- (16) Accounting Interface Front-End Consolidator
- (17) Accounting Interface Detailed Listing
- (18) Accounting Interface Tape
- (19) Collocation Code Funding Analysis
- (20) Collocation Code Summary—Debits
- (21) Collocation Code Summary—Credits
- (22) Collocation Code Summary—Net
- (23) Claim Adjustments by Type
- (24) Financial Transactions by Type
- (25) Collocation Code Audit Trail
- (26) CCN Listing by Collocation Code
- (27) Funds Availability Report
- (28) Budget Relief Funds – Summary Report
- (29) Budget Relief Funds– Detail Report
- (30) Week-To-Date Funds Availability – Summary Report
- (31) Week-To-Date Funds Availability – Detail Report
- (32) Collocation Code Log Report
- (33) Inter-Agency Transfer Report
- (34) Reports of 1099 correction and re-issuance must be provided to the State

5.6.10.7 Performance Standards

- (1) Deposit refund checks to DHSS within twenty-four (24) hours of receipt.
- (2) Provide deposit receipt and check log to DHSS within twenty-four (24) hours of depositing the refund checks.
- (3) Enter all financial transactions to the on-line financial file within twenty-four (24) hours of receipt.
- (4) Prepare and process adjustments/voids against refunds and returned warrants within ten (10) business days of receipt of the refund or returned warrant.
- (5) Provide manual warrants within 24 hours of receipt of request if required.

5.6.11 Third Party Liability (TPL)

The operation of Third Party Liability (TPL) encompasses both automated and manual functions necessary to maintain third party resource data on Medicaid recipients, process claims data against third party resource information, recover funds from third parties as necessary, and pay insurance premiums for certain recipients. These functions are primarily the responsibility of the Contractor following policy decisions made by DHSS.

5.6.11.1 Business Needs

The goal of the TPL function is to obtain the maximum cost avoidance and reimbursement for treating Medicaid recipients who have insurance coverage. The TPL unit is responsible for monitoring the third party insurance identification process and verifies the accuracy of TPL files to facilitate accurate cost avoidance. They also collect payments from pay and chase claims. The TPL information is obtained from the Medicaid applicant, claims, data matches, and other sources and then entered into the Eligibility Information System (EIS) and MMIS.

Claims subject to TPL processing are handled in one of two ways, the claim is either “pay and chased” or cost avoided. The fiscal agent pays certain services and the insurance company is sent a facsimile claim by the TPL Contractor, to reimburse the State. These “pay and chase” services are identified by claim type and eligibility code. Claims for cost avoided services are denied if the file shows TPL coverage and the provider has not billed the insurance company first. The TPL staff determines primary, secondary, and tertiary carriers and identifies a separate carrier for some services on those complex pay and chase claims. TPL recoveries are reconciled by the TPL Contractor by recipient, provider, and claim and then deposited. Claims attachments with discrepancies in TPL information are suspended to the TPL unit for resolution. The TPL unit has on-line update capability on both the EIS and the MMIS.

The unit calculates premiums for recipients in the working disabled program, notifies recipients of the amount and collects premiums. They also collect funds from Miller trusts and estate recovery actions for long term care recipients.

The unit also monitors the contract with the TPL Contractor for data matches with major insurance carriers for possible insurance coverage and subsequent recoveries. The TPL Contractor also performs a Medicare recovery process, for claims paid on behalf of recipients

who are subsequently determined to have Medicare coverage. The fiscal agent voids the claims after the TPL Contractor has verified that the recipient has Medicare coverage. The TPL Contractor is responsible for verifying the payment of Medicare crossover claims to determine if the Medicare payment exceeded the Medicaid allowable. The TPL Contractor receives a paid claims file from the fiscal agent and compares the amount paid by the fiscal agent to the Medicare allowable amounts. Trauma cases and the resulting subrogation recoveries are performed in conjunction with the Department of Law.

DHSS has identified additional MMIS functionality that is required for compliance with the Deficit Reduction Act of 2005. The MMIS must be capable of full compliance with all of the requirements of the Act including the following TPL-related functions:

- (1) Eliminating fraud, waste and abuse in Medicaid.
 - (a) Process eligibility transactions (270/271) with third parties legally responsible for payment of a claim for a health care item or service
 - (b) Accept coverage eligibility and claims data from third parties
- (2) Flexibility in cost sharing and benefits.
 - (a) Process alternative Medicaid premiums
 - (b) Correctly apply cost sharing, including special rules for cost sharing for prescription drugs
 - (c) Correctly apply emergency room copayments for non-emergency care
 - (d) Correct use of benchmark benefit packages
- (3) Compliance with reforms of case management and targeted case management, including allocating the costs of any part of such services which are reimbursable under another federally funded program in accordance with OMB Circular A87 (or any related or successor guidance regulations regarding allocation of costs among federally funded programs) under an approved cost allocation program.

5.6.11.2 State Responsibilities

- (1) Develop and provide policy information to the fiscal agent.
- (2) Monitor the Contractor's performance of the TPL functions.
- (3) Accept TPL resource based on information received from the data matches processed by the TPL Contractor.
- (4) Update EIS on-line with insurance information identified by the TPL Contractor and other sources.
- (5) Define criteria for cost avoidance of claims and "pay and chase" claims, and provide criteria to the fiscal agent. Currently, "pay and chase" claims include, travel and accommodations, personal care attendants, preventive pediatric services, prenatal care, court-ordered insurance, eyeglasses, and home-and-community based services. Pharmacy uses coordination of benefits for most claims however, there has been a reason to keep "pay and chase" active for this provider type.

- (6) Define and provide to the fiscal agent the criteria for accident and trauma claims.
- (7) Define policy for recovering TPL.
- (8) Identify recipients eligible to participate in Medicaid through payment of premiums.
- (9) Calculate premium payments for eligible recipients.
- (10) Prepare and send invoices for premium payments to eligible recipients.
- (11) Process premium payments received from eligible recipients.

5.6.11.3 Contractor Responsibilities

The TPL function has four major processes:

- (1) Administering TPL Recipient Resource Data.
- (2) Administering TPL Insurance Carrier Data.
- (3) Processing Claims with TPL Rules (Cost Avoidance). This will include claims with TPL amounts, claims for which TPL data exists within the MMIS but is not on the claim, claims for which TPL data exists on the claim but not within the MMIS, claims for services which are known to be non-covered by other third party payers, drug claims for which Medicare Part D coverage exists, and claims for clients for whom Medicare Part and/or Part B are primary payers.
- (4) Update and Maintain Carrier Code database including national carrier identification codes and apply them to the TPL process as they are assigned and provide this capability to State staff.

5.6.11.3.1 Administering TPL Recipient Resource Data

- (1) Accept current and historical insurance coverage data including national carrier codes, carrier, policy number, group number, sponsor (if required) or policyholder, type(s) of coverage, dates of coverage for each type, BIN and PCN number for pharmacy policies, monthly premium amount, premium payment date(s), the date the coverage was added to the database, and the date the record was updated. Develop the capability for maintaining and applying multiple policies including Medicare for a single recipient, including the capability to designate the hierarchy of policies (e.g., primary, secondary, tertiary, etc.). This will include serving as the source data repository for clients' Medicare Part D Plan information. Because Medicare Part D has unique coverage rules that are separate and distinct from other third-party pharmacy drug plans, the Contractor will provide the ability to distinguish Medicare Part D Plans from other third-party pharmacy drug plans.
- (2) Accept type of insurance coverage for each policy - inpatient, outpatient, physician, pharmacy, dental, and all others, with effective dates of coverage for each.
- (3) Map and convert coverage codes transferred from EIS to coverage types defined by DHSS for the MMIS.
- (4) Provide the capability to send the ANSI X-12 insurance query to insurance companies and receive the response when TPL is identified on a claim, via file update, and on request.

- (5) Edit TPL data for presence, format, validity, and consistency with other data in the update transaction and in the TPL files.
- (6) Maintain pharmacy benefit manager's BIN, Processor Control Numbers and any other data required for billing pharmacy TPL.
- (7) Produce computer-generated letters to recipients requesting additional information, including the specific types of coverage when a claim indicates a third party payment but there is no corresponding TPL resource record on the database.
- (8) Provide copies of the MMIS eligibility file and paid claims file to the TPL Contractor on a schedule determined by DHSS.
- (9) Provide the capability to maintain and update coverage limits for all insurance coverage types and to pay the claim when benefit limits have been reached. Provide the ability to identify this condition on the claim. Insurance coverage limits may be expressed in dollars, number of services, and excluded procedures, as well as lifetime and annual benefits.
- (10) Process and maintain the CSED (Child Support Enforcement Division) referral and court order indicators transmitted on recipient updates from the Eligibility Information System (EIS). A possible alternative source for this CSED referral data is an interface directly with CSED.
- (11) Accept and process insurance cancellation data from CSED or other sources (e.g., claim denials, TPL Contractor, recipients, insurance carrier) and notify CSED of cancellation information received from other sources.

5.6.11.3.2 Administering TPL Insurance Carrier Data

- (1) Provide on-line update capability for TPL carrier data.
- (2) Edit TPL carrier data for presence, format, validity, and consistency with other data in the update transaction and in the TPL files.
- (3) Maintain insurance carrier information including the name and address, telephone number, contact person, and update date for all insurance carriers doing business in the State of Alaska. Allow on-line update. Integrate and crosswalk the National Common Carrier ID into this insurance carrier information process when they are made available.
- (4) Provide a mass update capability to update the TPL carrier data and corresponding TPL resource data when a TPL carrier changes its name, policy data, or other carrier data.

5.6.11.3.3 Processing Claims with TPL (Cost Avoidance)

- (1) Edit claims against TPL coverage, including Medicare Parts A, B and D, and apply TPL edits to the appropriate claim types and only to claims covered by the recipient's insurance coverage at the provider, recipient, service type, procedure code, and procedure modifier levels.
- (2) Provide the capability to ignore clients' Public Health Service coverage as a prior resource to Medicaid in the claims processing function. Provide the capability to

recognize and apply Public Health Service coverage as a prior resource to State-funded medical assistance programs.

- (3) Bypass TPL cost avoidance edits when known service limits on the policy have been reached. Provide the ability to identify this condition on the claim record.
- (4) Pay claims for recipients with third party coverage when the service is not covered by the third party insurance as identified by revenue, procedure or diagnosis code, by carrier ID and in the type of coverage on the TPL resource database. Provide the ability to identify this condition on the claim record.
- (5) Deny claims for recipients covered by other health insurance according to DHSS policy.
- (6) When a claim is denied because of TPL coverage, notify the provider via a Remittance Advice.
- (7) Utilize accident and trauma claims data to generate and mail follow up letters to recipients in support of the State's subrogation function.
- (8) Provide paid claims data to the TPL Contractor when retroactive TPL coverage is identified.
- (9) Provide the ability to identify on the claim record all conditions where the claim contains TPL information that is not present on the TPL resource database. Research these conditions and update the TPL resource database with new validated resource coverage information in accordance with State-specified parameters.
- (10) Identify and provide claim information to the TPL Contractor when retroactive TPL coverage is identified from a processed claim but there is no corresponding TPL resource record on the eligibility file.

5.6.11.4 Interfacing Systems

- (1) EIS for third party coverage data
- (2) TPL Contractor for provision of recipient and claims data
- (3) Other insurers for submission of 'pay and chase' claims
- (4) Child Support Enforcement Division for court-ordered child support information
- (5) DEERS for Tri-Care/Champus eligibility data matches

5.6.11.5 Inputs

- (1) EIS Transaction Update (TPL Coverage)
- (2) Child Support Enforcement Division (CSED)
- (3) TPL Coverage Update
- (4) Request for re-submission of claim
- (5) Request for Trauma & Accident Claims
- (6) Update Service Coverage for Recipient

5.6.11.6 Outputs

- (1) Potential Recoveries Report
- (2) Clients With TPL Report
- (3) Client Resource Insurance Audit Listing
- (4) Carrier Audit Listing
- (5) Summary of Closed TP Cases Report
- (6) Trauma Detail Report
- (7) Accident Detail Report
- (8) Accident/Trauma Inquiry Report
- (9) Benefit Recovery Audit Listing
- (10) Carrier Master Listing
- (11) Cost Avoidance/Provider Returns Report
- (12) Third Party Payments Reported on Claim Third Party Adjustments
- (13) Suspect Medicare Eligibles Report
- (14) Claims With Trauma Indicated Report
- (15) Third Party Overpayments Report
- (16) Weekly Control Totals Reports
- (17) Clients With Retroactive TPL Report
- (18) TPL Purged History Record Report
- (19) TPL Cost Avoidance Summary Report
- (20) Weekly Case Tracking Report By Specialist
- (21) Paid Claims Previously Denied Due to Third Party Liability Report
- (22) Data Match Report
- (23) Post Payment Bill Report
- (24) Monthly TPL Contractor Adjustment Report
- (25) DEERS Match Sponsor/Dependent Report
- (26) CSED Client Resource Listing Report
- (27) CSED Payment and Collections Report
- (28) Premium Payment Reports
- (29) Client Listing of Insurance Premium Processing Report

5.6.11.7 Performance Standards

- (1) Post TPL recovery amounts and denial information to the benefit recovery and tracking database within two (2) business days of receipt of the recovery data.

5.6.12 Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a mandated program within Medicaid that provides for the periodic screening of children in order to provide preventive health care and detect health defects at as early an age as possible. It also allows physicians the opportunity to give parents and guardians guidance in terms of maintaining a healthy growing environment for their children. The main goal of the program is to improve the health status of children within the Medicaid program and, at the same time, decrease the cost of treatment for health problems by detecting such problems at the earliest age possible.

EPSDT provides Medicaid eligible recipients under the age of 21 with periodic health screen visits. The EPSDT Subsystem, a component of the Alaska MMIS, is concerned specifically with tracking and reporting on services to recipients eligible for the EPSDT program.

5.6.12.1 Business Needs

The primary objectives of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Function is to ensure adequate, preventive care type services are available and are utilized by all children under the age of 21. In order to accomplish this overall objective, proposed EPSDT Systems must meet the following business needs:

- (1) Identify all individuals eligible for EPSDT services.
- (2) Systemically produce customized notification letters to recipients when a child is due for services based on a State-defined periodicity schedule, and date of last notification sent regarding this recipient. This notification process will include the capability to exclude by reason code(s) specific recipients from the notification process at the State's discretion.
- (3) Perform tracking and monitoring of recipient screening, referral, and follow-up treatment, and provide linking of costs to specific conditions. Such tracking will identify the provider making the referral, type of referral, and the provider to whom the patient has been referred. There may be multiple types of referrals. The Contractor's solution must accommodate this.
- (4) Provide reports necessary for the State to effectively monitor the program as well as satisfy all Federal reporting requirements.
- (5) Maximize federal funds for the provision of health care to Alaska eligible recipients under the age of 21.
- (6) Support an automated exchange of data between the MMIS and other databases such as the RPMS for client screening data, ORCA for children-in-custody data, and the Bureau of Vital Statistics for date of birth and death records.

5.6.12.2 State Responsibilities

- (1) Provide the criteria to be used to outreach (inform and periodically re-inform) eligible recipients as to the availability and description of EPSDT services.
- (2) Provide guidance in the development of all EPSDT outreach materials.
- (3) Provide approval for all EPSDT outreach materials.
- (4) Provide the Contractor with the current periodicity schedule(s).
- (5) Provide Public Health screening, outreach, referral, and follow-up updates via data prepared by DPH.
- (6) Determine, interpret and establish policy and administrative decisions for EPSDT program service provisions.
- (7) Establish criteria for providers to be enrolled as screening providers.
- (8) Establish criteria for evaluation of EPSDT screen completion by providers.
- (9) Determine the reimbursement schedule for screening providers.
- (10) Determine or approve the criteria for matching treatment services to screening referrals.
- (11) Monitor program effectiveness using the reports produced by the MMIS and RPMS.

5.6.12.3 Contractor Responsibilities

The functions of the EPSDT system include:

- (1) General EPSDT Requirements
- (2) Identification
- (3) Outreach
- (4) Tracking referrals
- (5) Reporting

5.6.12.3.1 General EPSDT Requirements

- (1) Operate and maintain the EPSDT function including the creation of an EPSDT Master File case tracking database. The database will include notification, outreach, screening, referral, and treatment data for all recipients eligible for EPSDT services.
- (2) Provide the flexibility to accommodate rapid and straightforward expansion of EPSDT services by appropriate DHSS and/or CMS representatives.

5.6.12.3.2 Identification

- (1) Provide for the automatic identification and notification to parent or guardian of all children eligible to receive EPSDT screening. This notice process will occur on a periodicity schedule established by the State. The notice process must be flexible and allow for content on screening notices to vary depending on the type of screening due. This notification process will include the capability to exclude by reason code(s) and

effective date specific recipients from the notification process at the State's discretion. Include only Medicaid recipients in the EPSDT processing. Recipients eligible for other Alaska programs should be excluded from EPSDT unless they also have Medicaid eligibility for the same time period. Identification should be available by relevant criteria such as: location, provider type, client age/age group, screening status, screening due date, eligibility status, typical provider, State custody status, Native Corp. and Public Health Nursing (PHN) region.

- (2) Provide the capability to update EPSDT recipient records via batch processing with data from other MMIS functions or DPH's RPMS, or directly on-line by DPH or designee. Remote access to this online function will be required. Data entry edits for format and validity will be required for specific fields; e.g., prevent entry of data for clients greater than age 21. The goal of the data-entry process for EPSDT data is single entry of data into a system with interfaces between systems to update the MMIS EPSDT function.
- (3) Provide a process to close EPSDT records for those clients who are deceased based on date provided by the Bureau of Vital Statistics or other State-approved source. Such records are excluded from future notice action and notice-due lists but may be included in the federal reporting process for the fiscal year in which the client expired. EPSDT records for recipients who are 21 years of age should be archived seven (7) years after the end of the Federal fiscal year in which they turn 21. Provide a monthly report of the records archived with the reason and date each record was archived.
- (4) Provide Screening Eligibility and Due Lists to the RPMS. There are two separate RPMS systems. One is operated by the Division of Public Health (DPH), and the other is operated by the Indian Health Service (IHS). Interface will be required with both systems. Due lists must be in a format meeting the specifications of DPH and HIS.
- (5) Develop ASCII file for transmission of Eligibility Screening Due data to DPH and IHS RPMS systems.
- (6) Provide on-line inquiry access to the EPSDT database. Access to data should be through user-friendly systems navigation technology and a graphical user interface (GUI) that allows users to move freely throughout the system using pull down menus and "point and click" navigation without having to enter identifying data multiple times. At a minimum, inquiry ability must be provided based on client identification number, client name, date of birth, provider identification number, location, type of screen, client age/age group, date of service and/or type of outreach activity.
- (7) Provide an on-demand function to produce Screening Due lists by location/region, due date ranges, client identification number, and provider identification number.
- (8) Provide for context sensitive help on screens for easy point and click access to valid values and code definitions by screen field.

5.6.12.3.3 Outreach

- (1) Develop and provide brochures and templates for specialization outreach letters from the fiscal agent. Examples of the reasons for these letters include but are not limited to availability of a provider type in an area (specialty clinics) and notices of new vaccines.

This process must be flexible and allow for content to vary depending on the type of notice.

- (2) Provide on-line, updateable letter templates for all EPSDT notices.
- (3) Produce and mail criteria-specific, customizable outreach notification letters. Outreach letters are sent based on the existing State protocol, which considers not only the recipient's eligibility and screening due status, but the date of the last outreach letter sent to that recipient. This outreach will be provided for recipients who are due for a screen and have not received an outreach letter in a specified period of time, and clients requiring treatment but have not yet received that treatment. The criteria-specific aspect of the letters would allow for each to be customizable for groups such as those in foster care or those living in a particular community, among other criteria. The mailing of notifications must include a process to identify the correct address on the client's record for these notices.
- (4) Automatically generate notification/outreach letter to all clients who have become eligible or re-eligible for program participation regarding EPSDT services.
- (5) Automatically generate annual notices to non-participating eligible families regarding EPSDT services. ("Non-participating" is defined by the program as having not used any services except pharmacy during the prior 12 months.)
- (6) Provide a process to identify those clients for whom treatment has been refused so that these can be excluded from future due lists.
- (7) The 'outreach letter' process must allow for customization for "special groups" (subsets of those due for an outreach letter). For example, because of the State's continuing care agreements, some Native organizations send out their own outreach letters. This system will need to be able to provide to the Native organizations data indicating the clients they are to outreach based on criteria provided by the State. It will then need to be able to suppress outreach letters to that group, while indicating within the system that the letters have, in fact, been sent (by the Native organization). Another group requiring special care in outreach would be addresses receiving high numbers of letters (e.g., boarding schools might qualify to receive one-hundred outreach letters in a single month when a composite list with a single letter would be more appropriate). The system will need to be flexible enough to handle not only these cases, but other special outreach groups as they present themselves. Therefore, the system will need to be able to exclude some groups from outreach mailings, provide data on the same, and the outreach letter indicator must be able to be updated through the system and from other batch sources.
- (8) Utilize the address specified by the State for all letters and notices (i.e., residence address, custodial address, or guardian address) based on business rules provided by the State.
- (9) Maintain an on-line updateable periodicity schedules for screening by age range and professional services.
- (10) Automatically identify and report on EPSDT eligible children due for screening according to periodicity schedules, with individual, updateable schedules for: medical, vision, hearing, dental, immunization, and behavioral health assessments.

5.6.12.3.4 Tracking

- (1) Accept and process EPSDT screening, outreach, and follow-up data via updates provided by DPH or any other entity, no less frequently than daily.
- (2) Accept and update EPSDT screens from the claims function on a daily basis.. Provide a process for capturing within the EPSDT function EPSDT clinical data attached to the HIPAA-compliant claim.
- (3) Capture the EPSDT referral data on the HIPAA-compliant claim within the claims and EPSDT functions.
- (4) Capture screening data from DPH within the EPSDT function and process these screening transactions within the claims function as approved claims with zero payout.
- (5) Develop an electronic interface for receipt of screening data from DPH or their designee's RPMS.
- (6) Provide the capability for State staff to perform online updates to existing EPSDT screening records or add new screening records in the EPSDT database (information-only screening data) without creating a new screening transaction within the claims function.
- (7) Provide the capability to match paid screening claims with information-only and/or zero-paid claims for the same date of service and count as a single screening. The purpose of this requirement is to prevent duplicate screenings within the database and provide accurate reporting of EPSDT data.
- (8) Match treatments from claims transactions to EPSDT referral and treatment files using paid claims and DPH zero-paid claims data and State-approved criteria for the matching process.
- (9) Track abnormal conditions that have been referred but not yet treated, to claims submitted for the recipient, until all abnormal conditions have been treated. Automatically close the referral as "no information" or "data unavailable" if no treatment claim has been submitted within 9 months from the date of the referral.
- (10) Maintain, for each EPSDT enrollee, current and historical EPSDT screening results, referrals, diagnosis and treatments for abnormal conditions identified during the screenings.
- (11) Maintain, for each EPSDT enrollee, current and historical outreach effort data.
- (12) Maintain, for each EPSDT enrollee, current and historical immunization data.

5.6.12.3.5 Reporting

- (1) Produce EPSDT reports containing recipient-level, regional, and summary data to meet State and federal reporting requirements and management needs.
- (2) Automatically generate management reports on the utilization and cost of EPSDT screening, diagnosis, referral, and treatment.
- (3) Produce on a scheduled and on a demand basis the CMS-416 and CMS-420 and other reports using subsets of CMS-416 data. Alternate versions include at a minimum, by Native Corporation region, alternate age groups, by title (using eligibility subtypes to

determine those qualifying during the time period under Title XIX, Title XXI, or both), and reports that consider alternate dental scenarios.

- (4) Report flexibility is required, including the ability for all reports to be available in monthly, quarterly, year-to-date, State and federal fiscal year versions, as well as being able to be presented by PHN or Native Corporation region, and by provider type. This report flexibility will also need to accommodate reporting on subpopulations such as: recipients in State custody, by age groups, and by location, successful versus attempted outreach (i.e., outreach letters sent versus returned letters) will need to be delineated in reports, as will both the number of recipients served and the number of families served.

5.6.12.4 Interfacing Systems

- (1) RPMS for screening due lists to and screening data from DPH
- (2) RPMS for screening due lists to and screening data from HIS
- (3) ORCA for addresses and other data for recipients in State custody
- (4) Date of Birth and Date of Death data from the Bureau of Vital Statistics to prevent outreach letters from being sent to parents of deceased clients

5.6.12.5 Inputs

- (1) Eligibility Updates
- (2) Screenings
- (3) Claims
- (4) Treatments
- (5) Periodicity Schedule

5.6.12.6 Outputs

- (1) EPSDT On-Line Menu Screens
- (2) EPSDT Screen Adds Not Found on Master
- (3) EPSDT File Maintenance Log—Medicaid Number Order
- (4) EPSDT File Maintenance Log—Alphabetic Order
- (5) EPSDT Master File Audit Trail
- (6) EPSDT Month-To-Date Screening List (Must include EPSDT claims with zero payout and indicate whether screen was provided by a Public Health Nurse, Tribal or Private provider)
- (7) EPSDT Monthly Screening Control Report
- (8) EPSDT Unmatched Referral Follow-up Document
- (9) EPSDT Referral Suspense Report
- (10) EPSDT Referral Suspense Report—Summary

- (11) EPSDT Monthly Outreach Report
- (12) EPSDT New Screening Records from HCFA 1500 Form
- (13) EPSDT Screening Notification Letters
- (14) EPSDT Statewide List of Providers by Location/Region
- (15) EPSDT Statewide List of Providers Accepting New Patients by Location/Region
- (16) EPSDT Birth date Update from Eligibility File
- (17) EPSDT Client Name Browse On-Line Screen
- (18) EPSDT Medicaid Number Browse On-Line Screen
- (19) EPSDT Quarterly Report (HCFA 420)
- (20) EPSDT Quarterly Eligibility Status Report
- (21) EPSDT Quarterly YTD Referral/Treatment Follow-up Report
- (22) EPSDT Private Provider Resource & Utilization Quarterly Summary
- (23) EPSDT Unmatched Over-Age Claims Purge List
- (24) EPSDT Year-To-Date Claims Status Report by Age
- (25) EPSDT Medicaid Enrolled Provider List
- (26) EPSDT Periodic Screening Cost Analysis
- (27) EPSDT Periodic Screening Return on Investment (ROI)
- (28) EPSDT MMIS Authorized Service Report and Cost Analysis
- (29) EPSDT Month-To-Date Client Status Report (Medical) - PHN
- (30) EPSDT Month-To-Date Client Status Report (Dental) – PHN
- (31) EPSDT Month-To-Date Client Status Report (Medical) – non-PHN
- (32) EPSDT Month-To-Date Client Status Report (Dental) – non-PHN
- (33) EPSDT Month-To-Date Client Status Report (Immunization)
- (34) EPSDT HCFA 416 Annual Report
- (35) Monthly ID Change Report (Reconciliation Reports)
- (36) EPSDT SCHIP Report (416 Subset)
- (37) EPSDT SCHIP Report - Alternate Ages (416 Subset)
- (38) EPSDT Nursing Report (416 Subset)
- (39) EPSDT Dental Alternate Scenarios (416 Subset)
- (40) EPSDT Screens Report by Native Region (Children/Families) – Quarterly, YTD, and Annual
- (41) EPSDT Outreach Report by Native Region (Children/Families) – Quarterly, YTD, and Annual

- (42) EPSDT Screens Report by Age and Native Region – Quarterly, YTD, and Annual
- (43) EPSDT Screens Report by Native Region and Provider Type – Quarterly, YTD, and Annual
- (44) Monthly EPSDT Summary by PHN Region
- (45) EPSDT Monthly Screens Reported by PHN Region
- (46) Nursing Eligibility and Dues Lists

5.6.12.7 Performance Standards

- (1) Accept and update EPSDT screening data from claims no less frequently than daily.
- (2) Produce and distribute EPSDT reports meeting EPSDT program standards in accordance with the schedule specified in Section 5.6.19.7.
- (3) Produce and distribute EPSDT outreach letters in accordance with section 5.6.12.3.3.
- (4) Track unmatched referrals for follow-up and reporting.
- (5) Interface with ORCA, RPMS, and other systems as necessary.
- (6) Track immunization records of recipients.

5.6.13 Managed Care Function

Currently, the Alaska Medicaid Program has no managed care component except the Recipient Lock-In. In the future, Alaska may implement primary care case management (PCCM) and some form of provider risk-sharing arrangement, as well as high risk case management and disease-specific case management. The new MMIS must be capable of supporting the requirements for implementing and operating these changes. Design and development must be structured to accommodate these capabilities with minimal change and cost.

5.6.13.1 Business Needs

The objectives of the Managed Care function are:

- (1) Maximize cost containment, while assuring appropriate access to quality medical care.
- (2) Manage services delivered to Medicaid recipients through contracts with providers, direct care management, and other management practices.
- (3) Provide high-risk and disease-specific care management to improve health outcomes for high-risk conditions and specific disease conditions.
- (4) Provide outreach to recipients who could benefit from managed care services.
- (5) Recruit and enroll providers for participation in managed care as primary care case managers.

5.6.13.2 State Responsibilities

- (1) Determine policy governing the PCCM program and provide policy to the fiscal agent.
- (2) Identify recipient population to be included in the PCCM program.

- (3) Identify providers eligible to participate in the PCCM program.
- (4) Determine case management fees and provide rate data to the Contractor.
- (5) Analyze provider SURS data to identify underutilization and excesses in referral practices.
- (6) Approve Contractor procedures for enrolling recipients.
- (7) Approve Contractor provider outreach and enrollment procedures.
- (8) Approve form letters and other correspondence to be used in the PCCM program.

5.6.13.3 Contractor Responsibilities

The system to be provided under the new MMIS contract must be capable of supporting the managed care functions and features described below. The business processes required to meet the objectives of the Managed Care business area are:

- (1) Recipient Outreach and Enrollment
- (2) Provider Recruitment and Enrollment
- (3) Claims Processing
- (4) Quality of Care Monitoring
- (5) Reporting

5.6.13.3.1 Recipient Outreach and Enrollment

Maintain complete historical records of recipient eligibility with enrollment, re-enrollment, and disenrollment history with primary care providers (PCPs).

- (1) Provide on-line and batch enrollment update capabilities.
- (2) Edit on-line update transactions to ensure that only valid data is added to the database, and provide audit trails and control reports for all updates.
- (3) Provide enrollment broker services to manage the enrollment process.
- (4) Provide outreach to recipients in the form of publications and notices to recipients explaining the PCCM program and the requirements for enrollment.
- (5) Provide lists of participating providers to recipients.
- (6) Notify recipients of their eligibility and their right to choose an available PCP in their area. Notification must also inform the recipient that if a provider is not chosen within a State-specified time frame, a provider will automatically be assigned.
- (7) Provide a recipient hotline to respond to recipient questions regarding the PCCM program and provide tracking and reporting on inquiries received.
- (8) Maintain a correspondence file to indicate mailings to recipients for a variety of notices (ID cards, freedom of choice letters, etc.).
- (9) Provide on-line inquiry to recipients' eligibility and enrollment records.

- (10) Allow enrollment, re-enrollment, enrollment changes, and disenrollment to and from the PCPs.
- (11) Provide PCP information to DPA for inclusion on recipient ID cards.
- (12) Provide on a daily and monthly basis, enrollment notification to the PCPs of recipient enrollment activity via electronically transmitted rosters that include:
 - (a) Recipient's unique membership ID number
 - (b) Recipient's name
 - (c) Recipient's sex
 - (d) Recipient's date of birth/death
 - (e) Recipient's case ID
 - (f) Recipient's residential address
 - (g) Recipient's mailing address
 - (h) Recipient's phone number
 - (i) Enrollment begin and end dates
 - (j) Third Party Liability information
 - (k) Capitation amount
 - (l) Medicare number
 - (m) Tribal codes
 - (n) Enrollment, re-enrollment, disenrollment, or change reasons
 - (o) Share of cost/copayment requirements
 - (p) Mental health indicators
 - (q) Other data determined by DHSS as needed
- (13) Automatically assign a PCP, using an algorithm table, to recipients not making a selection within the designated time frame. The automated assignment feature should take into account, at a minimum, the following:
 - (a) Provider location
 - (b) Provider availability
 - (c) Recipient geographical area which includes the residential region/district/village and zip code
 - (d) Number of PCPs in the specific zip code
 - (e) Total number of recipients with each PCP for that zip code.
 - (f) Recipient relationships (i.e., family members)
 - (g) Medical conditions
- (14) Provide the capability to support continuity of enrollment for families throughout all the enrollment processes.
- (15) Provide the capability to enroll deemed eligible (newborns) and/or family add-ons.
- (16) Provide the capability to verify eligibility and enrollment of recipients for the PCPs and other providers.

5.6.13.3.2 Provider Recruitment and Enrollment

- (1) Provide outreach and actively recruit providers to participate in the PCCM program as primary care providers.

- (2) Enroll providers as PCPs and maintain enrollment status, geographical locations served, associated dates, maximum recipient enrollment, and alternate PCP (when PCP is on vacation or ill).
- (3) Maintain cross-reference to recipients enrolled with the PCP to ensure that the maximum enrollment is not exceeded.
- (4) Maintain historical data of provider status and associated dates.
- (5) Provide on-line inquiry and update capability to PCP data.
- (6) Respond to inquiries from providers regarding the PCCM program.

5.6.13.3.3 Claims Processing

- (1) Generate case management fee payments for PCPs on a monthly basis.
- (2) Produce remittance advices for case management fee payments.
- (3) Edit claims received for services provided to recipients enrolled in the PCCM program to determine if the services were provided by the primary care provider.
- (4) Process and pay claims for services provided by the primary care provider.
- (5) Link all claims for referred services (and any claim for an enrolled recipient) to the PCP.
- (6) Deny fee-for-service claims submitted by referred to providers if the claim lacks the PCP ID.
- (7) Deny fee-for-service claims submitted by providers other than the PCP if the claim lacks referral data and the service is included in the under PCCM plan.
- (8) Include PCP associations in the response to AVRS and EVS inquiries.

5.6.13.3.4 Quality of Care Monitoring

- (1) Provide the capability in SURS to report on PCPs as a class group and types of PCPs within the overall PCP group by geographic regions.
- (2) Provide the capability in the SURS to report on enrolled recipients as a class group, by geographic region, aid category, and disease category.
- (3) Provide the capability in SURS to consolidate the provider's PCP practice with the same provider's non-PCP practice in a single profile.

5.6.13.3.5 Reporting

- (1) Provide the capability to produce demographic reports as needed to study growth trends.
- (2) Provide the capability to produce comparative analysis reports such as the number of recipients eligible to choose a PCP vs. the number of recipients who are assigned through the auto-assignment process.
- (3) Provide reports that include and differentiate case management fees paid, provider participation within the PCCM program, and utilization statistics for PCCM enrollees.

5.6.13.4 Interfacing Systems

- (1) Provision of PCP data to DPA for inclusion on ID cards

5.6.13.5 Inputs

- (1) Eligibility Updates
- (2) Provider Updates
- (3) Claims for PCCM Recipients

5.6.13.6 Outputs

- (1) Audit Trail of Eligibility Updates
- (2) Case Management Fee Claims Processed
- (3) Claims for Services Provided by Primary Care Providers
- (4) Claims for Services Referred by Primary Care Providers
- (5) Claims Denied for Non-Referral of Services
- (6) SURS Reports
- (7) Demographic reports as needed to study growth trends.
- (8) Comparative analysis reports
- (9) Case management fees paid
- (10) Provider participation within the PCCM program
- (11) Utilization statistics for PCCM enrollees

5.6.13.7 Performance Standards

The specific performance requirements for the Managed Care Function will be defined during the requirements analysis task when managed care is implemented.

5.6.14 Home and Community-Based (HCB) Waivers

The home and community based waiver programs serve individuals in a home or community environment as an alternative to institutionalization. The new MMIS must demonstrate that it is capable of supporting the requirements for implementing and operating these programs. Design and development must be structured to accommodate these capabilities with minimal change and cost. These four programs are administered by the Division of Senior and Disabilities Services (DSDS) and include the following categories:

- (1) Developmental Disabilities (DD) waiver
- (2) Children with Complex Medical Conditions (CMC) waiver
- (3) Older Alaskan (OA) waiver
- (4) Adults with Physical Disabilities (APD) waiver

The plan beneficiaries are eligible by virtue of either their participation in the federal SSI program, or by having met the requirement for SSI (except for income) and the need for institutional care. The benefits include an array of medical and social services. Many home and community-based services are not part of the traditional Medicaid benefit package. Services are client-specific and arranged in a care plan overseen by a care coordinator. The care plans are submitted to DSDS, who is responsible for review of care plans and submission of service authorization request and response information to the fiscal agent's MMIS for use in claims processing. The servicing provider then submits a claim for payment of home and community-based services to the fiscal agent after the services have been rendered.

The four waiver programs serve different populations, but the processes for eligibility verification, benefit determination, claims processing and reporting are similar and in general follow the requirements for other Medicaid services.

5.6.14.1 Business Needs

The business objectives for the four home and community based waiver plans are to:

- (1) Provide care arrangements for elderly and disabled recipients in home and community settings, in lieu of institutional placement, by working with families and caregivers to develop the appropriate service plans and provide the necessary services.
- (2) Recognize individual needs in care plans by providing client specific rates based on need and service delivery arrangements.
- (3) Maintain a repository of eligible recipients, authorized providers, prior authorizations, and individual services with client specific rates. Provide interfaces for prior authorization of services with electronic access by both the State and program providers.
- (4) Participate in the other MMIS functions, including claims processing, financial management, information management, utilization review, TPL decision support, and provider services and training.
- (5) Monitor the services to insure compliance with quality standards and State regulations.
- (6) Meet all CMS requirements for federal certification and reporting.

5.6.14.2 Business Processes

The business processes required to provide services and pay claims for recipients receiving services through the HCB waiver programs are:

- (1) Recipient Eligibility
- (2) Benefit Package Description
- (3) Provider Enrollment
- (4) Reference Files For Reimbursement Description
- (5) Prior Authorization
- (6) Reimbursement Rates
- (7) Claims Processing

- (8) Claims Payment
- (9) Financial Services
- (10) Third Party Liability
- (11) Reporting Requirements

These business processes generally follow the business processes for other Medicaid services, and are described below to indicate those requirements that may vary from the business processes described in previous sections of the RFP.

5.6.14.2.1 Waiver Programs Recipient Eligibility

Financial eligibility for participation in the home and community based waiver programs is determined through the Division of Public Assistance field offices. Determinations of medical need are made by DSDS based on an assessment document developed by care coordination provider agencies in the field. The assessment and the detailed service plan for each prospective waiver client are sent to DSDS for determination of level of care and approval of the service plan.

The medical approval is routed to the DPA field office for assignment of a waiver eligibility code and entry into the EIS. Each waiver program has a series of three to five codes that designate unique eligibility status. Co-payments are not required on the waiver services. Waiver recipients would be subject to co-payments required for other Medicaid services.

Routine eligibility processing requirements for Medicaid are found in RFP Section 5.6.2.

5.6.14.2.2 Benefit Packages

Home and community based waiver services are designed to support an elderly or disabled individual in a home or community setting. The services include an array of social services:

- (1) The Older Alaskan Waiver provides care coordination, residential supported living, chore and respite, environmental modification and transportation and meals.
- (2) The Adult Disabled Waiver provides care coordination, residential services, day services, environmental modification, transportation and meals.
- (3) The Developmental Disability Waiver and the waiver for Children with Complex Medical Conditions provide care coordination, residential services, day services, environmental modifications and chore and respite services.

Procedure codes and service descriptions are provided to the fiscal agent by DHSS. The fiscal agent needs to restrict the procedure codes to the authorized providers. Updates are provided by the DHSS as needed.

Routine MMIS requirements for the benefit package function are provided in RFP Section 5.6.3.

5.6.14.2.3 Provider Enrollment and Relations

Participating providers include the community care coordination agencies, social service community providers and housing related service providers. The array of Medicaid providers is also available to provide services to home and community based waiver participants.

The community providers participating in the home and community based waiver program require certification from the waiver agency as a condition of program participation. Community programs complete the program certification request and submit it to the respective Program Administrator who approves the participation and authorized services. The agency sends the certification to the provider, who submits the certification with the provider enrollment request to the fiscal agent. When the fiscal agent receives the enrollment application and the certification, the provider is enrolled as a waiver provider. New home and community based waiver providers submit a provider participation application to the fiscal agent for participation in the Medicaid program. Approvals for these applications would come from DSDS. The provider file at the fiscal agent must have the capability to limit participation of these providers to waiver services and/or waiver participants.

The specific enrollment, file maintenance, technical assistance and training requirements for all providers are covered in RFP Section 5.6.4.

5.6.14.2.4 Reference Databases

Rates for individual services are provider and client specific and negotiated between the State and the service providers. The rates are included in the care plan cost sheet that is submitted to DSDS and are currently transmitted to the fiscal agent via the prior authorization. In the future, the waiver agencies may change to provider-specific rates. The system provided must have capability to establish unit prices for HCB waiver services that are different by provider for the same procedure code. Rates that are different by client would still need to be provided on the prior authorization.

The specific functional requirements for the MMIS reference database are covered in RFP Section 5.6.5.

5.6.14.2.5 Prior Authorization

All HCB waiver services require prior authorization and are provided pursuant to a care plan. The care coordination agencies convene a team consisting of family members, the service agencies and the care coordinator (case manager) to develop a service plan for each prospective waiver client. The individual care plans are sent to DSDS for approval and a prior authorization is submitted to the fiscal agent.

5.6.14.2.5.1 Division of Senior and Disabilities Services (DSDS)

The Division of Senior and Disability Services (DSDS) uses a software tracking system, called COSI for transmitting the care plan updates from the community providers to DSDS in Anchorage. The care plans, along with the cost sheet, are entered by the care coordination

agencies into COSI, or sent hard copy to the Division of Senior Services Program Office for approval. The Program Office approves the services, including approval of individual provider or recipient-specific rate information, and transmits a prior authorization record to the fiscal agent for assignment of an authorization number. The fiscal agent enters the authorization on the PA file and issues a PA number that is transmitted on COSI to the provider. The provider uses the prior authorization number on their claims. PA numbers apply to cost sheet updates as long as the PA time period is valid. The fiscal agent also produces and sends notices to the recipient, the waiver agency, and the care coordinator.

The general MMIS functional requirements for prior authorization are found in RFP Section 5.6.6.

5.6.14.2.6 Reimbursement

Reimbursement for HCB waiver services is based on fixed and/or negotiated rates for routine services. Care coordinators and private duty nurses have fixed rates. The units are hourly, daily and monthly plus a per visit rate for some services.

The general reimbursement requirements for MMIS services are covered in RFP Section 5.6.7.

5.6.14.2.7 Claims Processing

HCB waiver services are billed on the HCFA 1500 claim form.

5.6.14.2.7.1 Division of Senior Services

Claims would be processed just like other Medicaid claims and are subject to all the routine edits and audits, as described in Section 5.6.8 of this document.

5.6.14.2.8 Claims Payment

Claims payment would be driven by the values on the cost sheets submitted by the respective program providers. The claims are processed and priced using MMIS criteria for eligible recipient, eligible provider, eligible service and allowable pricing from rates on the PA file.

The general claims payment requirements are identified in RFP Section 5.6.9.

5.6.14.2.9 Financial Services

HCB waiver services are identified by collocation code and follow the comparable process for other Medicaid services in assignment of account categories. The budget for these service categories is managed through DHSS under the procedures in place for allocation of budget to collocation codes and review by DHSS staff.

The general accounting and financial requirements for AKSAS for Financial Services are identified in RFP Section 5.6.10.

5.6.14.2.10 Third Party Liability

HCB waiver services would be included in the third party requirements for other Medicaid services. Because of the nature of HCB services, the available coverage from insurance plans is minimal. The DPA eligibility worker would request insurance information from clients at intake and add the coverage information to the eligibility record pursuant to program guidelines.

The general TPL requirements for Medicaid recipients are identified in RFP Section 5.6.11.

5.6.14.2.11 Reporting Requirements

All data residing in the MMIS pertaining to HCB waiver services will be available for export to the decision support system or data warehouse applications operated by the DHSS or their agent.

Requirements for decision support and data warehouse applications to support DHSS medical care programs are included in RFP Section 5.6.18.

5.6.14.3 Interfacing Systems

Interfaces for HCB waivers are included in the corresponding functional area RFP sections above.

5.6.14.4 Inputs

- (1) Eligibility Updates (File transfer from EIS to update MMIS)
- (2) Provider file updates (Transfer of provider update information to the fiscal agent file)
- (3) Procedure code updates
- (4) Reference file updates (Updates by DHSS, either on-line or by file transfer, of reimbursement methodology changes)
- (5) Claims submitted by community providers, either by direct entry, electronic submission or hard copy
- (6) Recipient Inquiry (On-line inquiries by providers on eligibility status of clients)
- (7) Claims Inquiry (On-line inquiry by community providers on status of pending claims)
- (8) Prior Authorizations (Updates from DSDS, either hard copy, on-line or by file transfer of procedure code files)

5.6.14.5 Outputs

The State is required to submit an annual waiver program report, the HCFA 372 for each HCB waiver program. Information for the report includes services and payments for waiver recipients, for both waiver services and regular Medicaid services, which comes from the MMIS. The State is also required to show cost effectiveness for waiver services through a series of complex formulas comparing costs of waiver and supplemental Medicaid services with the reported cost of institutionalization. These reports could be produced either through standard reports in the MMIS, or through a series of queries in the decision support system. DSDS program administrators also need to access the decision support system for ad-hoc reports on all

aspects of cost and utilization for the waiver recipients. The HCB services are included in MARS reports and the program recipients and providers are included in the SURS universe.

5.6.14.6 Performance Standards

Performance standards specified above for each functional area will apply to the corresponding HCB waiver functions.

5.6.15 Pharmacy Point-of-Sale (POS)

The Pharmacy real time Point-of-Sale (POS) system encompasses the automated functions necessary to receive and adjudicate all pharmacy claims including multi-ingredient compounds and Partial Fills in both electronic and paper formats. It also includes other electronic features related to pharmacy claims processing. Using the POS device or POS software on their systems, the pharmacist can check recipient Medicaid and Medicare Part D eligibility on-line, submit claims for real-time adjudication, verify a drug's PDL status, perform Prospective Drug Utilization (ProDUR), determine if prior authorization is required for a pharmacy claim and submit the Prior Authorization (PA) request on-line, if needed. As with many State MMIS systems the current Alaska system has separate processes for MMIS and POS that require communication activities between both systems. Batch claims submitted by the pharmacy to the MMIS enter the POS through the sequential terminal. Batch claims in the NCPDP Batch 1.1 format are fed directly into the POS processor. The current point-of-sale electronic format is NCPDP V 5.1. Paper claims are date stamped, given an ICN and entered directly into the POS processor. In the future the POS will accept claims sent in the NCPDP script standard via any E-Prescribing network between Alaska Medicaid and enrolled prescribers and pharmacy providers.

DHSS has identified additional MMIS functionality that is required for compliance with the Deficit Reduction Act of 2005. The MMIS must be capable of full compliance with all requirements of the Act including the following prescription drug requirements:

- (1) Drug pricing and reporting in accordance with the DHSS promulgated federal regulations.
- (2) Accepting and processing NDCs received from professional claim forms (CMS-1500) and formats (837-P).

5.6.15.1 Business Needs

The business needs for the State cover functions associated with processing, monitoring, and paying all pharmacy claims. The primary objectives are to provide:

- (1) An immediate response pharmacy claims adjudication system that is HIPAA and NCPDP compliant.
- (2) Automated Prospective Drug Utilization Review with clinical edits and prior-authorization. and Retrospective Utilization Review.
- (3) The ability to handle multiple benefit packages.
- (4) The ability to provide flexible benefit administration.
- (5) The ability to handle flexible pricing.

- (6) The ability to maintain a Preferred Drug List and process claims accordingly.
- (7) The ability to correctly process Partial Fill claims.
- (8) The ability to correctly process and price multi-ingredient compound claims.
- (9) The ability to correctly apply coordination of benefit rules to real time claims processing for recipients with TPL and/or Medicare Part D eligibility.
- (10) The ability to handle Third Party Liability (TPL) billing and collection with Coordination of Benefits.
- (11) The ability to provide full audit capabilities.
- (12) The ability to handle full financial transaction processing.
- (13) The ability to perform full accounting, payment and collection processing.
- (14) The ability to handle single adjustments and automatic mass adjustment reprocessing.
- (15) The ability to provide Pay and Chase capability in both manual and automated formats in the unusual cases when the State elects an alternative to Coordination of Benefits.
- (16) The ability to handle pending HIPAA and Sate requirements for security and confidentiality.
- (17) The ability to meet the State's needs for on-line information access.
- (18) The ability to handle sanctions and incentives.
- (19) The ability to perform compliance monitoring and reporting.
- (20) The ability to handle exception processing.
- (21) The ability to cross reference client eligibility records and appropriately apply this in the processor and in the graphical user interface when more than one client identifier exists for a unique client.
- (22) The ability to share (receive and send) claims data with Medicare Part D plans and apply this data in the prospective and retrospective Drug Utilization Review process.
- (23) The ability to meet the State's needs for timely processing.
- (24) The ability to handle Federal, State, and Contractor interfaces and reporting.
- (25) The ability to meet the State's requirements for Disaster Planning and Recovery.
- (26) The ability to meet the State's need for safety planning and monitoring.
- (27) The ability to perform outcome analysis.
- (28) The ability to process claims from rural physician and nurse practitioner non-pharmacy dispensers of drugs.
- (29) The ability to provide workflow analysis, workflow simplification and upgrades.
- (30) The ability to provide training and communications to all concerned parties.
- (31) The ability to create and use an allergy and diagnosis file from MMIS claims data for DUR processing.

(32) State-of-the-art technology and industry standard interfaces to pharmacy providers for submission of pharmacy claims for clients eligible for Alaska Medical Assistance Programs.

(33) Interface with the MMIS for the acceptance and transfer of claims, recipient eligibility, provider eligibility, reference/formulary, and other MMIS data and payment of claims.

5.6.15.2 State Responsibilities

(1) Establish policies and guidelines to be followed by providers in using POS claims submission.

(2) Review and approve POS standards, documentation, and manuals furnished to providers.

5.6.15.3 Contractor Responsibilities

The POS function shall support the following major processes:

- (1) Pharmacy Claims Capture and Adjudication
- (2) Recipient Eligibility Verification
- (3) Provider Eligibility Verification including the correct use of the NPI and Taxonomy on inbound and outbound transactions.
- (4) Processing Prior Authorization Requests for Drugs
- (5) Exchanging Data Between the MMIS and the POS Systems
- (6) Exchange data between the POS System and Medicare Part D and Contractor systems
- (7) Providing Technical Assistance and Support to Providers
- (8) Reporting

The Contractor shall operate and maintain the automated POS system, and furnish provider training. The Contractor also must staff a help desk to handle PA requests, and provide other technical support related to the POS.

The fiscal agent shall provide a system that affords the functionality necessary to support the ePrescribing initiative as outlined in the Medicare Modernization Act.

The State provides policy direction and oversight of Contractor materials and performance.

5.6.15.3.1 Pharmacy Claims Capture and Adjudication

This process shall:

- (1) Perform on-line, real-time adjudication of pharmacy claims submitted through POS devices.
- (2) Reject or deny claims based on system edits supporting certain error conditions.
- (3) Use current NCPDP Versions for submission of claims (current POS version is 5.1 and batch version is 1.1).

- (4) Capture Pay or deny pharmacy (drug) claims data submitted through switches, POS devices or PC dial-up features. Allow claim reversals/voids/adjustments (void/rebill) from pharmacy providers. In the current system a reversal (Transaction Code B2) allows the provider to void a claim that was previously processed as paid. A re-bill (Transaction Code B3) allows the provider to cancel a paid claim and resubmit the claim within a single transaction. Allow processing of partial fills of prescriptions submitted through POS devices.
- (5) Verify that the provider is an eligible, enrolled Alaska medical assistance programs provider and approved for participating in the POS system, including authentication and certification for access to the POS system. Provider eligibility includes both prescribing and dispensing provider and maintenance of crosswalks of Medicaid provider NCPDP and MPI identifiers as well as associated taxonomy.
- (6) Verify that the recipient is eligible for the services on the date of service and process claims accordingly.
- (7) Indicate in the POS response whether the recipient does or does not have current third party insurance coverage, or Medicare Part B or D eligibility, including BIN number and other plan identifiers.
- (8) Provide ability to categorize and identify insurance plans (distinguish between third party insurance plans, Medicare Part B eligibility, and Medicare Part D plans) within the POS processor and apply editing and coverage rules based on that categorization.
- (9) Provide the following as appropriate for claims covered by third party insurance or Medicare Parts B and/or D and that contain a service designated for cost avoidance:
 - (a) Deductible, co-payment
 - (b) ANSI BIN numbers
 - (c) Insured appropriate billing number or Social Security Number
 - (d) Relationship to patient
 - (e) Deny and cost avoid the claim if appropriate
 - (f) Carrier codes
 - (g) Appropriate messaging to the provider related to third party insurance or Medicare Parts B or D
- (8) Process claims covered by third party insurance that contain a service designated as a pay and chase as specified by DHSS policy. Specific requirements for “pay and chase” activities are included in the TPL section. Process claims according to the Coordination of Benefits requirements noting different requirements for regular third party coverage and Medicare part B and D.
- (9) Provide access to information regarding recipient TPL and other payer coverage in prior periods. Access must be requested directly from the Pharmacy System, MMIS or AVR.
- (10) Use NDC Drug code, drug name, dosage, price Preferred Drug List, and any other data element maintained in the Reference files.
- (11) Provide a HIPAA-compliant coding structure for all pharmacy claims.
- (12) Perform all necessary logic and consistency editing for all submitted claims for acceptance by the POS and before transmittal to the MMIS or acceptance by the POS.

This includes, but is not limited to, logical dates of service (e.g., valid dates, not future dates), valid NDC code, number of units consistent with State and federal policy, balancing of segments within the claim record, third-party insurance or other payer coverage, data integrity/completeness, filing limitations, HIPAA and NCPDP compliance, etc.

- (13) Limit payment of pharmacy claims to drugs for CAMA and Medicaid claims to those which are manufactured by companies on CMS listing of manufacturers with drug rebate agreements except as directed by DHSS.
- (14) Limit payment of pharmacy claims for Medicare part D/Medicaid dually-eligible clients to those drugs excluded from the Medicare Part D formulary and in accordance with State coverage rules.
- (15) Provide the capability to process Medicare Part B crossover pharmacy claims from CMS-designated Contractors or providers and pay appropriate coinsurance and deductibles according to State rules.
- (16) Determine reimbursement for prescription dispensed, including calculation of the lesser of billed charge pricing methodology mandated by State regulation or State-approved policy (e.g. estimated acquisition cost or Federal Upper Limit). This includes the provider-specific dispensing fee and other prescription related fees (such as compounding fees, postage, etc.) with payment not to exceed the total amount billed by the provider. Allows for out-of-State enrolled pharmacies to submit claims and be paid at the rate allowed in their State according to their AWP- rate or WAC+ rate for brand and for generics, also charges a co-pay consistent with Alaska policy. Pricing algorithms will subtract other payer amounts in accordance with COB requirements.
- (17) Maintain standard claim control and tracking standards for claims submitted via POS and PC dial-up features.
- (18) Provide a test system within the POS processor to adequately test all changes to the adjudication rules before impacting production claims in accordance with State standards.

5.6.15.3.2 Recipient Eligibility Verification

- (1) The system shall provide verification that the recipient is eligible for Medicaid, other State-specific plans, Medicare Part B, Medicare Part D, and/or other third-party insurance plans.
- (2) The system shall identify any pharmacy service restrictions appropriate to the client.

5.6.15.3.3 Processing Prior Authorization Requests for Drugs

- (1) This process shall capture prior authorization requests for pharmacy services via online, real-time adjudication based on State-defined criteria. In order for the drug PA to be approved online, diagnosis and inclusive dates need to be submitted.
- (2) The DHSS Health Program Pharmacy and Ancillary Services Unit pharmacist directly approves some drug PAs that are then sent to the fiscal agent for entry into the POS.

5.6.15.3.4 Exchanging Data between the MMIS and the POS Systems

- (1) This process shall provide the interface between the POS with the MMIS for the acceptance and transfer of claims data, recipient eligibility and COB information, provider eligibility, reference/formulary, prior authorization, claims pricing and other MMIS data needed for POS claims adjudication and reporting.
- (2) This process shall include a balancing and reconciliation component between the POS processor and the MMIS source data to, at all times, maintain the integrity of the data used by the POS processor.
- (3) The POS processor shall send adjudicated claims data to the MMIS at specified intervals. This process shall include a balancing and reconciliation component between the POS processor and the MMIS.

5.6.15.3.5 Providing Technical Assistance and Support to Providers

- (1) This process shall provide support to Providers to select the most appropriate interface to communicate claims to the POS system. This may be through the use of a POS device or interface with the Pharmacy software system. For dispensing physicians, the system shall be able to support electronic submission of batch input pharmacy claims, support for a POS device, and submission of paper claims to the Fiscal Agent. Interfaces will comply with HIPAA and NCPDP standards.
- (2) This process shall provide a “live POS test” system to test new providers and new switch vendors who want to enroll and participate in the POS claims submission process.
- (3) This process shall provide the interface between POS and provider’s pharmacy software system.
- (4) This process shall provide on-line response notifications to providers, within 10 seconds of transmission. If the claim submitted is acceptable for further processing and if the drug is covered under the State Plan for the recipient, this process shall respond with the amount to be reimbursed to the provider. If errors are found, it shall notify the provider as to the nature of the error(s) and claims rejection.
- (5) This process shall provide a help desk with full provider inquiry response capability including but not limited to technical assistance, program drug coverage, eligibility, provider, policy and procedure responses, assistance in determining prescriber ID numbers, COB payor information, and override authorization for early refill or other ProDUR and clinical edits.
- (6) This process shall log and track all contacts with providers, and provide data and reports on provider contacts to comply with the requirements identified in the Provider Inquiry section of the RFP.

5.6.15.3.6 Reporting

- (1) This process shall produce all defined and State-approved reports regarding POS claims submission.

- (2) The reporting component will meet current CMS reporting requirements for POS functionality.
- (3) This process shall produce detail and summary reports on paid, rejected and denied claims.
- (4) This process shall produce Medicare Part D summary reports on claims paid and claims cost avoided for Medicare Part D recipients.
- (5) This process shall provide reports on all activity related to use of the “live POS test” system by new providers and switch vendors.
- (6) This process will report system outages to the State in accordance with the standards and timelines set forth in other sections of this document.
- (7) This process will report system problems to the State within 24 hours of identification of the issue.

5.6.15.4 Interfacing Systems

- (1) MMIS for provider, recipient, reference and claims history data
- (2) Providers for POS claims submission
- (3) MMIS for recipient eligibility and other payer coverage data
- (4) First Data Bank for drug file data
- (5) NABP for national provider identifiers
- (6) Medicare Part D Plans or other CMS Contractors for data sharing

5.6.15.5 Inputs

- (1) Drug Claim Submission (POS)
- (2) Drug Claim submission (Paper)
- (3) Recipient Eligibility Verification Request
- (4) Provider Eligibility Data Request
- (5) NDC Coverage Data Request
- (6) Prior Authorization Data Request
- (7) TPL Data
- (8) Claim Adjustments/ Reversals/Voids
- (9) Multi-ingredient compound claims submitted to the POS.
- (10) Partial fill claims submitted to the POS.
- (11) Part D plan paid claims data

5.6.15.6 Outputs

- (1) POS Claim Submission Statistics Report

- (2) Weekly POS Transaction Totals Report
- (3) Unsuccessful POS Transmissions and Claim Errors Report
- (4) Claim extract for input into MMIS
- (5) Paid claims data to Part D plans or CMS Contractors

5.6.15.7 Performance Standards

- (1) The Pharmacy POS shall provide on-line response notifications to providers within 10 seconds of receipt of incoming claim transactions.
- (2) The Pharmacy POS shall provide POS function availability 23 hours a day, seven days a week.
- (3) The Pharmacy POS shall have no more than five percent (5%) of incoming calls to the Help Desk ring busy.
- (4) Ninety-five percent (95%) of incoming calls that do not ring busy must be answered by a live operator.
- (5) Hold time shall not exceed two minutes for ninety-five percent (95%) of calls.
- (6) The average hold time shall not exceed thirty (30) seconds.
- (7) The Pharmacy POS will notify the State within 24 hours of any claims processing errors/problems identified.
- (8) The Pharmacy POS will comply with all standards relating to system outages as provided in other sections of this RFP.

5.6.16 Drug Utilization Review

The Drug Utilization Review (DUR) system encompasses both on-line prospective drug utilization review (ProDUR) for pharmacy claims submitted through the Point of Sale function and retrospective review of drug utilization by recipients.

5.6.16.1 Business Needs

The primary objectives of the Drug Utilization Review (DUR) function are to:

- (1) Provide a prospective and concurrent review of prescription practices at the pharmacy and recipient level against a patient history file containing drug use, diagnosis, and allergy information for the last six months to assure appropriate and beneficial use of pharmaceuticals (ProDUR).
- (2) Perform after the fact review of the prescribing habits of individual physicians in a peer review process.
- (3) Meet federal and State regulations regarding the quality and care of drug dispensing.
- (4) Provide a mechanism for referrals of recipients for lock-in to specific providers.
- (5) Develop new therapeutic criteria necessary to correctly identify drug misuse for new and currently available drugs.

- (6) Provide advice and consultation with prescribers, pharmacies, and dispensing physicians through counter detailing techniques.
- (7) Provide quarterly newsletters to prescribers and dispensers.
- (8) Establish a computer-based system for retrospective application of appropriate screening criteria against Medicaid recipient data to identify Medicaid recipients at-risk of drug-induced illness.
- (9) Review and communicate relevant individual patient medical history information about inappropriate drug use to the DUR committee.
- (10) Report to the DUR committee provider patterns in medication prescribing, and identify those providers whose prescribing patterns fall outside the normal parameters.
- (11) Produce patient profiles with medical claims, dental, lab, prescription, inpatient, outpatient, hospital, ambulatory surgery centers, mental health, Medicare crossovers, and DME claims for review and intervention by the DUR committee.
- (12) Produce provider profiles for pharmacy and prescribers for the DUR committee and upon their request complete interventions with the clinical pharmacists doing the tasks.
- (13) Verify treatment of disease is completed with medications as elucidated in national guidelines, and provide intervention when guidelines are not followed.
- (14) Ensure that step therapy has been provided when appropriate.

5.6.16.2 State Responsibilities

- (1) Develop and provide to the Contractor the State policy for the performance of DUR activities.
- (2) Monitor the Contractor's performance of the DUR function.
- (3) Provide written approval of the Contractor's DUR procedures.
- (4) Provide written approval of the DUR newsletters, letter templates, and other written materials used in the DUR activities.

5.6.16.3 Contractor Responsibilities

The business processes required to support the DUR function include:

- (1) Prospective DUR (ProDUR), including clinical edits
- (2) Retrospective DUR (RetroDUR)
- (3) Editing for Prior-authorizations
- (4) Medication quantity limits

5.6.16.3.1 Prospective DUR System

- (1) Provide an automated, integrated, on-line, real-time ProDUR system that incorporates use of the MMIS EVS and POS capabilities, including direct access to the MMIS and point-of-sale review and response.

- (2) Compare a prescription claim against recipient claims history and explicit predetermined standards, including monitoring for:
 - (a) Therapeutic appropriateness
 - (b) Over-utilization
 - (c) Under-utilization
 - (d) Appropriate use of generic products
 - (e) Therapeutic duplication
 - (f) Drug-disease contraindications
 - (g) Drug-pregnancy contraindications
 - (h) Drug-drug interactions
 - (i) Incorrect drug dosage or duration of drug treatment
 - (j) Clinical abuse/misuse
- (3) Provide a methodology to validate that step therapy has been provided when appropriate, including a series of questions to determine if previous steps using less costly therapeutic substitutes have been tried before dispensing more costly medications.
- (4) Generate alerts based on clinical or program compliance issues associated with a recipient's prescription for the pharmacist to evaluate.
- (5) Maintain flexible, user-controlled parameters to adapt the situations in which particular on-line ProDUR messages will be generated.
- (6) Allow providers to override a ProDUR message and/or be able to comment on the ProDUR messages according to the NCPDP standard.
- (7) Provide information and data, as required by DHSS, to support ProDUR criteria or criteria enhancements.
- (8) Updates ProDUR files on a daily basis.
- (9) Provide access to current MMIS Reference File data.
- (10) Reports on drug utilization by DHSS user-defined criteria (e.g., utilization individual drugs, doses and prescriptions by pharmacy or drug).

5.6.16.3.2 Retrospective DUR System

Provide an automated integrated system used to maintain and develop RetroDUR databases and required reports for the retrospective DUR program.

- (1) Maintain file formats and DUR data elements consistent with the prospective DUR criteria used for collecting and processing data from medical and pharmacy claims information.
- (2) Maintain therapeutic criteria files for at least thirty (30) therapeutic classes and at least three thousand (3,000) exception criteria standards of the highest significance used to identify specific pharmaceutical use problems. The drug-patient criteria should relate to the patient's age and sex and interaction with the drugs being taken at a specific time.
- (3) Maintains quantitatively significant values or severity ratings on the criteria files that appear on patient-specific alerts.

- (4) Can change therapeutic criteria within 30 to 60 days of a request by the State or the DUR Committee with State approval.
- (5) Maintain and update the RetroDUR database with newly supplied and replacement pharmacy, hospital inpatient, outpatient, medical, and laboratory claims information including drug NDC, brand and generic names, units used, days supply, prescriber, paid amount, pharmacy number, recipient ID number, age, date of birth, and sex.
- (6) Conduct recipient utilization reviews and submits relevant information about inappropriate drug use based on individual patient medical history to the DUR committee.
- (7) Produce recipient profiles no less than every month with a minimum of five (5) months of data. Data should include total number of prescriptions, total dollars of prescriptions, outpatient dollars and services, and inpatient dollars and services. The State would prefer to have the profiles provided to the DUR committee members via a secure Internet access, but will accept a paper mailing. If secure Internet access is available, profiles should be provided via secure electronic media and/or on paper based on the committee member's preference.
- (8) Provide on-line access to the profiles with the capability for the user to select and print profiles chosen from those produced according to therapeutic class and problem noted. The number of profiles requested may vary between 50 and 200.
- (9) Indicate the severity code and source of each recipient profile criteria assigned and whether it indicates:
 - (a) Over or underutilization
 - (b) Drug-drug interaction
 - (c) Drug-disease or drug-pregnancy contraindication
 - (d) Duplication of therapy
 - (e) Unnecessary drug
 - (f) Therapeutic appropriateness or therapeutic duplication
 - (g) Incorrect drug dosage or duration of drug treatment
 - (h) Clinical abuse/misuse
 - (i) Appropriate use of generic products
- (10) Produce monthly provider profiles for prescribers and pharmacies and ranking reports showing the top ten prescribers for a particular drug and where a single provider ranks compared to his peers or within a specialty. Profiling is done for a particular drug, therapeutic class or generic cross reference.
- (11) Identify providers whose medication prescribing patterns fall outside normal provider patterns in a report to the DUR Committee.
- (12) Identify all providers associated with the criteria and medications resulting in a recipient exception profile during recipient drug utilization reviews; specific providers causing the exception are highlighted.
- (13) Provide the capability to suppress provider profiles related to previously identified criteria for a patient, after the initial flagging, for a period specified by the DUR

Committee, to prevent a provider receiving multiple correspondences from the DUR Committee for identical or similar situations.

- (14) Can submit on-line request for the RetroDUR system to generate follow-up drug history profiles and reports.
- (15) Utilize the integrated on-line case tracking and letter generation system to allow DUR staff to indicate profiles requiring intervention. The system automatically generates a case tracking record allowing the DUR staff to choose a standard letter or to choose a totally customized letter. The letter indicates the exception criteria, allows a Statement concerning the criteria and any other information from provider profiling the user wants to insert.
- (16) Case tracking information must include the dates of each activity, provider's response to the intervention letter, and answers to survey questions on the response.
- (17) Provide on-line inquiry access to the DUR database and case tracking system to Contractor and State DUR staff and provide access to State-specified data on the database to DUR Committee members.
- (18) Provide on-line access to all reports designated by DHSS to be available on request in the media specified by the user.
- (19) Produce a monthly summary report containing a count of patients whose profiles are being distributed for the current month, a listing of patient names, and a listing of drugs that caused the profiles to be generated. Include a count of providers who caused profiles to be flagged, and a listing of their names.
- (20) Produce an Alaska Medicaid population drug therapy risk assessment report. This report will be generated before and after interventions are instituted to determine the impact of the DUR program on drug expenditures and drug therapy induced hospitalizations.
- (21) Produce cost savings reports with data including the cost of drugs, cost of outpatient services, cost of inpatient services, total cost of care and average cost for each data item for all recipients of an age group.
- (22) Produce monthly operational reports for DHSS showing the status of DUR activities.
- (23) Produce all CMS-mandated RetroDUR reports; including completion of complete annual report.
- (24) Allow users to develop provider/prescriber specific reports. These reports include summaries of drug prescribing behaviors or patterns, and analysis reports using data from the DUR database. Requests are entered on-line, with user-defined parameters, and are available for on-line viewing the next day.
- (25) Coordinate DUR committee activities, including preparing and sending out profiles, setting up committee meetings, and performing follow-up activities on reviewed cases.
- (26) Provide a clinical pharmacist on-site in Anchorage to oversee DUR committee activities and perform DUR activities requiring clinical knowledge.

- (27) Develop new DUR criteria and modifications to existing DUR criteria and disease guidelines, and upon DHSS approval of the criteria and guidelines, update the DUR criteria database.
- (28) Prepare a quarterly DUR newsletter, and upon DHSS approval of the content, mail the newsletter to prescribers and dispensers.
- (29) Prepare and obtain DHSS approval of the DUR intervention letter templates.
- (30) Provide intervention by the clinical pharmacist for prescribers and pharmacists identified by the DUR committee, including but not limited to sending a report card to the top ten prescribers.
- (31) Provide counter detailing by the clinical pharmacist as requested by the DUR committee, i.e., visit physician offices to provide advice and consultation on prescribing patterns to encourage the use of less expensive but equally effective drugs.
- (32) Provide a methodology to verify treatment of disease is completed with medications as elucidated in national guidelines, and provide intervention when guidelines are not followed.

5.6.16.4 Interfacing Systems

There are no external automated interfaces for the DUR function.

5.6.16.5 Inputs

- (1) ProDUR requests
- (2) RetroDUR data requests

5.6.16.6 Outputs

- (1) Profile reports on ProDUR recipients
- (2) Frequency reports for ProDUR messages
- (3) Periodic summary and detail reports showing the frequency of each ProDUR message for POS pharmacy providers
- (4) ProDUR system usage reports
- (5) ProDUR exception reports, including detailed, summary, and exception reports
- (6) Report showing cost savings generated by ProDUR alerts and denials
- (7) RetroDUR recipient profiles
- (8) RetroDUR provider profiles
- (9) RetroDUR Provider ranking and trending reports
- (10) Intervention letters for recipient profiles
- (11) Provider intervention letters for provider and recipient profiles
- (12) RetroDUR case tracking reports

- (13) RetroDUR monthly summary report
- (14) Drug therapy risk assessment report
- (15) DUR cost savings reports
- (16) DUR Monthly operational report
- (17) Annual CMS DUR report

5.6.16.7 Performance Standards

- (1) Provide DUR criteria for new drugs within two weeks of its introduction.
- (2) Provide criteria identifying drugs removed from the market within two weeks of its removal.
- (3) Complete all intervention suggested by the DUR Committee within 25 days of the committee meeting.
- (4) Provide DUR reports to DHSS by the 5th of the month for the prior month activity.
- (5) Complete CMS annual DUR report by May 1 of the year the report is due.
- (6) Provide ordered recipient DUR profiles within five days of the request.
- (7) Provide the quarterly DUR newsletter by the 30th of the month following the quarter.

5.6.17 Drug Rebate

The Drug Rebate function receives information from CMS on a quarterly basis regarding manufacturers with which drug rebate agreements exist. As part of this function, it accepts and processes the Drug Rebate Manufacturer Agreement data from CMS, which contains National Drug Codes (NDCs), the rebate per unit amount determined by CMS using manufacturer-supplied data, and NDC correction records from previous quarters.

5.6.17.1 Business Needs

The primary objective of the Drug Rebate function is to ensure compliance with the Centers for Medicare and Medicaid Services (CMS) drug rebate program established under OBRA 90.

5.6.17.2 State Responsibilities

- (1) Determine and provide to Contractor the policies for performance of the drug rebate function.
- (2) Approve Contractor's procedures for drug rebate processing.
- (3) Approve invoice adjustments over \$1,000.00.

5.6.17.3 Contractor Responsibilities

The Drug Rebate function summarizes and tracks prescription drugs provided to recipients on a quarterly basis. Using the NDC code and the Drug Rebate Manufacturer Agreement data, it totals, by manufacturer, the amount of all drugs prescribed for Alaska MMIS recipients covered

by the agreement. Claims for non-Medicaid recipients or pharmacies receiving drugs under the 340(b) program as identified by the Health Resource Services Administration (HRSA) Pharmacy Affairs are not included in the totals. The Drug Rebate function calculates the amount of rebate for each manufacturer and generates the invoices, which are transmitted electronically. It then creates transactions to update the MMIS claims history files. As rebates are received, the State enters this information into the system through a workstation. The Contractor must provide access to a minimum of ten (10) years of drug rebate data on-line with data over ten years archived and retrievable within twenty-four (24) hours of a request.

Drug manufacturer disputes, resulting resolution, and rebate assessments are tracked through the Drug Rebate function. Updates to the HCFA 64 financial tracking are also required to report drug rebate collections. The quarterly Drug Rebate Manufacturer Agreement data from CMS is saved by the Drug Rebate function. As changes to the drug rebate data are received by the State between updates, they are entered into the system by the State from a workstation. Data that can be modified at the workstation includes manufacturer data, coverage dates for drug rebates.

The business processes required to support the Drug Rebate function include:

- (1) Maintain Drug Rebate Database
- (2) Drug Rebate Invoices
- (3) Payment Tracking
- (4) Interest Tracking and Recovery
- (5) Invoice Corrections
- (6) Dispute Resolution
- (7) Report Generation

5.6.17.3.1 Maintain Drug Rebate Database

- (1) Maintain a drug manufacturer database with all data necessary for processing drug rebate invoices including NDC level data a listing of manufacturers having drug rebate agreements with CMS or having a DHSS-approved drug rebate exemption. Update the database quarterly with information supplied by CMS.
- (2) Provide the capability to collect supplemental rebates, with separate invoicing and separate accounting.
- (3) Ensure that all drug rebate tables and databases are available for query and reporting by the users either on an isolated basis or with integration of data from other MMIS tables and databases.
- (4) Maintain appropriate and accurate information pertaining to unit rebate amounts, as well as other data elements necessary for the generation of accurate rebate invoices, including data required under the Veterans Health Act of 1993.
- (5) Provide on-line access to a minimum of ten (10) years of drug rebate data on-line, with data over ten years archived and retrievable within twenty-four (24) hours of a request.

- (6) Utilize NDC termination dates and DESI flags on the drug database from data supplied by First Databank.
- (7) Extract listing of quarterly unit rebate amounts and any address changes for drug manufacturers from the quarterly CMS tape.
- (8) Identify those public health services providers, reported by the HRSA Office of Drug Pricing, that have separate drug rebate agreements with manufacturers under the Veterans Health Act of 1993 Section 340(b), with effective dates.

5.6.17.3.2 Drug Rebate Invoices

- (1) Summarize recipient utilization of pharmaceutical products to determine appropriate rebates from drug manufacturers.
- (2) Generate invoices and cover letters on a quarterly basis (or more frequently, if CMS revises the rebate schedule) to drug manufacturers having rebate agreements with CMS using the tape data supplied by CMS and the pharmacy paid claims data. Invoices and cover letters are sent on paper or via electronic media.
- (3) Maintain all data used to generate invoices for research and resolution of errors.
- (4) Calculate quarterly rebate amounts due from each manufacturer based on NDC codes, the number of units per NDC from paid pharmacy claims (both original and adjusted claims), the CMS listing of quarterly unit rebate amounts, interest, and prior period adjustments.
- (5) Suppress invoice production if the amount of the invoice will not be cost effective to collect. The current threshold amount determined by DHSS is twenty-five dollars (\$25.00); future changes to the threshold amount will be determined by DHSS.
- (6) Exclude from drug rebate invoices those entities that receive drug pricing under the 340(b) program.
- (7) Process requests from drug manufacturers for detail claims listings to support drug rebate invoices.
- (8) Produce a drug utilization tape to send to CMS.
- (9) Add utilization information from claims using HCPC in the form of J-Codes, Q-Codes, and S-Codes that represent drugs. Following MMIS re-development link claims with NDC's coming from CMS 1500's and 837P.

5.6.17.3.3 Payment Tracking

- (1) Post payments from the drug manufacturers at the NDC level upon receipt and reconcile any discrepancies between the invoiced amount and the amount paid by the manufacturer.
- (2) Deposit drug rebate checks in a State-designated bank account within 24 hours of receipt.
- (3) Track payments and other correspondence from drug manufacturers regarding the drug rebate process and perform follow-up activities on unpaid invoices.
- (4) Provide follow-up reports to flag invoices which have not been paid.

5.6.17.3.4 Interest Tracking and Recovery

- (1) Produce and mail late penalty interest invoices on unpaid balances that are still outstanding for thirty-eight (38) days or more.
- (2) Maintain federal T-Bill interest rate data for calculating overdue interest charges, and calculate interest on invoices that are still outstanding after thirty-eight (38) days. Display the interest as a field on the drug rebate database.
- (3) Create drug rebate accounts receivable accounts due when unpaid balances exceed 38 days to transmit to AKSAS.

5.6.17.3.5 Invoice Corrections

- (1) Manually enter corrections to invoices when necessary based on the resolution of disputes or other factors as approved by the State, and produce report on corrections to invoices. Obtain DHSS approval of all invoice adjustments over \$1,000.00.
- (2) Include the capability to change a manufacturer's invoice and the quarterly CMS tape after manual review and before each item is sent.
- (3) Maintain an audit trail of all changes made to invoices and flag invoice records that have been changed to facilitate future processing.

5.6.17.3.6 Dispute Resolution

- (1) Maintain a separate database of all paid pharmacy claims for disputed products (NDCs) for the rebate quarter under review to facilitate dispute research.

5.6.17.3.7 Report Generation

- (1) Generate reports listing prescriptions which require verification from the pharmacies
- (2) Produce report files on the drug rebate processing that are accessible on-line with the ability to print the reports upon request of the State.
- (3) Provide monthly reports to DHSS of drug rebate activities, including amounts collected, outstanding receivables, number of disputes received and resolved, and other data on the processing of drug rebate information.

5.6.17.4 Interfacing Systems

- (1) CMS for manufacturer rebate data
- (2) HRSA Pharmacy Affairs for public health services providers with separate agreements
- (3) MMIS

5.6.17.5 Inputs

- (1) National Drug Code File Request
- (2) Accounts Receivable Data Request
- (3) Paid Claims Data Request

5.6.17.6 Outputs

- (1) Manufacturer invoices for drug rebates
- (2) Cover letters for drug rebate invoices sent to manufacturers
- (3) CMS drug utilization tape
- (4) Reports on drug rebate processing including collections, outstanding receivables, disputes received and disputes resolved
- (5) Quarterly drug rebate information in a form compatible with HCFA-64 reporting requirements
- (6) Reporting the top ten manufacturers with outstanding drug rebate invoices on quarterly HCFA 64 data
- (7) Creating a quarterly file of drug rebate amounts per unit to download for drug rebate processing
- (8) Producing reports on overpayments and outstanding rebate payments by NDC
- (9) Creating a weekly drug rebate report of outstanding balances with amounts adjusted and amount received at the labeler level

5.6.17.7 Performance Standards

- (1) Update the manufacturer rebate data within five (5) days of receipt of the update from CMS.
- (2) Generate and mail invoices to manufacturers within five (5) days of the receipt of the CMS drug rebate tape.
- (3) Generate initial collection letters to non-responding manufacturers thirty-eight (38) days from the mailing date of the invoice.
- (4) Collect at least ninety percent (90%) of the total of accounts receivables outstanding at the beginning of the quarter plus invoices issued during the current quarter by the end of the current quarter.

5.6.18 Data Warehouse (DW)/Decision Support System (DSS)

The DW/DSS must consist of a repository for all the data requested to support the functionality outlined in section 5.6. It must be a function-rich set of business intelligence tools that will empower the program to focus on its health care and operational activities data analytics and overall decision-making capabilities. At a minimum, it must provide access to information, including on-line access to flexible, user-friendly reporting, analysis, and modeling functions. The front-end tools of the DW/DSS must support multiple levels of users which range from executive users to power users. The tools supplied must provide abilities to perform query and analysis, report writing, and tools for data access and modeling. The DW/DSS will provide decision-making support and standardized reporting with the ability of users to develop semi-structured and non-structured decisions. It also will provide the ability to easily detect, analyze, and report patterns in Medicaid program expenditures and utilization as well as access to costs, use, and quality of care.

The DW/DSS further provides on-line report and data extraction capabilities that allow the user to access and manipulate information from claims history, prior authorization, reference, recipient, provider, and financial files and tables. The data provided by the system supports group and independent decision-making and integrates decision making among organizational groups and levels. The DW/DSS must allow users to develop queries for modeling, data analysis, forecasting, and trend analysis. Information obtained via this reporting capability may be used for research, planning, and investigation purposes.

The DW/DSS must provide the following functionality to users:

- (1) Be extremely easy to use without needing extensive training.
- (2) Provide users with the ability to compare aggregate and summary-level information and to identify problems and opportunities.
- (3) Be designed to maximize the professional efficiency and effectiveness of managers and professional staff in their access, use, presentation, and reporting of information.
- (4) Provide non-technical end-users with an extensive array of executive-level yet powerful and highly flexible capabilities for users to identify and test assumptions about the program, including Performance Standards (particularly with regard to budget management, cost containment, utilization management, program operations, and access and quality of care).
- (5) Must have significant privacy and security features to allow for the sharing of data among State agencies. This would also include the support of de-identified data logic so that members receiving services from multiple agencies can be “linked” without violating any HIPAA or Federal statutes.
- (6) Implement a data model that is flexible and allows for the addition of new data elements with minimal effort.
- (7) Include all data elements to support those efforts described in this RFP.
- (8) Support for the State of Alaska – DHSS and designee’s access via internet and intranet.
- (9) Support application delivery both internal and external to the State of Alaska - DHSS WAN.
- (10) Built upon a platform that will be reliable, stable and allow for recoverability in any event.
- (11) Include a tool for extraction, transformation and load (ETL) that will allow for fast data transfers, easy data mappings preferably through visual tools, data cleansing, have some type of metadata management capabilities and built in quality controls.
- (12) Convert and load all data necessary to operate the new DW/DSS and produce a set of comprehensive balancing reports that demonstrate the conversion was successful and contains the appropriate data.

The DW/DSS defined in this document is intended to replace the current decision support capability incorporated in the STARS and JUCE models and to add operational activities tracking data.

The State will use MMIS generated operational reporting to monitor daily system performance recognizing that DW/DSS updating processes impact the timeliness of this information. To the extent possible, all other reporting will be supported by the DW/DSS.

5.6.18.1 Business Needs

The goal of the DW/DSS function is to provide analytical and decision-making capabilities to Medicaid data users through access to expenditure and service utilization data, as well as the tools to extract and analyze data. Currently, this data is obtained by reviewing existing production reports, viewing on-line screens, or generating new reports through either ad hoc query requests to the fiscal agent or queries through STARS, JUCE, or FHSC Remedy/CRM. The objective of the DW/DSS is to make data available more quickly and easily, thus eliminating the need to retrieve such information directly from the MMIS. As such, the DW/DSS should accommodate all levels of users and allow them to retrieve data without relying on programmers.

Specific goals to be met by the DW/DSS function include:

- (1) Quality of care measurements, such as (but not limited to):
 - (a) Admissions
 - (b) Re-admissions
 - (c) Discretionary surgeries
 - (d) Complications of treatment
 - (e) C-sections
 - (f) Deaths
- (2) Identification of inpatient and preventive ambulatory episodes of care.
- (3) Forecasting program costs accurately and evaluating cost containment and quality improvement initiatives.
- (4) Identifying high-cost cases to better focus utilization review and case management programs.
- (5) Analyze expenditures by data elements contained in the DW/DSS.
- (6) Provide the capability to support budget forecasting.
- (7) Analyze provider referral patterns and service delivery patterns.
- (8) Analyze billing practices by individual providers, provider types, or combination of providers.
- (9) Analyze the impact of changes made in the program.
- (10) Analyze and model proposed changes in program coverage, benefit coverage, or other characteristics.
- (11) Project the cost of program services for future periods based on past and current trends.

- (12) Compare current costs with previous period costs to establish a frame of reference for analyzing current expenditures.
- (13) Analyze the various areas of expenditures to determine areas of greatest cost or variance. Expenditures shall be inclusive of adjustments.
- (14) Review the utilization of services by various beneficiary categories, location, or other indicator to determine the extent of participation and relative cost.
- (15) Analyze progress in accreting eligible Medicare Buy-In beneficiaries and analyze the cost-effectiveness of purchasing coverage.
- (16) Review provider participation with respect to the number of beneficiaries served and analyze the capacity of providers to handle projected service demands.
- (17) Review claims processing and payment information to determine if providers are being reimbursed without unnecessary delay.
- (18) Develop third-party payment profiles to determine where program cost reductions might be achieved.
- (19) Perform geographic analysis of expenditures, beneficiary participation, and provider participation, and so on.
- (20) Provide comprehensive operational and financial performance reporting and trending analysis over time.

The DW/DSS must be a relational database that includes the full claim record for adjudicated and other recipient, provider, reference, prior authorization, and financial transaction data from the MMIS. In addition, the DW/DSS must include funding source data, financial adjustments, and other expenditures which were not processed in the MMIS but will be provided by Administrative Services and State-specified data from Vital Statistics and Occupational Licensing. It must also include tracking data as defined in 5.6.21. The database must maintain ten years of data history in order to identify and examine trends. In addition, the DW/DSS will include summary level databases of appropriate information to facilitate report generation and reduce response times. The DW/DSS needs to be updated at least weekly by the fiscal agent or provide access to current MMIS files directly from the DW/DSS.

The DW/DSS will provide certifiable MARS and SURS reporting, and eliminate a separate MARS and SURS reporting system. The State expects users to be able to view reports at a workstation, eliminating the need to separately print and distribute MARS reports.

DHSS and other authorized DHSS staff need the ability to make routine requests for summary information and one-time queries without relying on programmer analysts or other technical experts. Routine requests from queries and standard queries for management, such as budget, operations, and utilization statistics, will be made available on-line to avoid the need to print and distribute. Analysts seeking to review service delivery and utilization for a particular group will obtain that information at their desk, eliminating the need to search through hard copy reports.

5.6.18.2 State Responsibilities

- (1) Define overall MMIS data elements required for the DW/DSS.

- (2) Describe the functional groups of users and types of reporting to assist in the data mart creation.
- (3) Participate in the Contractor's analysis of the DW/DSS environment.
- (4) Define parameters for ad hoc reports and provide requests to the Contractor for more complex report.
- (5) Request reports to add to the standard report generation list.
- (6) Prioritize requests for ad hoc reports and file extractions.
- (7) Monitor production and review ad hoc reports.

5.6.18.3 Contractor Responsibilities

The DW/DSS is a tool that allows users to view data within a database and generate reports and models of that data as they desire. The DW/DSS will replace MARS and SURS reports. Such production reports will be identified early on, and generated on a regular schedule. Other reports will be generated on an as-needed, or ad hoc, basis.

DW/DSS tools provide the following functions:

- (1) Extract, transformation and load (ETL)
- (2) Database inquiry
- (3) Modeling
- (4) Planning
- (5) Forecasting
- (6) Program evaluation
- (7) Pseudo language for equations
- (8) Drill Down capabilities
- (9) Generation of unduplicated counts
- (10) What if queries
- (11) Graphics
- (12) Geographical mapping
- (13) Report generation
- (14) Aggregated and summarized data
- (15) Ability to define calendars (e.g., State fiscal year, federal fiscal year, calendar year, etc.)
- (16) On-line help
- (17) On-line look-up of data element and field definitions

To support the required functionality, the DW/DSS must provide the following:

- (18) Extract Data From MMIS And Other State Systems And Update DW/DSS Database

- (19) DW/DSS Query Capabilities
- (20) DW/DSS Reporting Capabilities
- (21) DW/DSS Graphics Capabilities
- (22) DW/DSS Analytic Capabilities
- (23) DW/DSS Decision-Making and Presentation Capabilities
- (24) Operational Support

5.6.18.3.1 Extract Data from MMIS and Other State Systems and Update DW/DSS

- (1) The database must provide access to current data. The DW/DSS must be updated at least weekly or may access current MMIS files directly for required data, and must include the following information:
 - (a) Claims
 - (b) Claims adjustments
 - (c) Claim specific and non-claim specific financial transactions, including data on ProShare and Reimbursable Services Agreement expenditures
 - (d) Consolidated accounting ledger data
 - (e) Drug rebate invoice and collection data
 - (f) Collections
 - (g) Accounts receivable
 - (h) Recipient eligibility, demographic, beneficiary, enrollment, program, LTC liability, lock-in, and roster history data
 - (i) BENDEX, EDB, SRF, and SDX data
 - (j) Provider entity data
 - (k) CLIA data including CLIA numbers, types, and certification dates
 - (l) Reference data, such as procedure, diagnosis, DRG, drug, and pricing
 - (m) Referral and pre-authorization of medical service data
 - (n) EPSDT data
 - (o) TPL data
 - (p) Vital Records data
 - (q) Occupational Licensing data
 - (r) Budgetary data
 - (s) Funding Source data
 - (t) Call center and EVS management reporting data
 - (u) Case tracking data
- (2) Application performance and availability requirements for the DW/DSS are the same as the MMIS system as a whole. The DW/DSS must be available 24 hours with the exception of an agreed upon maintenance window with data loads and offloads being conducted during weekends.
- (3) The DW/DSS must be balanced to the source data to assure the integrity of the data loads and their impact on the DSS tables. The Contractor will provide a balancing process and sufficient reporting to establish that all updates to the DW/DSS accurately and clearly reflect the MMIS and all other sources of base data used for the update. The Contractor

will conduct balancing for each update, and will confirm the accuracy and integrity of the update prior to making the DW/DSS available to users. Contractor will provide the all results to the State for review concurrently with their own internal review. Out-of-balance situations resulting from data load errors must be resolved within one business day of the update. Contractor will notify all users and the State of Alaska - DHSS of any problem or issue that affect data accuracy or integrity immediately. The Contractor must specify the efforts, timeline, and corrective action plans to resolve any problems as expeditiously as possible. All status and availability changes/updates must be posted to all users daily or as they occur.

- (4) The DW/DSS will include the ability to rollback updates as required to maintain the integrity and consistency of the data.

5.6.18.3.2 DW/DSS Query Capabilities

- (1) A user-friendly graphical query language to construct database queries that accommodates varying levels of user skills (from the basic, occasional user to the power user).
- (2) An on-line library/catalog for storage and retrieval of standardized or frequently used queries, with security levels (creator, user, read-only) to eliminate inadvertent changes to the query.
- (3) A flexible and easy to use, on-line capability for specifying query selection criteria (data element-specific for ad-hoc queries), query computation, sort, and format (report presentation) characteristics and the capability to save and view or print the criteria used in the query.
- (4) Access to a “notes” field to input user information on the purpose of the query or other informational messages.
- (5) Access to the full range of data attributes on the database for building queries.
- (6) Ability to schedule queries to run during 'off-peak' hours and to save generated data sets automatically in a variety of different formats (.xls, .dbf, .txt, and html) to a specified directory on the DHSS LAN and DHSS WAN.
- (7) Options to select query report presentation to be displayed on-line, in multiple media with options to de-identify protected health information.
- (8) Allow for summary by State fiscal year, federal fiscal year, calendar year, and any combination thereof, and year-to-date, fiscal- year-to-date, from any point in time.
- (9) The ability to track claims on both an incurred (date of service) and paid (date of payment) basis.
- (10) The ability to reconstruct a stream of claim adjustments for a single service to identify the actual total amount paid and total units of service and to determine the amount paid and units of service within a given reporting period. This process will need to account for all claim adjustments (voids and credits) and perform appropriate decrements to amounts and units as a result of these transactions.

- (11) The ability to save extracted data within the DW/DSS, based on selected storage parameters, and the ability to retrieve the saved extracted data for use at a later time.
- (12) Selection parameter capability to have any correct/valid value, set of individual values, or range of values.
- (13) Capability to construct and utilize compound expressions that evaluate more than one comparison at a time, using any valid combination of logical operators (AND, OR, NOT, IF, ELSE, THEN), comparison operations (<, <=, >, >=, =, <>, not equal to), and parentheses.
- (14) A sampling capability that can generate statistically valid stratified random samples of items in the DW/DSS database with appropriate descriptive statistics and confidence levels.
- (15) Capability to generate random samples from all specified items (e.g., providers, recipients, claims) in the database, or from the results of a query, (e.g., all recipients under age 21, all providers with claims paid on specified dates).
- (16) Capability to execute queries that perform unduplicated counts (for example, unduplicated count of recipients receiving services), total counts (for example, total number of services provided for a given aid category), or a combination of unduplicated and total counts.
- (17) Capability to perform a minimum of four (4) level sorts for a requested query; and to drill-down to identifiable data.
- (18) Calculation capabilities, including: sum, average, count, minimum, maximum, subtotalling and grand totaling, calculation of percentiles, simple and complex cross-tabulation.
- (19) Statistical analysis capabilities and routines.
- (20) A selection of pre-defined, standardized calculations for use in generating queries such as, age, member months, elapsed time, utilization rates, per number of members, and ratios.
- (21) Capability to recreate query results previously generated by use of an "as of date".
- (22) Capability to estimate the query processing time to pre-define a maximum query processing time for both on-line and batch retrieval requests.
- (23) Capability to prioritize queries according to State-defined parameters at the individual query level and at the user level, and update priorities based on instructions from staff assigned by DHSS to have the security and authority to prioritize requests.
- (24) Capability for automatic and manual termination of queries that exceed State pre-defined processing time thresholds, including the capability for the user and/or system administrator level to manually terminate a query from the user work station.
- (25) Capture of the user's ID for each query and store the processing time, by user ID, of the query.
- (26) Capability to prompt user with suggestions of query structure for more efficient operation (wizard-type building for queries).

- (27) The ability to specify the number of returned records in a group when executing a query and to estimate the total time to complete based on the initial return.

5.6.18.3.3 DW/DSS Reporting Capabilities

- (1) Print preview capabilities.
- (2) Provide a selection of report templates defined by DHHS of information used by DHHS in the management of its programs and decision making.
- (3) Report writing capabilities that support the efficient use of format, text type/fonts, screen grid designs, and illustrations to enhance the visual display of information.
- (4) Page formatting features for creating presentation quality reports.
- (5) Capability for user-defined headers, footers, columns, and rows with header/footer information including items such as: date, run time, and page numbers on reports.
- (6) Capability to segregate and subtotal data, define page breaks based upon user-defined parameters within reports.

5.6.18.3.4 DW/DSS Graphics Capabilities

- (1) Geographical mapping using ARC/INFO, Arc View, or a functionally equivalent software product.
- (2) A range of graph types for data presentation, including:
 - (a) Bar chart
 - (b) Pie chart
 - (c) Stacked
 - (d) Side-by-side bar charts
 - (e) Single and multiple line charts
 - (f) Three (3) dimensional graphs
 - (g) Tree graphs
 - (h) Probability plots
 - (i) Trend lines
 - (j) Other common-use graphical presentation methods
- (3) Customization of chart attributes, including orientation, legends, tic marks, intervals, and scaling.
- (4) Ability to manipulate the font style and size of any embedded text or numeric information.
- (5) Standard editing capabilities as well as optional capabilities for shadowing, mirroring, highlighting, and flipping axis.
- (6) Capability to interface with a variety of printers, including laser, dot matrix, and plotter.
- (7) Enhanced graphical representation capabilities that can interface with other programs, such as power point and web based applications.
- (8) Gray scale and pattern printing and a symbol library.

- (9) Able to map at the borough, region, municipality, legislative district or zip code. Geo-coding of beneficiary and providers should be supported.

5.6.18.3.5 DW/DSS Analytic Capabilities

- (1) Summary and comparison of utilization, costs, expenditures, and services. This includes modeling and forecasting capabilities.
- (2) Trend analysis (as related to systems operation, costs, utilization, expenditures, services, disease categories) for all elements in the database.
- (3) Sub setting on any field or combination of fields in the database.
- (4) Providing a variety of statistical analysis techniques.

5.6.18.3.6 DW/DSS Decision-Making and Presentation Capabilities

- (1) Provide users with extensive and highly flexible capabilities for the visual presentation of information in tabular and graphic/chart form.
- (2) Use modern type and typographic techniques to provide a high degree of legibility and readability, and to provide the capacity for printing to high quality laser printers.
- (3) Provide high resolution on-screen multicolor displays of information and must provide flexible capability for users to print reports, text, tables, maps, and charts/graphs in hard copy form (black, white, multi-color) using high resolution printers (600 dpi or greater print resolution).
- (4) Present all information in well designed, polished tables and high-quality graphs, charts, and maps.
- (5) Provide users with executive-level features for the statistical and economic analysis of information.
- (6) Capability to compress reports to create self-executable compressed files to electronically transfer either inside or outside the agency using appropriate security measures for transfer of data.

5.6.18.3.7 Operational Support

- (1) Prepare and process updates to the DW/DSS using input from the MMIS and other State agencies.
- (2) Maintain a minimum of ten years of data in the DW/DSS.
- (3) Ensure that data is correctly updated in the DW/DSS and work with the other State agencies providing data to correct any errors identified in the update process.
- (4) Provide update and balancing reports to DHSS to verify the update process.
- (5) Provide the capability to reverse a DW/DSS update from the MMIS or other data source if reprocessing is required due to erroneous data received.
- (6) Load budget allocations for various categories of service and eligibility groups for the fiscal year and measure expenditures on an ongoing basis.

- (7) Operate the DW/DSS to meet the performance requirements for updates, response times, and hours of operation.
- (8) Provide and maintain complete documentation on the internet in MS-Word or PDF format, including a detailed user manual. Documentation must clearly define the operation and capabilities of the platform, and should include extensive “how to” examples.
- (9) Provide context sensitive application help.
- (10) Provide a data element listing and the capability to look up schema, element linkage and keying, and element descriptions and definitions field look-up functionality accessible to all users (this may be an external application but needs to be available simultaneously to the DW/DSS user).
- (11) Respond to State requests for information concerning the operation of the DW/DSS and production of ad hoc reports.
- (12) Make available at least one full-time ad hoc reporting specialist in Anchorage and one in Juneau to assist users in the development of specifications, research problems, review of production output and report formats, and to prepare specifications and produce reports of a more complex nature.
- (13) Update the application and reporting documentation as changes occur.
- (14) Develop and implement an automated update process to include the following data in the DSS from sources external to the MMIS:
 - (a) Financial adjustments from Administrative Services
 - (b) Expenditures, including those from ProShare and Revenue Sharing Agreements, from Administrative Services
 - (c) Funding Sources from Administrative Services
 - (d) Vital records data from Vital Statistics
 - (e) Provider licensing data from the Division of Occupational Licensing
 - (f) Case tracking data
- (15) Monitor the amount of data stored in saved extracts on the database and the DW/DSS usage to insure that the performance requirements are being met.
- (16) Maintain and upgrade the DW/DSS on an ongoing basis to provide continuous improvements in DSS performance and capacity.
- (17) When new versions of software used in the DW/DSS become available, advise DHSS of the potential benefits of the enhancements or upgrades.
- (18) Develop and obtain DHSS approval for criteria and procedures to purge saved extract files. Purge saved extract file data according to the approved purge process.
- (19) Provide a standard query via the DW/DSS to extract denied and pended claims for a provider to facilitate research and calculation of potential payable amounts for a provider. The query should include:
 - (a) Specification of parameters, including but not limited to provider number or numbers and claims types for inclusion or exclusion

- (b) Extraction of claims for a specified date range (incurred dates and/or payment dates)
- (c) Pricing of the claims in the universe of extracted claims
- (d) Elimination of duplicates within the universe of claims extracted
- (e) Production of a report or data file for analysis of the potentially payable claims

5.6.18.4 Interfacing Systems

- (1) MMIS for provider, recipient, reference, claims, TPL, and prior authorization data
- (2) Financial adjustments from Administrative Services
- (3) Expenditures, including those from ProShare and Revenue Sharing Agreements, from Administrative Services
- (4) Funding Sources from Administrative Services
- (5) Vital records data from Vital Statistics
- (6) Provider licensing data from the Division of Occupational Licensing

5.6.18.5 Inputs

- (1) Claims History
- (2) Recipient/Beneficiary/Eligibility/other demographic data
- (3) Provider/Provider Rate/Provider Ownership/other demographic data
- (4) TPL/TPL Insurer/TPL Tracking
- (5) Reference (Procedure, Drug, Diagnosis Code, DRG, RBRVS, etc.)
- (6) EPSDT
- (7) Long Term Care
- (8) Prior Authorization

5.6.18.6 Outputs

- (1) Claims History
- (2) Recipient/Beneficiary/Eligibility
- (3) Provider/Provider Rate/Provider Ownership
- (4) TPL/TPL Insurer/TPL Tracking
- (5) Reference (Procedure, Drug, Diagnosis Code, DRG, RBRVS, etc.)
- (6) EPSDT
- (7) Long Term Care
- (8) Prior Authorization
- (9) Standard reporting to meet MARS requirements, as well as ad hoc reporting capabilities
- (10) Standard reporting to meet SURS requirements, as well as ad hoc reporting capabilities

- (11) Standard reporting as identified for each of the major information sets included in the DW/DSS

5.6.18.7 Performance Standards

- (1) Update DW/DSS on a weekly basis from the MMIS and all data sources This would also include any ETL processing necessary. Balancing and validation reports must be prepared and submitted to DHSS to demonstrate the update was successful.
- (2) Resolve all DW/DSS data load errors within one (1) business day of identification of the error.
- (3) Resolve DW/DSS functionality errors within five (5) business days of identification of the error.
- (4) DW/DSS application availability is defined as are all MMIS system components with the same daily availability, performance standards, and maintenance timeframes as the MMIS system.

5.6.19 Management and Administrative Reporting

The information access and decision support function encompasses both automated and manual processes required to provide standard MMIS Management and Administrative Reporting (MARS). These functions are primarily the responsibility of the Contractor, and follow DHSS policy decisions.

Text within this section presents standard MARS reporting requirements that must be supported by the new system including the DW/DSS. The State recognizes that the Contractor's solution for meeting these requirements may include alternative reporting methods, content, and formatting for presentation of data. During the Requirements Analysis the Contractor will present, walk through, and educate State staff about this reporting conceptual equivalency. Reporting methods, content, and formatting will be resolved during this process, addressing both the program management requirements of the State and the new functionality offered by the Contractor.

5.6.19.1 Business Needs

The primary objectives of MARS are to provide:

- (1) Information on Medicaid program costs and trends with the ability to analyze these historical trends and predict the impact of policy changes on programs.
- (2) Reports that monitor the progress of claims submission and claims processing activity.
- (3) Information on provider performance showing the extent of participation and service delivery.
- (4) Reports of recipient enrollment, participation, and program usage analysis.
- (5) Information and statistical data on the status of the State's waiver programs.
- (6) Provide and fulfill federal reporting requirements for State Medicaid Programs, including but not limited to MSIS and MMA.

5.6.19.2 State Responsibilities

- (1) Define required MARS reports and the format, content, frequency, and media for the reports. The State will focus these requirements on NARA standards for record storage.
- (2) Approve, in writing, the content, format, and documentation of all MARS reports.
- (3) Define State and federal budget categories of service, eligibility codes, provider type and specialty codes, district codes, accounting codes, and other codes necessary to produce the reports.
- (4) Define the distinct characteristics to categorize and report by separate and unique program areas.
- (5) Initiate or approve report changes, additions, deletions, and other maintenance to MARS reports.
- (6) Monitor production of all reports and review reports produced to assure compliance with RFP and contract requirements.
- (7) Review balancing reports to ensure internal and external report integrity.
- (8) Provide the Contractor with budget data required for the production of specified MARS reports.
- (9) Review provider costs and establish a basis for cost settlements or compliance reviews.
- (10) Respond to requests from other State divisions and CMS for data on the Medicaid program requiring the use of MARS reports.

5.6.19.3 Contractor Responsibilities

The functional analysis describes the business processes required to meet the objectives of the MARS business area. To support the MARS functions, the business processes include:

- (1) Operating, balancing and maintaining the MARS function according to all federal MMIS and State requirements.
- (2) Producing MARS reports in the media, format, and schedule needed by the State, including on-line MARS reports, the ability to produce reports in DHSS-specified media, and the ability to download MARS data to the State system. All MARS reports must be retained on optical storage for easy access via State LAN/WAN systems.
- (3) Providing and maintaining complete on-line documentation that meets the requirements specified in Section 5.7.5.5.1 on the LAN/WAN or website. The documentation must define the purpose of each report and specifically describe the definition of each reporting category (and the data elements contained therein), their sources, the formulas used in calculating any elements, the frequency of the report, and the report distribution and media.

5.6.19.3.1 Operate and Maintain MARS

- (1) Provide a MARS capability flexible enough to meet both existing and proposed changes in format and data requirements of federal statistical reporting without major reprogramming or expense.

- (2) Provide maximum flexibility to meet the unique reporting needs of the Alaska medical assistance programs.
- (3) Provide information on program status and trends, and the capability to analyze historical trends and predict the impact of policy changes on programs.
- (4) Provide expenditure, eligibility, and utilization data to support budget forecasts, monitoring and Medicaid program modeling, to include:
 - (a) Eligibility counts and trends, by aid category and benefit program
 - (b) Utilization patterns, by aid category and category of service or other State-approved category
 - (c) Expenditures and trends, by State, federal, or budget category of service
 - (d) Lag factors between date of service and date of payment based on expenditures to determine cash flow trends
- (5) Meet all enhanced requirements for the MSIS, including reporting of off-system payments and claiming of FFP. Meet all federal deadlines for providing MSIS data. CMS-2082 type data including demographics on gender, age, race, and ethnicity, is to be provided on-line in both federal and State fiscal year formats.
- (6) Provide information to support institutional and capitation fee setting.
- (7) Provide the capability to report institutional data using Medicaid and Medicare cost centers with a cross-reference between Medicaid and Medicare to facilitate reconciliation of data.
- (8) Cross reference State-defined categories of service and eligibility classes to federal classifications for purposes of satisfying Federal statistical and financial reporting requirements. Present these crosswalks to the State for approval.
- (9) Make recommendations for improvements to reporting processes and assist the State in designing non-federal reports.
- (10) Generate reports at monthly, quarterly, semiannual, annual and biannual intervals, as specified by the State.
- (11) Provide all required MMA file and MMA State Response File reports.
- (12) Produce the monthly CMS MMA file.
- (13) Receive, validate, process and post the CMS MMA State Response file as directed by the State.
- (14) Provide all files required by CMS to support the Medicare-to-Medicaid crossover claims process, including E01 and E02 transmissions.
- (15) Provide the capability to use the E02 transaction as a batch query tool to access information within the CMS and CMS Contractor databases to support claims processing and reporting requirements.
- (16) Provide for a standard DOS/DOP cut-off for cost audit data with the capability to report prior year data separately from current year data, as well as summary data for all claims.

- (17) Provide the flexibility to change or add provider types, categories of service, special programs, recipient categories of eligibility, provider types and specialties, and carry through corresponding changes in affected MARS reports.
- (18) Identify all third party liability activities that impact on financial and MARS reporting. These activities include but are not limited to, health insurance premium payments, outstanding receivables and payments for casualty recovery cases, eState recovery cases, insurance post payment billing and collection, and insurance premiums.
- (19) Maintain the integrity of data element sources used by the MARS reporting function and integrate the necessary data elements to produce MARS reports and analyses.
- (20) Maintain the uniformity and comparability of data through the MARS reports, and between these and other functions' reports, including reconciliation between comparable reports and of all financial reports with claims processing reports.
- (21) Provide counts of services based on meaningful units, by service category, defined by DHSS (e.g., days, visits, units (including decimals), prescriptions, etc.), counts of claims, and unduplicated recipient and provider counts.
- (22) Build and maintain a MARS master file/database using data elements identified from the recipient, provider, reference, third party resource, and claims history databases.
- (23) The MARS master file/database must include, but is not limited to, the following types of data:
 - (a) Adjudicated claims data
 - (b) Suspended claims data
 - (c) Adjustment/void data
 - (d) Financial transactions for the reporting period
 - (e) Reference data for the reporting period
 - (f) Provider data for the reporting period
 - (g) Recipient data (including LTC, EPSDT, cost of care, copays, benefits used and insurance information) for the reporting period
 - (h) Budget data from the AKSAS system
 - (i) Financial data, for the reporting period, from other inputs not available from or through the MMIS claims financial function
- (24) Capture and maintain the necessary data to meet all federal and State requirements for MARS. The Contractor will identify and provide all federal MARS reports required to meet and maintain CMS certification.
- (25) When an error in a MAR report is identified, provide an explanation as to the reason for the error and correct the report. When the error is the result of a MMIS system component error, the error will be corrected and a MARS rerun will be done.
- (26) The Contractor will analyze, recommend and provide for use of Minimum Data Set (MDS) information within MARS.
- (27) Capture and maintain on-line at least four (4) years of MARS reports and five (5) years of annual reports, with reports over four (4) years archived and available to DHSS within 24 hours of the request.

- (28) Provide on-line access to the MARS eligibility crosswalk and benefit program data and the capability to update or change the crosswalk and use these changes in the generation of MARS reports without major reprogramming or expense.
- (29) Provide totals and subtotals on all MARS reports.

5.6.19.3.2 Produce MARS Reports

- (1) Generate reports at monthly, quarterly, State fiscal year, federal fiscal year, or calendar year intervals, as specified by the State. Each report should include year-to-date and prior year totals in addition to monthly or quarterly totals. Reports showing paid amounts, outstanding amounts, and adjustments must also be produced on a calendar or fiscal year basis as specified by the State. Provide all reports with totals for Medicaid, totals for other programs, and grand totals that include the combined total for Medicaid and other programs. Generate all reports to be sent to CMS in the media required.
- (2) Generate reports to include the results of all financial transactions, whether claim-specific or non-claim specific.
- (3) Track and report expenditures funded by Medicaid and State-only programs for special populations.
- (4) Provide a system status dashboard available to specified State staff online.
- (5) After each MARS run and before delivering the reports to the appropriate State staff, within the established time frames, balance MARS report data to comparable data to ensure validity. Results of balancing will be provided to the State within two business days after completion of the production run. Balancing must include accuracy and consistency verification of process summaries within and between MARS reports, other MMIS input components and claims processing reports.
- (6) Respond to State inquiries and requests for information concerning MARS reports.
- (7) Provide data to other State agencies upon the request of DHSS. The Contractor may make reasonable charges to other States or other State agencies requesting special reports with the approval of DHSS.
- (8) Produce, submit and correct, if necessary, the MSIS/CMS Tapes according to CMS time frames. Media may change based on CMS and State approval.
- (9) Provide hospital and LTC reports on request to include details and summary information by facility on rates, patients, patient days, admission and discharge data, and payments (including TPL amounts and patient liability/cost of care payments) for the current period and year-to-date by payment date or service date range.
- (10) Produce automated CMS-372 and other specified waiver reports.
- (11) Produce all required CMS MMA files in a timely and accurate manner.
- (12) Process all CMS MMA response files in a timeline approved by the State.
- (13) Produce reports of TEFRA clients (eligibility code 54) in the same format as the waiver reports, broken down by category of service, date of payment, recipient, and summary for all recipients.

- (14) Produce and deliver the following reports/files to other State agencies:
 - (a) Monthly data file to the DHSS data warehouse
 - (b) Recipient data to the Laboratory Services Division of DPH annually
 - (c) Recipient data to OCS annually
 - (d) Recipient and claim data to Vital Statistics annually
 - (e) Claim data to the Epidemiology Division of DPH annually
- (15) Provide the capability to produce MARS reports by program and plan. Reports for other State programs in addition to the standard MARS reports will be developed as system modifications.
- (16) Perform any necessary corrections and rerun, verify, and distribute corrected MARS reports when problems are identified.

5.6.19.3.3 Provide On-Line Documentation

- (1) Provide and maintain complete documentation as specified in Section 5.7.5.5.1 This documentation must be complete, including formulas and data elements for calculated fields.
- (2) Provide training in the use of the MARS function to State personnel on an ongoing, as needed, basis.

5.6.19.4 Interfacing Systems

- (1) CMS and CMS Contractors for provision of statistical data
- (2) CMS and CMS Contractors for receipt of statistical data
- (3) Other MMIS/DSS components
- (4) External users (State and Federal)

5.6.19.5 Inputs

The inputs to MARS are internal MMIS files of claims, provider, recipient, reference, financial transaction, budget, and financial data from sources external to the MMIS for both Medicaid and non-Medicaid categories.

5.6.19.6 Outputs

- (1) Medical Assistance Financial Status (MR-O-01)
- (2) Medical Assistance Program Status (MR-O-02)
- (3) Financial Summary (MR-O-03)
- (4) Expenditure Analysis (MR-O-04)
- (5) Medicare Participation Analysis (MR-O-05)
- (6) Provider Participation Summary (MR-O-06)
- (7) CMS 2082 Reports (MR-O-07 and MR-O-42 through MR-O-58)

- (8) Operations Performance Summary (MR-O-08)
- (9) Claims Processing Performance Analysis (MR-O-09)
- (10) Claims Processing Throughput Analysis (MR-O-10)
- (11) Error Distribution Analysis (MR-O-11)
- (12) Provider Participation Analysis (MR-O-12)
- (13) Cost Settlement Analysis (MR-O-13)
- (14) Cost Settlement Details (MR-O-14)
- (15) Provider Claims Filing Analysis (MR-O-15)
- (16) Provider Claims Filing Details (MR-O-16)
- (17) Third Party Payment Analysis (MR-O-17)
- (18) Provider Error Frequency Analysis (MR-O-18)
- (19) Provider Ranking List (MR-O-19)
- (20) Drug Usage Frequency Analysis (MR-O-21)
- (21) Recipient Participation Summary (MR-O-22)
- (22) District Participation Analysis (MR-O-23)
- (23) District Expenditure Analysis (MR-O-24)
- (24) Benefit Usage Analysis (MR-O-25)
- (25) Drug Usage By Eligibility Classification (MR-O-26)
- (26) Recipient Cost Sharing Summary (MR-O-28)
- (27) CMS 372 Home & Community-Based Waivers Report (MR-O-30)
- (28) CMS 372 Recipient Detail Report (MR-O-31)
- (29) TEFRA Client Report (new report)
- (30) CMS-120 Monthly Statistical Report, Part IV Section A (MR-O-36)
- (31) CMS-120 Monthly Statistical Report, Part IV Section B (MR-O-37)
- (32) Summary Report of Sterilizations and Hysterectomies (MR-O-38)
- (33) Detail Report of Sterilizations (MR-O-39)
- (34) Detail Report of Abortions (MR-O-40)
- (35) Detail Report of Hysterectomies (MR-O-41)
- (36) Claims Processing Statistics Report (MR-O-60)
- (37) Claims Processing Exception Report (MR-O-61)
- (38) Control File Transactions List (MR-O-63)
- (39) Healthy Baby Report Series (MR-O-67 through MR-O-80)
- (40) Lag Adjustment Factor Report (MR-O-81)

- (41) Financial Summary↓Month of Service ((MR-O-89)
- (42) Incurred Expense Report↓Month of Service (MR-O-90)
- (43) Incurred Expense Report↓Month of Payment (MR-O-91)
- (44) Recipient, Provider, Reference, and Claims Files for DPH-Epidemiology
- (45) CMS 416
- (46) MSIS
- (47) CMS 21
- (48) MMA Response File validation, audit trail and error reports
- (49) Monthly Management Summary Reports for Mental Health Services
- (50) Monthly Management Summary Reports for Substance Abuse Services
- (51) MMA monthly reports, including State Response file (SRF) data download in format compatible with desktop software applications, SRF monthly file summary, and SRF problem report
- (52) Medicare Part D Eligibles Reports, including Pharmacy system detail report of Part D eligibles without Plan Enrollments, an Aged Report of Part D ‘derived’ clients, Part D client claims paid, Part D client claims cost avoided, reconciliation report of Part D eligible clients with and without Part D plan enrollment, and tracking reports to demonstrate client information for Part D eligible clients before and after MMA State response file posting

5.6.19.7 Performance Standards

The following performance standards apply to all MMIS reports.

All standard production reports must be available on line for review by DHSS staff pursuant to the following schedule:

- (1) Daily reports – by 10:00 AM of the following business day.
- (2) Weekly reports – by 10:00 AM of the next business day after the scheduled production date.
- (3) Monthly reports – by 10:00 AM of the third business day after month end cycle.
- (4) Quarterly reports – by 10:00 AM of the fifth business day after quarterly cycle.
- (5) Annual reports – by 10:00 AM of the tenth business day after year end cycle (State fiscal year, federal fiscal year, waiver year or calendar year).
- (6) Balancing reports are to be provided to DHSS within two (2) business days after completion of the MARS production run.

Ninety-eight percent (98%) accuracy is required on all MMIS reports. The Contractor is expected to identify and correct any errors on reports. For report errors identified by DHSS, the Contractor has ten (10) business days to correct the error.

Meet all required CMS deadlines for submission of required federal reports.

5.6.20 Utilization Review and Quality Assurance

The Utilization Review and Quality Assurance function encompasses the Surveillance and Utilization Review (SURS) of providers and recipients in the Medicaid program, and PERM audits of claims. The Department will perform the SURS function, including making requests to update the SURS parameters and generating profile requests, with the fiscal agent providing support and assistance to the Department SURS staff, developing and maintaining the SURS control file, and producing the SURS profile and case reports.

Text within this section presents standard SURS reporting requirements that must be supported by the new system including the DW/DSS. The State recognizes that the Contractor's solution for meeting these requirements may include alternative reporting methods, content, and formatting for presentation of data. During the Requirements Analysis the Contractor will present, walk through, and educate State staff about this reporting conceptual equivalency. Reporting methods, content, and formatting will be resolved during this process, addressing both the program utilization review and quality assurance requirements of the State and the new functionality offered by the Contractor.

5.6.20.1 Business Needs

The primary objectives of the Utilization Review and Quality Assurance function are to:

- (1) Provide profiles, on request, of all health care providers and recipients through which the quality, quantity, timeliness of services, participation and access to services, and disease management can be identified and assessed, and exceptions noted.
- (2) Provide profiles, on request, of all providers, recipients, diagnosis, procedures, prior authorizations, and edits by health care programs through which the quality, quantity, timeliness of services, participation and access to services, and disease management can be identified and assessed, and exceptions noted. Health care program profiles must have the ability to profile any specific health care programs such as Medicaid, CAMA, Denali KidCare, Waivers, I.H.S, and other groups of providers, recipients, services, diagnosis, clinical indicators, procedures, or other data elements used to define a peer group as defined by the State.
- (3) Provide profiles, on request, of all diagnoses through which the quality, quantity, timeliness of services, participation and access to services, and disease management can be identified and assessed, and exceptions noted. Diagnosis profiles must have the ability to profile on any diagnosis code used and maintained by the Alaska MMIS.
- (4) Provide profiles, on request, of all procedures through which the quality, quantity, timeliness of services, participation and access to services, and disease management can be identified and assessed, and exceptions noted. Procedure profiles must have the ability to profile on any procedure code or procedure code modifier used and maintained by the Alaska MMIS such as CPT, ICD-9 surgical procedures, HCPC, ABC, Revenue, and CDT.

- (5) Provide profiles, on request, of all prior authorizations through which the quality, quantity, timeliness of services, participation and access to services, and disease management can be identified and assessed, and exceptions noted. Prior authorization profiles must have the ability to profile on any prior authorization data element or group of data elements, as defined by the Department, used and maintained by the Alaska MMIS.
- (6) Provide profiles, on request, of all system edits through which the quality, quantity, timeliness of services, participation and access to services, and disease management can be identified and assessed, and exceptions noted. System edit profiles must have the ability to profile on any system edit or group of edits, as defined by the State.
- (7) Provide continuous, interrelated statistics in concert with management reporting data to show how the total health care delivery system and its individual components are meeting program objectives.
- (8) Support management in the process of ensuring that only medically necessary and covered services and items are provided in the appropriate setting and at the lowest cost.
- (9) Assist in protecting Medicaid participants against over utilization, underutilization, and inappropriate health care services.
- (10) Provide required support for Medicaid fraud and abuse activities as appropriate.
- (11) Provide selective medical care data to monitor Professional Review Organization (PRO) and QIO activities.
- (12) Provide selective third party liability data to monitor TPL and TPL Contractor activities.
- (13) Provide a basis for conducting medical and fiscal reviews to verify that the paid health care services were documented and that payments were made in accordance with State and federal policies, regulations, and statutes.
- (14) Develop and maintain the SURS control file, balancing, and reporting.
- (15) Provide support to State staff by researching, preparing and organizing information, reports, and materials necessary for Recipient Lock-in Fair Hearings and Provider SURS case appeals.
- (16) Provide management with information to assist in overall program direction, supervision, and policy-making.
- (17) Provide the capability to ensure compliance with federal quality control standards and requirements to maintain the maximum level of federal financial participation.
- (18) Provide selected claims samples for review to allow for an analysis of recipient eligibility for services and the timeliness and accuracy of payments for services.
- (19) Examine and evaluate the adjudicated claims to determine whether the claims were processed properly, whether federal and State regulations were applied appropriately, and whether the claim was paid or denied correctly.
- (20) Identify and initiate corrective actions for any errors or anomalies found.
- (21) Provide the capability for State users other than SURS unit staff to utilize the SURS system capabilities to identify and research aberrant patterns.

- (22) Provide the capability to separately identify peer groups and parameters created in the SURS control file by other than SURS unit staff that utilize the SURS system.

5.6.20.2 State Responsibilities

- (1) Establish policy and make or delegate administrative decisions concerning the operation of, and any changes to, the utilization review and quality assurance function.
- (2) Investigate potential provider or beneficiary fraud or abuse or inappropriate billings to the Medicaid Program.
- (3) Act as liaison, as necessary, for agencies involved in SURS activities.
- (4) Updates the SURS control file and the parameters for the reports.
- (5) Determine or approve modification of reports to meet State and federal requirements, as necessary.
- (6) Monitor the Contractor's operation of the utilization review system.
- (7) Review cases and determine if further action is required.
- (8) Conduct on-site, full-scale investigations and audits of provider abuse or fraud of the Alaska Medicaid program to document non-compliance with regulations or laws, intentional misrepresentation of services, the occurrence of unnecessary or inappropriate services, or defects in the quality of care.
- (9) Define the parameters for high risk/high cost cases, chronic and catastrophic disease cases, signal health events, and episodes of care.
- (10) Define parameters and request ad hoc reports via the on-line request system or provide the Contractor with the parameters for more complex ad hoc reports.
- (11) Establish policy and make or delegate decisions regarding the administration of the recipient lock-in program.
- (12) Define all parameters regarding utilization to be used by the Contractor in administering the recipient lock-in program.
- (13) Approve the Contractor's procedures for recipient lock-in program administration.
- (14) Review the Contractor's referrals for the recipient lock-in program, and review and approve recipient lock-in program activity.
- (15) Monitor the Contractor's performance of recipient lock-in program activities.
- (16) Conduct appeals and fair hearings related to lock-in decisions as needed.
- (17) Respond to recipient inquiries regarding lock-in status and lock-in processes.
- (18) Approve the text and selection criteria for standard REOMBs.
- (19) Provide the text and selection criteria for targeted REOMBs.
- (20) Approve the frequency and distribution of all REOMBs.
- (21) Establish and provide to the Contractor the claims sample criteria.
- (22) Review the results of the claims audit.

5.6.20.3 Contractor Responsibilities

The business processes for the Utilization Review and Quality Assurance function include:

- (1) Surveillance and Utilization Review (SURS)
- (2) Recipient Lock-In
- (3) Recipient Explanation of Medical Benefits (REOMBs)
- (4) Payment Error Rate Measurement (PERM)

5.6.20.3.1 Surveillance and Utilization Review

- (1) Provide a SURS capability flexible enough to meet the data requirements and reporting requirements of federal and State statistical reporting.
- (2) Provide and maintain access to the claims history database and associated recipient, provider, prior authorization, third party liability, and reference databases, and access data, according to State parameters, on the SURS parameter file for reporting.
- (3) Generate statistical profiles, by providers, recipients, diagnosis, procedures, prior authorization, system edit, and other claim-based data, summarizing information on claims history submitted by each provider over a specified period of time.
- (4) Provide a methodology to classify recipients into peer groups using criteria such as age, sex, race, living arrangement, geographic location, lock-in status, program, eligibility code, eligibility sub-type, cash grant indicator, and other claims-based data for the purpose of developing statistical profiles.
- (5) Provide a methodology to classify providers into peer groups using criteria such as category of service, provider type, specialty, type of practice/organization, location, facility type, billing vs. rendering provider, provider size, prior year billed amount, and geographical area, and other claims-based data (e.g., diagnoses, procedures) for the purpose of developing statistical profiles.
- (6) Provide the capability to utilize provider information and other claims-based data to group recipients and recipient information and other claims-based data to group providers, including the use of lists and ranges (e.g., group, individual, several groups, several individuals, or combinations thereof), as well as the capability to create class groups using claims-based data irrespective of the provider and recipient.
- (7) Provide the methodology to classify diagnosis, procedures, prior authorizations, and edits into peer groups using criteria such as diagnosis code, diagnosis code range and group, procedure code, procedure code range and group, edit number, edit number range and edit group, prior authorization type, provider type, claim type, category of service, health program, benefit program, provider specialty, clinical indicators, recipient eligibility code, recipient eligibility subtype, recipient eligibility cash indicator, submitter number, submitter number groups, provider ID number, provider ID number groups, pricing method, HIPAA covered and non-covered entities, HIPAA compliant and non-compliant submitters, electronic or paper submitters, and other criteria as determined by the State.

- (8) Provide the capability to create geographic grouping based on village code, geographical code, judicial districts, election districts, public health districts, or other Alaska-specific geographic codes.
- (9) Provide the flexibility to vary time periods for reporting purposes and to produce and store reports on daily, monthly, quarterly, or any other frequency specified by the Department.
- (10) Generate statistical norms, by peer group, for each indicator contained within each statistical profile by using averages and standard deviations or percentiles and provide the capability for the DHSS to use these norms to set exception limits. Provide on-line access to view and update (i.e., add, change, delete) these parameters.
- (11) Maintain a process to apply weighting and ranking of exception report items to facilitate the identity of the highest deviators.
- (12) Identify providers, recipients, case managers, and other peer groups defined by the DHSS who exhibit aberrant practice or utilization patterns, as determined by an exception process, comparing the individuals' profiles to the limits established for their respective peer groups.
- (13) Develop and maintain an on-line, parameter-driven DHSS approved control file that allows the State to specify data extraction criteria, report content, parameters, and weighting factors necessary to properly identify aberrant situations. Provide for up to 500 report items on the control file for each peer group and 500 matrix items. Provide up to 100 class groups per category of providers, recipients, and diagnoses. Provide for saving SPR and other control file parameters so that the user will not have to re-create class groups or matrix/report items associated with them.
- (14) Provide online current State of the art profiling algorithms for all provider types and recipients.
- (15) Provide training and ongoing assistance to DHSS staff in developing updates to the SURS parameter file and in utilizing the features of the SURS system.
- (16) Prior to the implementation of the new system, convert the current SURS parameter file to the new SURS system.
- (17) After SURS conversion, update the SURS control file to include current procedures, diagnosis, edits, groups, and other criteria as approved by the DHSS.
- (18) Provide security levels as approved by the DHSS to allow non-SURS users to create peer groups, determine parameters, use exception processing and obtain reports and prevent non-SURS users from changing SURS control file parameters.
- (19) Generate profiles for group billers, individual rendering providers, and other combinations of providers separately based on group provider claims. Generate profiles on primary care case managers, including all referrals and other services received by their enrollees.
- (20) Generate lists of providers, recipients, and other peer group participants who are found to be exceptional, ranked in order using State-defined parameters.

- (21) Generate reports using up to thirty-six (36) months of the most recent paid and denied claims data, including adjustments and voids, for the analysis and development of all reporting.
- (22) Generate frequency distributions, as defined by the State.
- (23) Provide the capability to force/suppress exception processing for those participants specified by the State and generate reports of those forced or suppressed including begin and dates forced or suppressed.
- (24) Produce utilization review reports for providers, recipients, and other user-defined class groups.
- (25) Provide claim detail reports, with multiple user-defined select and sort formats and provide the ability to export these reports to the DHSS specified software such as Excel or Access.
- (26) Identify the amount of federal funds involved on utilization review profiles and show appropriate titles and totals.
- (27) Maintain thirty-six (36) months of utilization review and quality assurance reports available for on-line viewing and printing or downloading at State request.
- (28) Provide the ability to show, print, and record parameters used in the production of utilization review reports and queries on request.
- (29) The DW/DSS proposed for ad hoc reporting must be capable of supporting the following special report needs of the utilization review and quality assurance function:
 - (a) Detail of paid services, with sufficient information to facilitate analysis of data for the most recent thirty-six (36) months of paid claims for selected providers and recipients and access to ten (10) years of claims data for research and reporting
 - (b) Drill down capability from summary-level reports to individual provider/beneficiary reports to the underlying detail records
 - (c) Capability to perform detailed comparisons across provider and/or beneficiary peer groupings
 - (d) Capability to retrieve and combine claim detail data from multiple user-specified criteria used in generating SURS profiles into a single report or data file. For example, combine the claim detail from criteria associated with comprehensive office visits with the claim detail from criteria associated with referrals to other providers, and then sort the details by beneficiary name
 - (e) Use the on-line capability to graph, chart, and map SUR data. For example, when a particular criterion is used repeatedly over time, users must be able to graphically compare an individual's analysis results for that criterion to the peer group analysis results for that criterion over a user-specified period of time. Or, for example, the user must be able to map the location of all providers excepting for specified criteria using user-specified location (e.g., village, election district, or other State-specified geographical areas).
 - (f) Reports which identify all services received by recipients who are receiving a specific service or drug, are enrolled in certain programs, have a certain living arrangement, or are receiving services from certain providers or provider groups

- (g) Trending and frequency distribution reporting using State-specified criteria
 - (h) Ranking reports using State-specified criteria
 - (i) Targeted extract and parameter reporting
 - (j) Treatment analysis capability using combinations of diagnoses, procedures, and outcomes, to analyze signal health events and episodes of care
- (30) The system must provide for an automated interface with CMS for the Medicare/Medicaid Reinstatement/Sanction Report data.
- (31) Operate and maintain the utilization review and quality assurance system according to State specifications.
- (32) Perform research and provide the State with data and information on policies and regulations which were in place at the time questionable claims were paid, and provide claim copies and other supporting information upon request.
- (33) Initiate corrective action against actual misutilizers in accordance with DHSS decisions.
- (34) Provide data and information to the State upon request for cases that have been referred to the Medicaid Provider Fraud Unit in the Department of Law.
- (35) Provide staff to testify in court when requested by DHSS regarding claims processing, claims payment, or other fiscal agent activities.
- (36) At the request of the DHSS, notify by letter recipients who have received services within the last year from a provider who has been terminated or suspended as a result of the utilization review and quality assurance activities. Obtain prior approval from the DHSS of the text to be used in the letter.
- (37) Provide training to designated State staff in the utilization of all standard reports, use of the case management system, use of the SURS system and use of the ad hoc reporting capabilities.
- (38) Respond to State requests for information regarding utilization review and quality assurance data.

5.6.20.3.2 Recipient Care Management Program

- (1) Using utilization review and quality assurance reports, and medical records review by a qualified health care professional, identify and refer recipients to DHSS for the recipient care management program. State-defined criteria for identifying candidates for the recipient care management program include, at a minimum:
- (a) Number of physicians
 - (b) Number of pharmacies
 - (c) Number of ER visits
 - (d) Number of prescriptions
 - (e) Controlled drugs
 - (f) Diagnoses
 - (g) Total cost
 - (h) Complications of recipients' medical conditions
 - (i) Recipient's chronic illnesses

- (2) After reviews are complete and it is determined that the recipient's use of medical services is not medically necessary one of the following will be done with the DHSS approval:
 - (a) Recipient will be notified in writing that the DHSS will restrict their choice of providers; or
 - (b) Recipient will be notified in writing that the recipient's usage of Medicaid services will be monitored for 90 days
- (3) Recruit providers who are willing to serve as primary care providers in all geographical areas of the State. If no providers in a specific area are willing to serve, notify DHSS of the problem area.
- (4) Once the provider has been selected for the recipient, prepare and send the notice approved by the department to the recipient notifying the recipient of their selection and placement in the Care Management Program. This notice will also inform the recipient of their selected providers.
- (5) Set the management program indicator on the MMIS recipient database for each primary care provider for one year.
- (6) Re-assign a recipient to a primary care provider if a selected primary care provider requests the re-assignment or can no longer serve as the primary care provider, or the recipient moves to another geographical location or the department finds that the recipient does not have reasonable access to Medicaid services of adequate quality.
- (7) Enter information into the DPA eligibility system (EIS) for each selected recipient for the Care Management program. Coupons generated each month from EIS will include the name and address of the primary care providers selected for that recipient.
- (8) No less frequently than every three quarters, review the recipient's utilization to determine if the problem(s) have been corrected. If utilization is still high and medical records review support the need for continued placement in the care management program, notify the department and upon the department's approval extend the restriction for one additional year. If the over utilization has been corrected, release the recipient from restriction. Prepare and send notification letters to the primary care provider(s) and the recipient as approved by DHSS.
- (9) After a recipient has been released from the care management program restriction, review the recipient's utilization and medical records after two quarters to determine, if the recipient again meets criteria for placement in the care management program. Notify DHSS of the results of the review. Prepare and send letters to the primary care provider(s) and the recipient as approved by DHSS.
- (10) Log all recipient care management program activity in the case management system, including the type of activity and the date the activity occurred.
- (11) Provide information to DHSS regarding care management program records when requested for use in appeals and fair hearings.
- (12) Prepare and submit to DHSS all care management program activity and cost savings reports, including summary and status reports.

- (13) Provide monthly reports of all recipients in the care management program and those recipients being evaluated for participation in the recipient program.
- (14) Provide quarterly and yearly reports of all recipients in the care management with cost savings analysis based on quarterly and yearly comparisons.

5.6.20.3.3 Recipient Explanation of Medical Benefits (REOMBs)

- (1) Produce flexible, user-friendly Recipient Explanation of Medical Benefits (REOMBs) in accordance with federal regulations. Statements shall be clear and easy to read and in logical plain English.
- (2) Maintain a process to generate and distribute REOMBs monthly to all recipients or to a sample, defined by the State, of recipients receiving services during the reporting period.
- (3) Provide the capability to include State-defined return addresses (i.e., a standard return address for the regular monthly sample and an address specified by the requestor for targeted REOMBs) on the REOMBs and provide window envelopes in which the specified return address appears for return of the REOMBs.
- (4) Provide the capability to exclude confidential services from the REOMBs as defined by DHSS.
- (5) Provide the capability to produce targeted REOMBs with user-provided text and parameter-defined populations at the request of DHSS.
- (6) Produce and provide to DHSS, accessible on-line, summary and detail reports of REOMBs generated and mailed by type of sample (e.g., regular monthly sample, all recipients, and targeted samples) and a total for all REOMBs.
- (7) Produce mailing labels for REOMBs in the REOMB cycle, or provide window envelopes for mailing REOMBs.
- (8) Mail standard and targeted REOMBs to recipients on a monthly basis.

5.6.20.3.4 Payment Error Rate Measurement (PERM)

- (1) Generate a claims sample listing and control report after the last processing cycle of each month.
- (2) Generate recipient history profiles for each claim selected for the claims sample.
- (3) Provide on-line inquiry capabilities to support research of sampled claims.
- (4) Provide on-line access to the imaged claim documents in the sample.
- (5) Perform the adjudicated claims sampling assessment monthly.
- (6) Provide the selected claims samples for review based on the sample criteria provided by the State.
- (7) Receive and review monthly samples of Medicaid claims, both for hard copy and electronically submitted claims.

- (8) Provide recipient history profile and supporting documentation for each sampled claim, including a copy of the original hard copy claim or facsimile of the electronically submitted claim and any accompanying attachments.
- (9) Provide a monthly claims sampling assessment report to DHSS. Include in the report the results of the sampling, an explanation of discrepancies, and an analysis of trends in claims processing.
- (10) Develop a plan of action to correct errors discovered during the claims review and submit the plan to the State for approval.
- (11) Implement a State-approved corrective action plan within the time frame negotiated with the State.
- (12) Provide documentation to the State demonstrating that the corrective action is complete and meets State requirements.

5.6.20.4 Interfacing Systems

There are no automated external interfaces for the SURS function.

5.6.20.5 Inputs

- (1) SURS Parameter Updates
- (2) Strata Parameter Data for the Claims Sample
- (3) PERM Sampling Criteria

5.6.20.6 Outputs

The outputs for the Utilization Review and Quality Assurance function are listed below.

5.6.20.6.1 Surveillance and Utilization Review

- (1) Management Summary Reports
 - (a) Recipient
 - (b) Physician
 - (c) Inpatient
 - (d) Outpatient
 - (e) Long Term Care
 - (f) Dental
 - (g) Prescribed Drugs
 - (h) Other Providers
 - (i) Physician Treatment Analysis
 - (j) Inpatient Treatment Analysis
 - (k) Home Health
 - (l) Chiropractor Services
 - (m) Laboratory/Radiology
 - (n) Medical Supplier
 - (o) Durable Medical Equipment

- (p) Mental Health Services
 - (q) Vision Services
 - (r) Personal Care Services
 - (s) Therapy Services
 - (t) Rural Health Services
 - (u) Transportation Services
 - (v) Rehabilitation Centers
 - (w) Accommodation Services
 - (x) EPSDT Services
 - (y) Primary Care Case Manager
 - (z) Mental Health Prepaid Contractor
 - (aa) FQHC
 - (bb) Hospice
 - (cc) Any other category specified by the user
- (2) UR Management Summary↓Frequency Distribution
- (3) UR Management Summary↓Matrix Totals
- (4) Summary Profile Reports
- (a) Recipient
 - (b) Physician (Individual and Group)
 - (c) Inpatient
 - (d) Outpatient
 - (e) Long Term Care
 - (f) Dental
 - (g) Prescribed Drugs
 - (h) Other Providers
 - (i) Physician Treatment Analysis
 - (j) Inpatient Treatment Analysis
 - (k) Home Health
 - (l) Chiropractor Services
 - (m) Laboratory/Radiology
 - (n) Medical Supplier
 - (o) Durable Medical Equipment
 - (p) Mental Health Services
 - (q) Vision Services
 - (r) Personal Care Services
 - (s) Therapy Services
 - (t) Rural Health Services
 - (u) Transportation Services
 - (v) Rehabilitation Centers
 - (w) Accommodation Services
 - (x) EPSDT Services
 - (y) Primary Care Case Manager
 - (z) Mental Health Prepaid Contractor
 - (aa) FQHC
 - (bb) Hospice

- (cc) Any other category specified by the user
- (5) Claim Detail Report
- (6) Special Profile Reports
- (7) Control File Reports
- (8) Class Group Report
- (9) Input Balancing Report
- (10) Profiling Control Reports
- (11) Exception Ranking Report
- (12) Targeted Utilization Reports
 - (a) Ambulatory and inpatient services provided to nursing home residents within a single report by long term care facility (long term care wraparound reporting)
 - (b) LTC physician detail identifying the number of visits to LTC facilities, by rendering providers, by provider number, and gives details for recipients, including date of service and amount billed
 - (c) Identification and reporting of high risk/high cost cases, including paid claim detail by recipient
 - (d) Identification and reporting of chronic and catastrophic disease cases, including paid claim detail by recipient
- (13) Complaints/Tips Report
- (14) Selected Case Report

5.6.20.6.2 Recipient Care Management Program

- (1) Monthly Care Management Recipient Report
- (2) Recipient History Profiles
- (3) CMS Management Summary Reports
- (4) CMS Case Summary Reports
- (5) Status Report
- (6) Financial Report

5.6.20.6.3 REOMB

- (1) REOMBs
- (2) REOMB Summary Report
- (3) REOMB Detail Report

5.6.20.6.4 CPAS

- (1) Claims Sample Strata Selection Report
- (2) Claims Sample Control Report

- (3) Recipient History Profiles
- (4) Claim copies and supporting documentation
- (5) Data from supporting system databases (recipient, provider, reference)

5.6.20.7 Performance Standards

- (1) Produce and distribute reports in accordance with the schedule specified in Section 5.6.19.7.
- (2) Produce and mail REOMBs by the 15th calendar day of the month.
- (3) Perform adjudicated claims sampling assessment and provide outcome reports to the State within five (5) business days of month end.

5.6.21 Case Tracking

The case tracking requirements may be fulfilled using a single integrated case tracking system, or multiple tracking systems that meet the requirements. In addition to the overall requirements identified here, specific tracking requirements for some of the functions are included in the sections that address the specific functions (e.g., Provider Enrollment, Provider Inquiry, TPL, etc.)

5.6.21.1 Business Needs

The business needs for the Case Tracking function are:

- (1) Provide the capability to track, monitor, and report on fiscal agent activities.
- (2) Provide the capability to track the status of specific activities.
- (3) Provide the capability to automatically produce form letters.
- (4) Provide a tool for efficient and cost effective operations geared to continuous improvement in overall services.

5.6.21.2 State Responsibilities

- (1) Define activities to be tracked via case tracking capabilities.
- (2) Define the data to be included in the case tracking system(s).
- (3) Define the reporting to be provided for case tracking activities.
- (4) Approve the Contractor's procedures for updating the case tracking system.

5.6.21.3 Contractor Responsibilities

- (1) Provide integrated on-line case management capability to track the following activities:
 - (a) Appeals and fair hearings
 - (b) Provider and recipient telephone calls and correspondence
 - (c) Provider and staff training
 - (d) Provider manuals and other publications

- (e) Provider enrollment
 - (f) Suspended claims
 - (g) Prior authorizations
 - (h) Complaints
 - (i) TPL pay and chase activities
 - (j) SURS activity
 - (k) RetroDUR activity
 - (l) Recipient lock-in activity
 - (m) EPSDT activity
 - (n) Primary Care Case Management (PCCM)
- (2) Provide for four levels of security in the case management system:
- (a) Level 1: DHSS and fiscal agent access
 - (b) Level 2: DHSS access only
 - (c) Level 3: Designated DHSS staff access only
 - (d) Level 4: Type of case
- (3) Provide for automatic generation of case numbers on all cases, including an indicator to identify the type of case (e.g., utilization review, provider appeal, recipient appeal, primary care, eState recovery) and indicators identifying the category of service, procedure code, and provider type where appropriate for inquiry, analysis and reporting.
- (4) Provide templates as defined by DHSS for each stage of review activity which can be added to the original case record as the case progresses; provide the capability to add new templates via an on-line transaction. Provide the capability to specify the security level for each template. The specific templates to be used will be defined during the requirements analysis.
- (5) Provide the capability to select and download data from reports into the case management record or link reports to the case management record, and to export the data to spreadsheets, databases, and word processing packages.
- (6) Provide a menu-driven letter generation capability allowing users to choose a standard letter or to develop a customized letter.
- (7) Provide the capability to date-stamp all activity in the case record and to identify the person who performed the activity.
- (8) Provide the capability to assign and re-assign cases to an area, unit, or individual.
- (9) Provide the capability to prioritize cases within case type.
- (10) Provide a status indicator on each case management record to indicate whether the case is active, inactive, or closed.
- (11) Provide the capability to set follow-up dates on case records and provide for an automatic tickler capability to notify staff when follow-up is required.
- (12) Provide case management reports, including detail reports and monthly summary reports of all case management activity, and separate reports by type of case, type of action taken, and type of sanction (if sanctions were imposed). Ensure that all reports balance individually and in total.

- (13) Provide a query capability for the case tracking system by any data on the database with appropriate security access.
- (14) Provide a graphics capability, including mapping capability, in the case management reporting process.
- (15) Provide for a separation or partition between the functions of SURS and DURS within the case management system in order to maintain the separation between the functions as specified in OBRA 90.
- (16) Maintain case review data and record case activity by date in the case management system.
- (17) Provide an extract of data, as defined by the State, for importing to the DW/DSS.

5.6.21.4 Interfacing Systems

- (1) Imaging system for hyperlinks to imaged documents
- (2) MMIS reporting systems for hyperlinks to reports associated with individual cases

5.6.21.5 Inputs

- (1) Case additions and updates
- (2) Links to reports and other documents

5.6.21.6 Outputs

- (1) Case tracking reports
- (2) Tickler notices
- (3) Letters

5.6.21.7 Performance Standards

- (1) Produce and distribute reports in accordance with the schedule specified in Section 5.6.19.7.

5.7 Management and Operational Requirements

This section describes the management functions and operational tasks that the Contractor will be responsible for performing during on-going operations of the contract. The State expects that the methods and tools used to accomplish these tasks will be implemented during legacy Takeover and DDI and that there will be minimal alteration required for operations.

5.7.1 Performance Monitoring and Reporting

This section describes the process that will be used to develop standards for measuring and reporting Contractor quality assurance and contract management performance as discussed

below. An automated performance monitoring system will produce a performance “report card” that will be reported and reviewed on a regular schedule.

This contract is organized around the delivery of major components of work. For each of these the Contractor and DHSS will develop and agree, in advance to implement a performance monitoring process as described below. The State and Contractor will monitor contract performance using an automated performance monitoring system. The State believes that this is the most effective way to monitor the Contractor's performance, document performance levels in all critical areas of the system, facilitate the management of the fiscal agent contract, and enhance the investment made by the State and federal government in the administration of the Medicaid program. The following process or an equivalent proposal by the Contractor will be used:

- (1) The State will identify areas of Contractor performance where quality and or business function is critical to the mission of Medicaid program administration.
- (2) During contract implementation, the State will reach agreement with the Contractor concerning the levels of service deliver and quality that are desirable, acceptable and substandard for each area. The State and Contractor will develop means to measure those quality levels on a time basis appropriate for the requirement, collect and store the measurements.
- (3) The Contractor will provide a process and methodology to acquire, aggregate, and report all operational and performance metrics in an automated manner to appropriately identified users. Access to reporting must be available via a secure internet connection independent of the Contractor or State network.
- (4) To facilitate the continued improvement of performance and process efficiency, reporting must include both current values and historical data with sampling frequencies, and timeframes appropriate and agreed to by both parties for established metrics.
- (5) Reports will be flexible and adaptable to changes in the measurements as agreed upon by the State and Contractor.
- (6) During the course of the contract, the Contractor will measure performance using the automated performance monitoring system. State contract management staff will actively participate with the Contractor in the performance reporting process.
- (7) Individual metric data collection and reporting schedules will be established dependant upon the specific business need and requirement in questions. Monthly assessments of overall performance will be completed no later than the second Friday of each month.
- (8) A Contract Performance Review (CPR) meeting will be held each quarter no later than the second Friday following the end of the quarter to:
 - (a) Review overall contract performance
 - (b) Evaluate the operation of the performance program based on a quality review and assessment
 - (c) Adjust program categories and weighting factors as appropriate for current operating conditions and processes

- (d) Evaluate individual metrics and their continued relevance to the determination of actual performance and management of the contract
- (9) Each performance criteria will be assigned a relative impact/performance score. This score is an expression of the business consequence of the performance of the metric in question. Each metric is assigned a score based on the following criteria:

Business Impact: Low – 1, Medium – 2, High – 3

Contract Performance: Inadequate – - (minus) 1, Adequate – 0, Superior – 1

Scores are generated by multiplying the Business Impact by the current Contract Performance to establish the Monthly Performance Index.

Examples:

Metric A has a business consequence of Medium (2), and this month's performance was evaluated to be Adequate (0). Score for this month is $2 \times 0 = 0$.

Metric B has a business consequence of Medium (2), and this month's performance was evaluated to be Inadequate (-1). Score for this month is $2 \times -1 = -2$.

Metric C has business consequence of High (3), and this month's performance was evaluated to be Superior (1). Score for this month is $3 \times 1 = 3$.

Scores will be generated monthly for each metric. Metrics are summed for each major performance category to establish the monthly contract performance. Contract performance incentives and deductions will be determined as a result of this scoring.

- (10) Scores for individual metrics will be consolidated into major contract, business, and functional categories to determine overall performance.
- (11) The State and Contractor will agree to initial incentives and consequences for composite scoring for major performance categories. Adjustments to the scoring mechanism and incentive methodology are expected during the first year of the contract, and during the first year of operation of the new system.

5.7.2 Fiscal Agent Internal Quality Assurance

The fiscal agent is responsible for monitoring its operations to ensure compliance with State-specified performance requirements. A fundamental element of the fiscal agent quality assurance function will be to provide continuous workflow improvement in the overall system and fiscal agent operations. The Contractor will work with DHSS to identify quality improvement measures that will have a positive impact on the overall program. The quality assurance function includes providing automated reports of operational activities, quality control sampling of specific transactions, and ongoing workflow analysis to determine improvements needed to ensure that the fiscal agent not only meets the performance requirements for each functional area, but also identifies problems and implements improvements to its operations on an ongoing basis.

5.7.2.1 Business Needs

- (1) Establish, document, and maintain internal quality control and assurance procedures to ensure the accuracy and timeliness of all processing.
- (2) Provide continuous workflow evaluation and improvement in the performance of Contractor responsibilities.
- (3) Incorporating Payment Error Rate Measurement (PERM) as specified by CMS and the State.
- (4) Develop and implement a DHSS approved Quality Assurance Plan.
- (5) Maintain separate testing environments, emulating the production environment, where users can test system changes, edits, and pricing without affecting the production system itself.
- (6) Maintain internal quality control procedures for functionality and data integrity.

5.7.2.2 State Responsibilities

- (1) Consult with the fiscal agent on quality improvement measures and determination of areas to be reviewed.
- (2) Monitor the Contractor's performance of all fiscal agent Contractor responsibilities.
- (3) Act as liaison/final authority, as necessary, for agencies involved in QA activities.
- (4) Review and approve proposed corrective action(s) taken by the Contractor.
- (5) Review, monitor, and approve all PERM activities.
- (6) Monitor corrective actions taken by the Contractor.
- (7) Monitor and approve all activities of the internal quality assurance process.

5.7.2.3 Contractor Responsibilities

- (1) Work with DHSS to improve the overall medical assistance program in Alaska with increased focus on proactive improvements rather than retroactive responses.
- (2) Provide quality control and assurance reports, accessible on-line by DHSS and fiscal agent management staff, including tracking and reporting of quality control activities, identified problems, and tracking of corrective action plans.
- (3) Provide and operate a Quality Monitoring and Control unit under direct management control. Staff in the unit may not participate in the day-to-day operations they are monitoring. This unit will conduct internal quality monitoring activities and be responsible to observe, survey, analyze, assess, record, and report on operational internal quality monitoring as part of the performance report card and general operational performance improvement activities.
- (4) Provide a test environment and perform quality assurance monitoring testing, in a non-production environment, to evaluate the impact of changed edits or other test conditions, such that the fiscal impact of the changes can be determined.

- (5) Provide support for PERM activities including: drawing statistically valid random samples of claims; reviewing claims in detail to determine whether it was paid accurately, was medically necessary, the recipient was eligible on the date of service, and the claim processed correctly through edits and audits; calculate an accuracy rate based on the sample defined as the ratio of the dollar value of payments paid accurately to the dollar value of total payments made; and interface with PERM software as it is selected and used by CMS and the State.
- (6) Integrate internal system processing quality assurance controls in the MMIS that will: validate balancing of input and output from automated processes; validate the proper execution of batch jobs in the appropriate order; validate the generation of outputs appropriate for the cycle being executed; and document the balancing and control procedures for all automated processes.
- (7) Integrate other processing quality controls in the operations that will: validate balancing of input and outputs from automated or manual processes; validate the execution of process functional tasks in the appropriate order; validate the generation of outputs appropriate for the cycle being executed; and document the balancing and control procedures for all operational processes.
- (8) Designate an employee to serve as quality assurance manager and liaison between the Contractor and DHSS regarding Contractor performance.
- (9) For any performance level falling below a State-specified level reported on the monthly report card, explain the problems and identify the corrective action to improve the rating.
- (10) Investigate and audit identified problems in a timely manner and implement a State-approved corrective action plan within 10 business days of notice of the problem or the time frame negotiated with the State.
- (11) Provide documentation to the State demonstrating that the corrective action is complete and meets State requirements.
- (12) Perform continuous workflow analysis to improve performance of fiscal agent functions and report the results of the analysis to DHSS.
- (13) Provide DHSS with a description of any changes to the workflow for approval prior to implementation.
- (14) Develop and implement quality management and assurance best practices, such as Capability Maturity Model (CMM) , and Total Quality Management (TQM), with an approach that is consistent with industry standard principles and processes that should include delivering: Recurring process reengineering evaluation; Continuous performance measurement and improvement; and State and Contractor staff training and motivation for achieving higher quality standards.

5.7.2.4 Interfacing Systems

There are no external automated interfaces for this function.

5.7.2.5 Inputs

- (1) Quality control and assurance activity data

- (2) Performance monitoring criteria and activity data

5.7.2.6 Outputs

- (1) MMIS System Issue Report
- (2) Action Tracking Report
- (3) Telephone, AVR, and EVS monitoring reports
- (4) Quality control and assurance reports
- (5) Performance monitoring report cards

5.7.2.7 Performance Standards

- (1) Identify deficiencies and provide the State with a 1) report of the problem within one business day of discovery, and 2) corrective action plan within ten (10) business days of discovery of a problem found through the internal quality control reviews.
- (2) Perform quality control sampling that includes monthly audits of the operations described in the scope of work sections and weekly audits of a statistical sample of adjudicated claims.
- (3) Produce and distribute reports in accordance with the schedule specified in Section 5.6.19.7.
- (4) Initiate, document, notify the State, and implement plans for improvement for any function when quality standards deteriorate for two (2) consecutive months.

5.7.3 Contract Management

The Contract Management Function encompasses both automated and manual functions necessary to manage the fiscal agent operation and to report to DHSS on the status of operational activities. These functions are primarily the responsibility of the Contractor, following approval of the procedures and processes from DHSS.

5.7.3.1 Business Needs

The primary objectives of the Contract Management Function are:

- (1) Establish and maintain project management and control procedures to ensure that fiscal agent functions are performed in accordance with State specifications.
- (2) Establish and at all times maintain a fiscal agent organization and provide the levels of staffing required to perform fiscal agent functions and to meet or exceed all performance standards.
- (3) Establish and maintain interface protocols and lines of communication both internally and between fiscal agent and DHSS staff.
- (4) Establish and maintain internal quality control and assurance procedures to ensure the accuracy, consistency, timeliness and quality of all processing.

- (5) Establish and maintain a automated project tracking and control system and performance monitoring system to track and report operational performance and monitor operational activities.
- (6) Report to DHSS on the status of projects, maintenance tasks and ongoing operations by functional area, including the status of operational activities, operational performance, identification of new and status of ongoing quality improvement problems, opportunities, and mandated initiatives, and system maintenance/modification activity.

5.7.3.2 State Responsibilities

- (1) Work with the Contractor to reach agreement concerning the levels of quality that are desirable, acceptable and substandard for each area.
- (2) Work with the Contractor to develop means to measure the quality levels on a monthly basis, using the Performance Reporting System.
- (3) Review and approve the measurement, calculation, content, and format of contract management reports.
- (4) Approve Contractor's key personnel, including reviewing resumes of proposed key personnel and notifying the Contractor in writing of its approval or disapproval.
- (5) Monitor the Contractor's performance of all fiscal agent Contractor responsibilities, processes, and compliance with contract terms, standards, and conditions.
- (6) Provide the fiscal agent with the name of the DHSS contract administrator who will be the primary point of contact between the Contractor and the fiscal agent.
- (7) Provide access to appropriate DHSS staff to the Contractor in its performance of contract activities.
- (8) Assess and invoke damages for Contractor performance that does not meet contract requirements and non-compliance.
- (9) Assess and approve incentive payments for Contractor performance that significantly exceeds contract requirements.
- (10) Review and approve Contractor invoices and supporting documentation for payment of services.
- (11) Coordinate State and federal reviews, certifications and compliance audits.

5.7.3.3 Contractor Responsibilities

The Contractor's Contract Management responsibilities include:

- (1) General Contract Management
- (2) Training
- (3) User Support
- (4) Production Operations Support
- (5) Performance Monitoring and Reporting

5.7.3.3.1 General Contract Management

- (1) Provide an automated project tracking and control system to track operational performance and monitor operational activities. The automated tracking and control system shall be the repository for inventories of work done and work to be completed, and will include all areas of fiscal agent services including subcontracts and EDI.
- (2) Provide operational activity and performance reports, accessible and updatable on-line by DHSS and fiscal agent management staff. These activity reports must be in a downloadable format compatible with standard desktop applications for data manipulation, such as Excel or Access. The automated tracking with production reports must comply with the performance standards in section 5.6.19.7.
- (3) Provide an automated performance monitoring system to produce the “report card” on fiscal agent performance, including reporting which is accessible on-line by DHSS and fiscal agent management staff. The scope, format, content, measure criteria, and standards used in the report card must be approved by the State.
- (4) Provide monthly management summary reports to DHSS, accessible on-line, to report on the overall status of the project including, but not limited to the following minimum expectations:
 - (a) Status of operational activities
 - (b) Status of system maintenance and modification activities
 - (c) Status of internal quality control and assurance activities
 - (d) Performance monitoring report card
 - (e) Fiscal agent staffing levels

These reports will include baselines and aging data, as well as prior period performance data.

- (5) Provide internal contract management procedures and controls including:
 - (a) Management and control procedures to monitor all Contractor functions
 - (b) Management and control procedures to monitor all subcontractor functions.
 - (c) Inventory management procedures and controls
 - (d) Internal quality control and assurance tools
 - (e) Backlog monitoring, controls, and contingency plans
 - (f) Project monitoring, controls, and contingency plans
 - (g) Back-up and cross training plans
 - (h) Inventory/database of all provider, recipient, State, and other contacts (i.e., in person, telephone, written)
 - (i) Inventory/database of all other activities, i.e. training and educational, publications, appeals, fair hearings, maintenance items and enhancements, SURS cases, REOMBs, complaints, pends, claims resolution, and all other fiscal agent activities

These contract management control procedures must be fully documented in operations procedures manuals.

- (6) Provide the State with reasonable access to Contractor staff during normal working hours. Maintain access to staff for emergencies by designating and publishing an on-call list of Contractor staff with contact information for after business hours.

- (7) Operate its banking unit under separate management from its claims, computer operations and security units. Individuals in the same family may not work in any combination of the following: Provider call center (communications), provider enrollment, banking, finance, SURS, and system security. Appropriate separation of duties must be applied to all aspects of financial management.
- (8) For all large projects or other projects as determined by the State, the Contractor must create a staffing management plan, including organizational charts with defined responsibilities and contact information.
- (9) Provide coordination of on-site and any off-site work performed by fiscal agent staff.
- (10) Ensure that effective and efficient communication protocols and lines of communication are established and maintained both internally and with DHSS staff. No action shall be taken which has the appearance of or effect of reducing open communication and association between DHSS and fiscal agent staff, including both operations and systems staff.
- (11) Provide contract management reports to DHSS within the time frames specified by DHSS.
- (12) Schedule and conduct monthly project status meetings in conjunction with DHSS contract management staff including:
 - (a) Providing DHSS with an agenda and contract management reports at least five (5) days prior to the scheduled meeting
 - i) General status report
 - ii) Detailed report card of all activities
 - iii) Activities completed during the preceding period
 - iv) Activities planned for the next period
 - v) Report on issues that need to be resolved
 - vi) Report on the status of risks
 - vii) Quarterly status report that will summarize data from the monthly reports and include executive summaries for presentation to management and oversight bodies
 - (b) Recording and providing to DHSS minutes of all status meetings
- (13) Monitor quality and work toward continued quality improvement in all contract areas as described in 5.7.1.

5.7.3.3.2 Training

- (1) Provide initial and ongoing fiscal agent staff training including:
 - (a) Training of new fiscal agent staff when new staff or replacement staff is hired, including staff assigned to new positions. This training will be comprehensive and include training on general health care claims processing industry information such as the paper claim forms used, HIPAA transaction sets, HIPAA code sets, HIPAA privacy and security standards, NPI, prior authorization processes, provider and recipient services processes, customer service/telephone etiquette, fiscal agent

- processes and the use of all internal and external tools/applications available to staff and providers, and claims control processes.
- (b) Training of fiscal agent staff when changes are made to existing policies and procedures or when new policies and/or procedures are implemented. This training must be comprehensive in nature with the intent to not only inform about the new policies and/or procedures but to also train on the impacts of those new policies and procedures.
 - (c) Training on the Alaska programs and system for programmers new to the Alaska MMIS. This training will include training on general health care claims processing industry information such as the claim forms processed by the system (e.g., UB 92 and UB04, CMS 1500, ADA, etc.), mandated HIPAA transaction sets, basic HIPAA code sets applicable to each claim format, and NPI. It will also include an overview of operational processes.
- (2) Provide initial and ongoing State staff training in system functions and features including:
- (a) Training of new State staff when new staff or replacement staff is hired, including staff assigned to new positions. This training will focus on general fiscal agent system and operations capabilities and all Contractor-supplied desktop tools and applications, as well as job-specific focused training to support the State staff responsibility to perform contract monitoring activities.
 - (b) Training of State staff when new policies and/or procedures are implemented.
 - (c) Training of State staff when changes to policies and/or procedures are implemented. This training is intended to include training sessions to prepare for implementation of the new system.
- (3) Provide five levels of training:
- (a) Basic training for newly hired staff and existing staff who are using systems or system components for the first time or staff who need inquiry access only.
 - (b) Intermediate training for staff that use systems or system components routinely in their operational responsibilities, including inquiry, basic research, and/or update capabilities.
 - (c) Advanced training for staff that uses systems or system components to generate claims resolution reports and advanced queries.
 - (d) Special training as needed when major changes are made which affect staff or impact end users, such as the addition of new programs or rules.
 - (e) Developmental training for all staff that use the systems or system components in order to promote on-going increased knowledge and skill of the fiscal agent operation
- (4) Provide an annual training schedule and plan that includes, at minimum, quarterly in-person training and provide on-request training as needed through the use of tutorials or other electronic presentations. This annual fiscal agent staff training plan is subject to State review and approval. This plan will be developed and presented no less than on an annual basis with interim updates as policies and procedures are changed or developed.

The annual plan for the following year must be presented to the State by the close of business on the second Friday of December.

- (5) Provide a training room in the Anchorage facility with a minimum of ten (10) terminals and capacity for twenty (20) staff for both State and fiscal agent training, and which provides both bright and dim lighting for presentations.
- (6) Provide training materials and presentation equipment, including at a minimum:
 - (a) TV with video and CD players
 - (b) Training manuals
 - (c) Visual aids
 - (d) Use of State-of-the art technology as an alternative and supplement to in person training session offerings. Such technology may include the use of scheduled teleconferencing, video-conferencing, satellite, web-casting, as well as web-based tutorials accessible at staff and management convenience and/or other modes of conveying information.
 - (e) Provide capability for automatic tracking when tutorials are accessed. Provide tracking of all staff training attendance and/or participation.
 - (f) Provide a plan that includes mandatory training for all staff, dependent on their position, and obtain State approval. This plan will include initial and on-going training for staff at a minimum yearly.
- (7) Provide quarterly training on site in Anchorage, and training twice a year in Juneau. Training must be provided by live persons but may be provided from a remote site via teleconference or use of other technology.

5.7.3.3.3 User Support

- (1) The Contractor shall provide support for the MMIS, DW/DSS, and POS users with a fully functional Help Desk. The support should provide an adequate number of staff with expertise to support the requirements outlined in this RFP. The Help Desk must be available to Alaska State and fiscal agent staff from 7:00 am to 8:00 pm AK time.
- (2) The Contractor shall provide timely ongoing education and training of user support procedures and policies, particularly when a change in the process is needed or required.
- (3) The Contractor shall provide an acknowledgment of the receipt of a user support request by response to the requestor within no greater than 24 hours and indicate the time frame for a resolution to the issue or question.
- (4) The Contractor shall provide a response/resolution within 48 hours of receipt to requests made in any form (e.g., e-mail, phone) on routine issues or questions.
- (5) The Contractor shall provide a response within 24 hours to requests made on non-routine issues or questions providing the following information:
 - (a) Time frame for resolution.
 - (b) Contractor staff names and phone numbers assigned to the task.
 - (c) A brief description of the activities associated with resolving the issue.
- (6) The Contractor shall provide Help Desk performance reports to the State on a monthly basis within 3 business days of month end, in a State approved format, on non-routine

and routine issues and inquiries, including their current status, estimate for completion, progress and open issues.

- (7) The Contractor shall maintain a log of user support requests in a State approved format including at a minimum, a description of the question, the date received, the person requesting the information, the person assigned, the date issue was resolved, and a brief description of the resolution. Copies of the log shall be provided to the State on a monthly basis and/or on request. This log of user support requests should be automated and should allow for ad hoc and standard reporting. These reports should be used to identify user training needs which are to be incorporated into the fiscal agent and State staff training processes.
- (8) Recurring problems identified by the Help Desk must be documented and reported to the Contractor's management within one (1) business day of recognition so that deficiencies are promptly corrected. A detailed report of the recurring problems shall be provided to the State on a monthly basis.

5.7.3.3.4 Production Operations Support

- (1) Production operations support includes the managerial and technical services required to manage and operate the MMIS. Specific requirements include:
 - (a) Scheduling and monitoring batch production runs, including actively participating in the scheduled production meetings. This monitoring process is intended to include balancing of transactions within and across files, programs, databases and systems, and reconciliation to source files.
 - (b) Facilitating LAN and WAN connectivity for the MMIS.
 - (c) Administering all databases used to perform the MMIS and DW/DSS functions, including translator databases used for front-end and back-end activities and any separate adjudication engines used for unique components of the overall processing functions.
 - (d) Performance tuning.
- (2) The State expects that the Contractor shall provide all services associated with production operations support including, but not limited to, the following activities:
 - (a) Batch cycle scheduling specifications, including job turn-around time monitoring and problem resolution
 - (b) Data base administration
 - (c) Problem identification and resolution
 - (d) Software release and emergency implementation
 - (e) System human and electronic resources forecasting
 - (f) Response time monitoring and problem resolution
 - (g) Software migration
 - (h) Contractor's LAN support and administration
 - (i) MMIS security implementation and monitoring to meet or exceed all applicable federally-required security standards
 - (j) Daily, weekly, and monthly production status reporting
 - (k) Mainframe liaison support with DHSS
 - (l) System monitoring and maintenance

- (m) System start up, back up and disaster recovery/business continuity plans and processes
- (n) Maintain the processing and peripheral systems in a manner that meets the State's requirements and is compliant with current and future industry standards
- (3) The Contractor shall provide Database Administration and system support including but not limited to the following activities:
 - (a) Data modeling and normalization
 - (b) Logical database design
 - (c) Physical database design
 - (d) Database creation and update
 - (e) Coordination and consultation with applications software and testing teams
 - (f) Database standards identification and compliance monitoring
 - (g) Database maintenance, reorganization, and recovery
 - (h) Data queries and corrections
 - (i) Database performance analysis and improvement
 - (j) Database resource utilization and capacity planning

5.7.3.4 Interfacing Systems

Reports and statistics must be provided in downloadable format to the State's LAN/WAN.

5.7.3.5 Inputs

- (1) Operational activity data
- (2) System maintenance and modification activity data
- (3) Quality control and assurance activity data
- (4) Performance monitoring criteria and activity data
- (5) Fiscal agent staffing data, including notice of all hirings, terminations, resignations, reassignments, and disciplinary actions (if such actions affect or are the result of contact with DHSS staff, providers, or recipients)

5.7.3.6 Outputs

- (1) Operational activity reports
- (2) Telephone, AVR, and EVS monitoring reports
- (3) System maintenance and modification activity reports
- (4) Quality control and assurance reports
- (5) Performance monitoring report cards
- (6) Monthly management summary reports

5.7.3.7 Performance Standards

- (1) Provide monthly contract management reports within three business (3) days of the end of the reporting period.

- (2) Provide monthly performance monitoring report card within three (3) business days of the end of the reporting period.
- (3) Ninety-five percent (95%) of calls placed to the Help Desk during normal business hours must be answered by a Help Desk operator.
- (4) Incoming calls must ring three (3) or fewer times eighty-five percent (85%) of the time.
- (5) Calls must never be in the queue for longer than two (2) minutes and callers must never receive a busy signal ninety-five percent (95%) of the time.
- (6) Provide new user training a minimum of one time per quarter.
- (7) Provide refresher training a minimum of twice a year.
- (8) Provide training on system changes as a result of upgrades or other enhancements within two (2) weeks of the upgrade.
- (9) Other standards as Stated in this RFP and as agreed upon with the Contractor for purposes of monitoring performance levels of quality that are desirable, acceptable and substandard for each area.

5.7.4 Management of Change

The Contractor shall be responsible for implementing ongoing changes to all software, hardware and other component parts of the MMIS both during and after its implementation. DHSS and the Contractor will mutually agree on the classification of an issue (DDI change, System Maintenance, Enhancement Modification, or Addition). If the Contractor disagrees with the DHSS decision, the Contractor may present information supporting its position for consideration based on the dispute resolution process in 1.22 and Attachment A, A.7.

State of Alaska – DHSS will approve all changes to the production environment of the MMIS system.

For all issues requiring in excess of 80 hours of effort to development and implement the Contractor is required to develop and deliver Statement of Work (SOW) documentation containing the following:

- (1) A function specification document that delineates in detail the required functionality to be developed, anticipated impacts to current systems, operations, and documentation.
- (2) A technical specification document describing the technical changes required impacts, solutions, and technical requirements based on the functional specification and resulting documentation impacts.
- (3) An Execution and Implementation document that includes:
 - (a) Resources, and equipment required
 - (b) Detailed and summary cost (maintenance items have no cost component)
 - (c) Thorough discussion of development, and testing requirements
 - (d) Acceptance- implementation plan and schedule

- (e) Management summary of the issue and proposed solution with a recommendation as to the most appropriate and efficient course of action

All issues and their solutions will be reviewed, approved, and scheduled for development by the MMIS management group consisting of State of Alaska – DHSS and Contractor representatives.

All SOW documentation will be reviewed by the MMIS management group with a separate required approval by State of Alaska – DHSS.

Approved SOW will be placed in the current work queue and scheduled for development and delivery. Unapproved issues will be closed.

The Contractor will be required to provide an issue management system that serves as a project tracking and reporting system for all system changes. The issue management system must allow State and Contractor management staff to review current priorities and timelines, change priorities and estimated completion dates, and present the impact of changing priorities on estimated completion dates. DHSS requires that all system changes be thoroughly tested by the Contractor. All test plans and test results will be presented to DHSS for review and will be provided in an organized and complete form for ease of review. Each of these requirements is further discussed in the following sections.

5.7.4.1 System Maintenance – Including DDI

The Contractor shall be responsible for all maintenance, upgrades, and systems support required ensuring continued operation of the entire MMIS for the term of the contract. Maintenance includes the implementation of hardware and software upgrades, code set and table updates and the correction of defects and errors in source code for the entire MMIS. In general, the various types of maintenance include:

- (1) Activities necessary to correct a deficiency within the operational MMIS, including deficiencies found after implementation of modifications incorporated into the MMIS.
- (2) Activities necessary for the system to meet the requirements detailed in the contract and RFP.
- (3) Activities necessary to ensure that all data, files, programs, and documentation are current and that errors are found and corrected as they are defined.
- (4) Activities necessary to meet CMS certification requirements existing at the time of contract award and ongoing standards.
- (5) Maintenance activities for updates to tables, databases, patch sets, and code.
- (6) Changes to operating parameters concerning the frequency, quantity, format, sorting, media, and distribution of reports.
- (7) Changes to edit disposition parameters for established edit or audit criteria.
- (8) Changes, upgrades, and modifications to the software and hardware used in the development and management of the MMIS.

All requests for system maintenance will be documented in the issue management system provided by the Contractor. It is the Contractor's responsibility to demonstrate appropriate and successful testing of all proposed changes prior to submission to the DHSS MMIS system manager or designee for promotion approval. The Contractor is responsible for ensuring that only authorized change are made to any system software or component.

5.7.4.2 System Enhancement – Including Additions

Enhancements result when the State or the Contractor determines that an opportunity or requirement exists that must be evaluated for inclusion in the MMIS system. In general, the various types of system modification include:

- (1) Development of a new or improved capability.
- (2) Implementation of new or streamlined processing methodology, or utilization of new and improved products or processes.
- (3) Changes to approved report, screen, new data elements, or report items that require a programming effort.
- (4) Changes required by external entities, program and policy change that represent significant effort (in excess of 80 hrs).

All requests for system enhancement will be entered into the issue management system provided by the Contractor. The Contractor will be responsible for ensuring that only authorized changes to the production system are made, and then only after complete testing.

5.7.4.3 Issue Management Systems

The Contractor shall provide an automated on-line issue management system for capturing, tracking, and reporting all known system issues, including maintenance and modification requests with full and secure accessibility to DHSS via the internet. The tracking and reporting system must include, at a minimum, the following:

- (1) Issue Number: A unique number assigned each system change request.
- (2) State Issue Number: A unique number assigned by the State to each system change request, if different from the Contractor-assigned Project Number.
- (3) Priority: A ranking of the assigned priority of the issue, based on an assessment by the requestor of business and operational impact.
- (4) Functional Area: The functional or operational area most affected by the project.
- (5) Issue Description: A brief narrative description to identify the project.
- (6) Issue Classification: Maintenance or Enhancement. Determination to be made by appropriate contract management staff.
- (7) Input Date: Date the issue was created on the system.
- (8) Requester: Name of the individual initiating the issue.
- (9) Assigned Resource: Name of the primary resource person assigned to the issue.
- (10) Estimated Completion Date: Targeted or required project implementation date.

- (11) Estimated Hours: Total hours estimated to complete the project.
- (12) Activity log: A comment log that tracks all activity/progress for the issue including the labor hours and cost expended, updated on a weekly basis.
- (13) Attachments: The ability to attach multiple files to the record of the issue.
- (14) Total Hours: Total hours worked to complete the project.
- (15) Project Status: Appropriate classification of the current status of the issue (e.g., on hold, delayed, research stage, analysis stage, coding stage, testing stage, documentation, completed, approved, denied) and progress within the status category (e.g., in test with percent of unit testing completed).
- (16) Actual Completion Date: Date that the requester approves satisfactory completion of the project.
- (17) Actual Implementation Date: Date and time the approved change was migrated to production.

The automated system or a suitable reporting alternative shall provide on-line viewing of all issues; including, history, a variety of reports to track and trend issues, counts and summary data, and the issue management system. The system will provide ad hoc and standard report capabilities, including the flexibility to produce reports with varying content, format, sort, sub sort, and selection criteria to meet both State and Contractor reporting needs, using all defined project information. The system will allow State and Contractor management staff to review current priorities and timelines, change priorities by adding new tasks and target dates with the ability to see the impact of those new priorities on pre-existing priorities and their target dates. The issue management system must provide the State with the following minimum capabilities:

- (18) Web entry of new issue independent of network..
- (19) Provide online reporting and status inquiry for individual system issues, and the ability to filter and sort issues based on any of the input criteria.
- (20) Provide automatic notification to appropriate parties based on user selectable issue criteria.
- (21) Maintain and provide access on a request basis to all changes to the issue record, identifying the change made, the identification of the individual (login id) making the change, and the date and time of the change.
- (22) Maintain the issue record with the entire and complete record of the issue including: status, report and coding changes, attached test results, and record all notes from State and Contractor related to each system change request.

5.7.4.4 State Responsibilities

- (1) Input issues as they are identified.
- (2) Receive and review system issue requests initiated by Contractor staff.
- (3) Review and approval all system enhancement requests.

- (4) Determine priority for Contractor completion of system issue and enhancement requests and approve all requests prior to the initiation of work and prior to implementation on the production environment.
- (5) Assist the Contractor in conducting detailed requirements analysis on any major changes required.
- (6) Review and approve the functional specification document.
- (7) Review and approve the technical specifications document, as required.
- (8) Review and approve the Execution and Implementation Document.
- (9) Monitor Contractor maintenance and modification activities.
- (10) Review and approve test plans.
- (11) Review and approve test results.
- (12) Review and approve updates to system documentation.
- (13) Review and approve updates to user documentation and operations procedures.
- (14) Approve implementation of all system changes.

5.7.4.5 Contractor Responsibilities

The requirements for system maintenance and modification/enhancement are described below.

5.7.4.5.1 System Maintenance

The following detailed activities are performed by the Contractor when system maintenance activity is determined to be necessary:

- (1) Upon identification or notification of any item affecting the system accuracy, response time, effectiveness, or efficiency, execute the management of change process as described above. Notify all impacted parties as soon as practicable.
- (2) Initiate a new issue record as problems are found by the Contractor.
- (3) The Contractor will ensure provision of the specified number of staff/staff hours required to complete a system change request within the specified time frame.
- (4) Receive the system change requests from DHSS for system problems identified by State staff.
- (5) If not directly entered by the State requester, enter the system change requests into the issue management system.
- (6) Develop and deliver to the State the documentation (functional, technical, and execution) for resolution of issues as required.
- (7) Receive approved and denied system change requests from DHSS and update the issue tracking and reporting system with data from the approved/denied requests.
- (8) Perform maintenance activities according to the priorities assigned by DHSS.

- (9) Submit test plans, including test scenarios, criteria, and test data, to DHSS organized in a format such that all information can be completely reviewed without requesting additional information from the Contractor. These test plans must be complete, accurate and of sufficient depth and breadth for the condition(s) being tested.
- (10) Testing must include positive and negative testing of the change through complete processing and reporting cycles to ensure that no unanticipated changes occur in other areas of the system as a result of the change that is being made. Testing will be reviewed and annotated by programmer staff with test files and sources documented.
- (11) Perform testing according to the approved test plan. Review, track, and record test results for accuracy, validity, and consistency with the expected outcomes. A test team lead will assure internal quality control of testing. Sign off of the testing by the test team lead is required before submission for State approval.
- (12) Submit complete test results to DHSS for approval, including the data sets and test transactions, outcomes, status (i.e., failed, re-tested, passed, etc.), and supporting reports and test files organized in such a way that all information can be completely reviewed without requesting additional information from the Contractor. In addition, the acceptance test package must include:
 - (a) The test plan
 - (b) A matrix summarizing the test plan and outcomes
 - (c) Notations and findings of the testing
 - (d) Draft documentation updates associated with the change
 - (e) Supporting information to demonstrate which files were used for testing
- (13) Submit updates to systems documentation and all other necessary documentation to DHSS for approval. Verify that changes to system components of edit documentation are a true, complete and accurate reflection of the system.
- (14) Implement system changes upon approval from DHSS. Maintain documented, proven code promotion procedures and controls for promoting changes to production that account for the migration to production at each step of the migration process and prevent migration to production of code that has not been thoroughly tested, reviewed and approved. The State requires coordination across the Contractor's functional areas to assure all areas impacted by a system change are fully informed when changes occur and thoroughly trained on the requirements and impacts of the system change.
- (15) Maintain documented version control procedures that include the performance of regression tests when code changes occur or new software versions are installed, including an established baseline of test cases to be executed before and after each update to identify differences.
- (16) Verify the successful implementation of the correction, including monitoring accuracy of processing and correction of any problems. A quality control plan and process for implementation of system changes will be presented for State approval, will be incorporated in MMIS documentation and will be applied by the Contractor throughout the life of the contract.
- (17) Provide weekly reports of maintenance and modification activities to DHSS. This reporting includes findings of post-implementation monitoring activities.

5.7.4.5.2 System Modification/Enhancement

The following detailed activities are performed by the Contractor when system modification activity is determined to be necessary:

- (1) Execute the management of change process based on receipt of system enhancements requests for modifications identified by DHSS staff.
- (2) Prepare and submit an issue record to manage the requests for Contractor-proposed modifications.
- (3) Enter enhancement requests into the issue management project tracking and reporting system. Respond to enhancement requests within fifteen (15) working days of receipt.
- (4) Receive approved and denied system enhancement requests from DHSS and update the issue tracking and reporting system with data from the approved/denied requests.
- (5) Conduct detailed requirements analysis for major changes, including recommendations, if any, for alternative changes to meet the State's needs.
- (6) Submit requirements analysis and specifications, including a final resource estimate and schedule, to DHSS for approval. Track and report resource usage during the project. The State must approve resource expenditure which exceeds the estimate.
- (7) For changes, develop detailed design documentation, including inputs, outputs, flow charts, file/database changes, program narrative and logic, test plan, new software tools to be used, and user documentation.
- (8) Code modifications.
- (9) Prepare and submit test plans, including test scenarios, criteria and test data, to DHSS organized in a format such that all information can be completely reviewed without requesting additional information from the Contractor. These test plans must be complete, accurate and of sufficient depth and breadth for the condition(s) being tested. New programming staff must be trained on the testing requirements and protocols.
- (10) Testing must include positive and negative testing of the change through complete processing and reporting cycles to ensure that no unanticipated changes occur in other areas of the system as a result of the change that is being made. Testing will be reviewed and annotated by programmer staff with test files and sources documented.
- (11) Perform and document unit, module and system tests. Review test results for accuracy, consistency, and validity with expected outcomes. A test team lead will assure internal quality control of testing. Sign off of the testing by the test team lead is required before submission for State approval.
- (12) Submit complete test results to DHSS for approval, including the data sets and test transactions, outcomes, status (i.e., failed, re-tested, passed, etc.), and supporting reports and test files organized in such a way that all information can be completely reviewed without requesting additional information from the Contractor. In addition, the acceptance test package must include:
 - (a) The test plan
 - (b) A matrix summarizing the test plan and outcomes

- (c) Notations and findings of the testing
 - (d) Draft documentation updates associated with the change
 - (e) Supporting information to demonstrate which files were used for testing
- (13) Submit updates to systems documentation and all other necessary documentation to DHSS for approval. . Verify that changes to system components of edit documentation are a true, complete and accurate reflection of the system.
- (14) Submit training plan to DHSS for approval, if necessary. Training may be required for providers, for operations staff or for State staff or all of these depending on the type of modification made to the system.
- (15) Conduct required training.
- (16) Implement modifications upon approval of DHSS. The State requires coordination across the Contractor's functional areas to assure all areas impacted by a system change are fully informed when changes occur and thoroughly trained on the requirements and impacts of the system enhancement.
- (17) Maintain documented, proven code promotion procedures and controls for promoting changes to production that account for the migration to production at each step of the migration process and prevent migration to production of code that has not been thoroughly tested, reviewed and approved.
- (18) Verify the successful implementation of the correction, including monitoring accuracy of processing and correction of any problems. . A quality control plan and process for implementation of system changes will be presented for State approval, will be incorporated in MMIS documentation and will be applied by the Contractor throughout the life of the contract.
- (19) Maintain a test region or regions necessary for testing current production and modifications. This test region must be available to designated State staff.
- (20) Notify DHSS and receive prior approval when the expected enhancement cost will exceed the estimate by 10% or more.

5.7.4.6 Performance Standards

- (1) Notify DHSS of system problems identified by the Contractor within twenty-four (24) hours of identification of the problem.
- (2) Respond to system maintenance requests within ten (10) working days except for emergency requests for which a response is due within twenty-four (24) hours of receipt of the request. For more complex requests this response will be an acknowledgement and analysis of the scope of the request at the programmer level with an initial research and analysis findings report.
- (3) For system modifications/enhancements, present the State with a requirements specifications document for approval within fifteen (15) working days of receipt except for emergency system change requests for which a response is due within twenty-four (24) hours of receipt. The Contractor may request an extension if the request requires major system redesign.

- (4) 90% of schedule and cost estimates for system enhancements must be submitted within 10 business days after receiving request, and 100% must be submitted within 30 business days.
- (5) Maintain a ninety percent (90%) compliance rate in providing complete acceptance testing packages that meet the standards described under Contractor responsibilities.
- (6) Maintain a ninety-five percent (95%) accuracy rate on documentation updates. Accuracy is defined as documentation that correctly and completely describes the system processing and any associated manual operations.
- (7) Ensure that only authorized changes are made and then only after complete testing.
- (8) Ensure that all system changes are completed within the time frames agreed to by DHSS.
- (9) Provide required updates to documentation, including systems documentation, user manuals, provider billing manuals, and procedures manuals prior to the implementation of any system change or within a time period agreed to by DHSS.
- (10) Provide training to Contractor staff, State staff, and providers for any changes affecting these users prior to the implementation of a system change.
- (11) Provide weekly reports on the status of system maintenance and modification activities.
- (12) Provide monthly reports of programmer hours by the fifth calendar day of the month for activity completed in the previous month.
- (13) Provide monthly reports of modification/enhancement project progress and to-date cost report and time expended on each open project by the fifth calendar day of the month for activity completed in the previous month.

5.7.5 Other Requirements

This section of the RFP describes the State of Alaska requirements regarding data processing activities, standards, procedures, and other supporting functions.

5.7.5.1 Web Portal

To support the functionality described in this RFP, the Contractor must implement and maintain a web portal. The portal must support the following functionality:

- (1) Be compatible with standard browser technology, including Internet Explorer and Netscape Navigator.
- (2) Be accessible using TCP/IP protocol through various connection methods that include broadband, DSL, point-to-point, satellite, cable, and dial-up.
- (3) Be operational and accessible 24/7, except for DHSS approved scheduled downtime.
- (4) Provide navigation that all users can easily understand, including easy navigation between screens through help menus other user documentation.
- (5) Provide security but not require multiple sign-in steps.
- (6) Allow users to view and copy provider manuals, instructions, bulletins, program descriptions, eligibility criteria, and forms.

- (7) Provide links to other State and federal websites and external entities, including certifying agencies, SSA, public health care and nutritional programs, and other programs determined by DHSS to be appropriate for portal access.
- (8) Allow providers, recipients, trading partners, the State and the State's designees to register online for access to the secure areas of the portal.
- (9) Provide a transaction component of the portal that allows at minimum:
 - (a) Authorized trading partners to submit EDI files for immediate processing and retrieval of the corresponding response acknowledgement.
 - (b) Authorized trading partners to retrieve RAs and claims histories.
 - (c) Providers to initiate enrollment using an online application process.
 - (d) Providers and other entities to enroll as EDI trading partners using an online application process.
 - (e) Providers to view claim status information, payment history, recipient eligibility and benefit information, submit requests for PAs or updates to recipient insurance coverage, and view existing PA information.
 - (f) Provide interactive fee schedule functionality to allow providers to look-up procedure rates.
- (10) Provide hotlinks to frequently visited areas of the Contractor web site.
- (11) Provide low bandwidth versions of State-specified pages for easy access by providers with mobile, wireless web access.
- (12) Maintain HIPAA compliance and support the access, privacy, and security requirements described later in this section.

5.7.5.2 Data Processing

The data processing activities encompass both the automated and manual functions necessary to ensure effective operation through the policies, procedures, and programs established for systems control, reliability, documentation and backup. The policies and procedures for these functions will be modeled according to guidelines described in the following publications:

- (1) Automatic Data Processing Physical Security and Risk Management (FIPS PUB 31)
- (2) Computer Security Guidelines for Implementing the Privacy Act of 1974 (FIPS PUB 41)
- (3) Guidelines for Security of Computer Applications (FIPS PUB 73)
- (4) Federal Regulations at 45 CFR 95.621
- (5) Federal Regulations at 45 CFR 142, 160, and 164 (HIPAA)

5.7.5.2.1 System Reliability

The system must be available for processing to meet all production schedules, and for user inquiry, update, and ad-hoc queries twenty-four (24) hours per day, seven days a week except for regularly scheduled maintenance.

The system must be reasonably and adequately protected against hardware, software, and human intervention errors. If the system is down for more than twenty-four (24) hours, DHSS will expect the Contractor to employ the procedural steps necessary to switch to a backup system.

At a minimum, the following reliability requirements for key activities must be met:

- (1) Production of checks must not be delayed for more than twenty-four (24) hours from the normal schedule.
- (2) Claims processing must not be delayed for more than twenty-four (24) hours from the normal schedule.
- (3) Inquiry capability for claims in process, claims history, provider, reference information and other key files must not be delayed for more than twenty-four (24) hours from the normal schedule.

5.7.5.2.2 System Access and Navigation

The system must provide standard and consistent use of program-function (PF) keys, hot keys and/or other screen navigation mechanisms across functional areas, using techniques such as menus, windowing, split screens, and cursor-location sensitive inquiries. The system should be both menu-driven and command-driven for maximum flexibility. For example, a user should be able to access Reference database or Provider database information while inquiring on a paid claim, without having to return to a main menu. In addition, the following minimum requirements must be met:

- (1) The system must store screen selection parameters to eliminate re-keying elements needed for additional inquiries.
- (2) The system must allow forward/backward movement in multiple screen displays.
- (3) On-line help must be available, and descriptive error messages must be shown for all on-line errors. All elements shown on the screen should have a corresponding help message to explain the item in question. Help and error messages should be context-sensitive throughout the application.
- (4) Drill down or pop-up screens must be available for table driven elements such as edit error codes, procedure codes, categories of service and other coded elements appearing on the screen.
- (5) Capability to view the test system and the production system via split-screen with each system identified as test or production on the screen, i.e., allow logon to both systems at the same time.

5.7.5.2.3 System Auditability

Audit and control considerations are especially important where a large number of staff, with diverse skill levels and responsibilities interface directly with the system. Audit and control features apply to all areas of the system and should be considered an integral part of the overall system architecture.

Audit trails should be incorporated into the system to allow information on source documents to be traced through the processing stages to the point where the information is finally recorded. The ability to trace data from the final place of recording back to its source of entry must also exist. These audit trails may be supported by listings, transaction reports, update reports, transaction logs, or error listings.

The proposed system must be able to track changes that are made to data or edits and must include the following:

5.7.5.2.3.1 Data Maintenance Audit Trail

The proposed system must maintain and provide an automated history (audit trail) of all update transactions, both batch and on-line, including, but not limited to:

- (1) Date and time of change
- (2) Before and after status
- (3) Before and after data field contents
- (4) Terminal ID
- (5) Originating transaction and/or function
- (6) Operator Identifier or source of the update
- (7) Operator organizational unit

These audit trail records must be sorted, stored, maintained, and distributed in a timely manner by the Contractor as specified by DHSS.

5.7.5.2.3.2 Audit Trail Requirements

The proposed system must provide audit trails that comply with requirements of the Generally Accepted Accounting Principles (GAAP) and DHSS internal control objectives.

5.7.5.2.3.3 Data Capture for On-line Audits

The proposed system must create and maintain system audit trails as an automated by-product of the normal processing. These audit trails must immediately and automatically provide the ability to track data and edit maintenance by capturing, at a minimum, when the system is updated, when the change is effective, who made the modification, and the transaction involved in an update.

5.7.5.2.3.4 Before-Images of Data

The proposed system must ensure that all images of data prior to updates be retained by the system as defined in the Data Retention requirements.

5.7.5.2.3.5 Control and Balancing

The proposed system must provide reports to facilitate control and balancing of all processes as defined by DHSS as requested.

5.7.5.2.3.6 Edit Dispositions

The proposed system must maintain an audit trail showing the actual disposition of each edit and audit failed by a payment request or other transaction.

5.7.5.2.3.7 Overridden Edit/Audit Trail

The proposed system must produce appropriate information to establish an audit trail of instances where suspended payment requests with failed edit and/or audit conditions are automatically overridden (i.e., payment requests suspended with a "denied status" that have been overridden and released for further processing) based upon management's authority to make such decisions.

5.7.5.2.3.8 Payment Request Edit Failure Audit Trail

The proposed system must provide an audit trail for every payment request, payment request record, and adjustment that identifies all edits and audits failed by a payment request, payment request record, and/or adjustment from the time of input into the system through the adjudication process as well as the resolution and disposition associated with each edit and audit failure.

5.7.5.2.4 Telecommunication Links with Other Entities

The Contractor will be required to provide, at a minimum, the following telecommunications links with other entities:

- (1) The Contractor will links via the State's LAN/WAN for State offices designated by DHSS and Contractors performing State assigned tasks (such as Fraud Control Unit investigators, waiver case managers, audit/review Contractors, CSED, etc.)
- (2) The Contractor will be required to connect with LAN/WAN systems identified by DHSS.

The Contractor will be required to work with GCI, the State's telecommunications Contractor, to establish the required communications links with the State's LAN/WAN. A copy of the Comprehensive Telecommunications Service Agreement is included in the Bidders' Library.

Telecommunication links will be the expected choice for transferring data between the MMIS and other entities. DHSS must approve the standards, media, format, and timeliness of all transfer of data with other entities.

In addition, the Contractor will provide for the following:

- (1) The capture of data from other medical services programs.
- (2) On-line inquiry by entities outside of DHSS into MMIS data as specified by DHSS.

- (3) Compatible interface with the State financial system.
- (4) Secure e-mail capability between the Contractor and DHSS/DHSS.
- (5) Communications over the State's LAN/WAN will be via TCP/IP.
- (6) FTP capability utilizing secure communication between the Contractor and all State agencies.

The Contractor will be required to develop training materials and conduct training seminars on system navigation and telecommunication linkages for DHSS and other designated staff in Anchorage and Juneau.

5.7.5.2.5 Compatibility with State Environment

The Contractor must, during development, implementation, and operation of the MMIS, provide compatibility with the existing State environment. The MMIS must accommodate the hardware and software currently available to DHSS staff. Any proposed interfaces with DHSS equipment, and integration of DHSS equipment resources into proposed solutions, must conform to DHSS hardware, software, middleware and telecommunications configurations and standards. During the term of the contract, DHSS will consult with the Contractor regarding proposed changes to proposed LAN/WAN, Internet and desktop standards.

5.7.5.3 Security and Confidentiality

The proposed system must provide technical, physical, and administrative mechanisms to ensure the confidentiality, integrity, and availability of data. The proposed system shall provide security from anticipated threats or hazards to its data and must restrict the availability of data to appropriate staff and other designated individuals and organizations using standardized system applications and data security capabilities.

A Privacy and Security plan(s) shall be developed and, once approved by DHSS Security Officer and the State Security Officer, be implemented by the Contractor during the DDI phase and adapted to use during MMIS operations. The Contractor must provide, from the date of implementation, a totally secure environment for both on-line and batch access to DHSS data through the use of a fully implemented and documented security software package. DHSS must approve in advance the proposed software privacy and security provisions, its implementation, and procedures for use.

The Contractor shall ensure that the MMIS development and operations are in accordance with both State and federal statutes, regulations, and guidelines related to security, privacy, confidentiality, and auditing. Relevant regulations and laws include:

- (1) Medicaid confidentiality statute - Section 1902(a)(7) of the Social Security Act, codified at 42 U.S.C. Sec. 1396(a)(7)
- (2) Medicaid confidentiality regulations - 42 CFR Part 431, Subpart F
- (3) Health Insurance Portability and Accountability Act of 1996, Public Law 104-191

- (4) Standards for Privacy of Individually Identifiable Health Information - 45 CFR Parts 160 and 164
- (5) Security Standards for the Protection of Electronic Protected Health Information - 45 CFR Parts 160 and 164 Subpart C
- (6) National Institute of Standards and Technology, Computer Security Resource Center, Publications for Systems Security, including NIST Special Publication 800-66 an Introductory Resource Guide for Implementation the HIPAA Security Rule

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.

5.7.5.3.1 Privacy Requirements

The Privacy Plan must demonstrate how the Contractor and its system meet all requirements of law and supports DHSS's objective of ensuring that data is maintained confidentially and recipients are accorded appropriate privacy rights, including:

- (1) Assure that its and any subcontractors or agents, performance complies with Business Associate Contract terms, and is consistent with HIPAA Security and Privacy requirements.
- (2) Maintain policies, procedures and systems necessary for complying with privacy requirements to maintain confidentiality.
- (3) Ensure that protected health information and designated record set, as defined by HIPAA, are identified and classified along with other sensitive health information (e.g. mental health records, substance abuse, HIV status).
- (4) Support use and disclosure rules of privacy classifications and policies; including access and disclosure limitations based on identity and authority.
- (5) Supports an automated process to identify data that requires a consent or authorization prior to any release.
- (6) Maintain and support systematically a minimum necessary policy for use and disclosure of data and reporting (including user, role and/or context based access and security protocols).
- (7) Maintain policies, procedures and systems necessary for providing response to individual rights (e.g., individual request to inspect and copy records, requests for amendments, linking tracking of disclosures, consents, authorizations, and requests for restrictions on use of protected health information, response to complaints, mitigation measures, and sanctions).
- (8) Maintain Notice of Privacy Policy, and appropriate updates and notifications, on any websites.

5.7.5.3.2 Administrative Security Requirements

The Contractor's Security Plan must address industry best standards and administrative safeguards: actions, policies and procedures, in managing the selection, development, implementation, and maintenance of security measures to protect data and to manage the conduct

of the staff in relation to the protection of that information. The Contractor will be required to complete a State Security Framework document that must be approved by the State's Security Officer. The Security Plan must minimally address:

- (1) Description of security management program that includes establishing multiple levels of security administration to prevent, detect, contain, correct, and evaluate security violations or abnormal behavior for the system, applications, and databases.
- (2) Identification of all system components, interfaces, and network schema and a risk/vulnerability assessment and mitigation measures.
- (3) Periodic evaluation of security measures as defined by the National Institute of Standards and Technology 800 series publications.
- (4) Employee security policies (authorization, supervision, training, sanction, termination).
- (5) Security awareness training and monitoring.
- (6) Acceptable use documentation regarding the handling, storage, and destruction of electronic and printed information obtained from the system.
- (7) Acceptable use documentation regarding software and Internet capabilities accessed via State-owned assets and networks.
- (8) Security incident response plan, reporting procedure and mitigation of incidents.
- (9) Monitoring and detection of malicious software.
- (10) Contractual requirements (including HIPAA required business associate provisions) for subcontractors and agents.

5.7.5.3.3 Physical Security Requirements

Regardless of the equipment configuration, effective physical security measures must be implemented and maintained for all proposed MMIS equipment, sites, processing areas (including the mailroom), and secured storage areas. At a minimum, the MMIS Contractor must restrict perimeter access to equipment sites, processing areas, and storage areas through a card key or other comparable system, as well as provide accountability control to record access attempts, including attempts of unauthorized access.

The Contractor's facilities will meet at least the following requirements:

- (1) Data centers will be approved by DHSS.
- (2) Conforms to the Contractor's facility security plan, and includes provisions for contingency operations.
- (3) Limit access to authorized personnel only.
- (4) Employs safeguards for workstations with access to Medicaid recipient data (appropriate functions specified; physical safeguards employed).
- (5) Secures equipment and media with appropriate controls to regulate receipt, movement, re-use, removal, and disposal.
- (6) Windows or doors to the computer room will not have direct external access.

- (7) All visitors must wear badges and sign a logbook before entering the facility.
- (8) All data files will be secured in a fireproof vault when not in use.
- (9) An automatic heat and smoke detection system will be used in the computer room.
- (10) The data storage vault will be protected by an automatic fire detection and extinguishing system.
- (11) Use of current generation master files will be strictly limited to authorized production cycles only.

Any and all other security guidelines established by DHSS throughout the duration of the contract.

5.7.5.3.4 Technical Security Requirements: System Access

The proposed system must assure that the system is protected against unauthorized access to services, processes, servers, networks, applications, databases, and devices in accordance with DHSS and federal guidelines. All external access shall be gained via a State Security Office approved VPN level encrypted and authenticated method. At a minimum, the Contractor must:

- (1) Assign unique user identification to identify and track each user of the system, including authorized provider or other non-employee users. Provide the ability to assign multiple “permissions” to an user ID as well as single (and same) password use for all applications. Password begin/end dates and other updates must apply all applications using that password.
- (2) Maintain and generate periodic update and/or validation reports of authorized users and authorized level of system access.
- (3) Authenticate persons and entities seeking access; including encrypted authentication with a Directory Service with multiple backend processes (LDAP, Active Directory, and NDS). At a minimum, passwords will include eight alphanumeric characters. Passwords must expire on a staggered timeframe, be changeable at any time, and not be displayed on the screen.
- (4) Have an automated capability for supporting minimum necessary access by limiting individual access to specific applications, screens, databases, fields, and files. Access will be based on security authorization level, fixed expiration dates, or temporary suspension status.
- (5) Log unauthorized access attempts by terminal identification, user identification, date and time. Provide the ability to disable log-on capabilities if unsuccessful password entry is attempted after five (5) unsuccessful attempts and automatically notify security administration staff upon disabling long-on capabilities.
- (6) Create, maintain, add, change, delete and modify all user log-in accounts, profiles, and reset passwords as needed; including mass password expiration, mass system log-outs, parameter driven timeframes for password expiration, and password expirations lockout.
- (7) Develop a policy that establishes rules and procedures for emergency access to user accounts in situations where the account holder is not available.

- (8) Terminate electronic sessions after a DHSS specified time of inactivity on all systems, this time may vary by function.
- (9) Support security training through automated reminders and other mechanisms.
- (10) Support encryption and decryption of data within the system related to an individual's health, or provide an alternative security mechanism.
- (11) Access security should not require multiple sign-ons, after the initial sign-on, within an application, module, screen, table, data element, and function.

A procedure must be developed which ensures that the State will have authorized access to any systems functions. After State authorization has been given for an individual, the Contractor will be responsible for maintaining that individual's access. The Contractor must provide an automated workflow methodology for processing log-in requests from the end users. The method for accomplishing this task will involve use of an electronic form to be completed and reviewed at each stage of the process. This process will include notification to certain DHSS security employees. The DHSS approving authority will have the ability to electronically view, approve and forward the log-in request to the Contractor for completion. The Contractor will then notify the end user concerning the status of the request, i.e., approved or denied.

If the proposed workflow systems to process log-in requests are based on an electronic mail engine and software, the method for using electronic mail to notify users shall utilize current encryption technology at a standard at least equal to that specified by National Institutes of Standards and Technology, Computer Security Resource Center (NIST-CSRC). In addition, the use of digital certificates (i.e., the equivalent or better of Verisign or Entrust) can be used to authenticate the sending and receiving of the electronic transactions. If this method is employed, the State will supply digital certificates for its staff and the Contractor will supply the certificates for its own staff.

All access to the State's non-public accessible networks, systems, applications, databases, or devices shall be delivered via the State's DMZ/Extranet environment whereby the State will ensure the logical and physical access to the equipment, network connectivity, and availability of services.

5.7.5.3.5 Technical Security Requirements: Data Security

The integrity and confidentiality of recipient and all other data must be protected by safeguards to assure that information is not used or disclosed without proper authorization. Further, all individuals having access to the confidential data must agree in writing to abide by State and federal rules and policies related to confidentiality. The Security Plan shall demonstrate that the MMIS contains a sufficient number of controls to maintain data and information integrity, and provide three types of controls:

- (1) Preventive Controls: Controls designed to prevent errors and unauthorized events from occurring.
- (2) Detective Controls: Controls designed to identify errors and unauthorized transactions which have occurred in the system.

- (3) Corrective Controls: Controls to ensure that the problems identified by the detective control are corrected.

In addition to audit trails, specific data security requirements include:

5.7.5.3.5.1 Software Program Change Controls

The proposed system must ensure data integrity through system controls including restricting external access for software program revisions, updates and tests, and approved methodologies for promotion to production

5.7.5.3.5.2 Data Integrity Safeguards

The proposed system must employ mechanisms to prevent and detect the improper alteration or destruction of data within the system and during transmission.

5.7.5.3.5.3 Archive and Purge Controls

The proposed system must ensure that data maintained is properly and routinely purged, archived, and protected from destruction. All data purge schedules and procedures must be approved in advance by DHSS.

5.7.5.3.6 System/Application Security

- (1) On-line Security Checks: The proposed system must provide for adequate on-line security checks, including security by individual, location, files, and fields before allowing access to any DHSS files including data, software, resources, code or any other files resident with or accessed by DHSS.
- (2) Restriction of Override Capabilities: The proposed system must restrict access and the ability to modify or override system edits and audits, or alter system functionality, to staff authorized to implement such changes.
- (3) Terminal Restrictions: The proposed system must restrict applications and/or functions within application to specific workstations, workstation ports, or application servers.
- (4) Data Back-Up: The proposed system must provide retrievable, exact copies (data backup) on a DHSS approved schedule and site.
- (5) Required Security Controls: The proposed system shall provide role based multi-level security controls. System functionality must consist of level to prevent unauthorized use of system, restrict access to the database, maintain database process controls, and log all database transactions. The System shall provide access restriction capability for, but not limited to:
 - (a) Application module (e.g., purchasing, Financial management, personnel management)
 - (b) Screens and Tables
 - (c) Data Elements

- (d) Functions (Add, Change, Delete, Inquiry, etc.)
 - (e) Electronic Documents (Electronic Approvals)
 - (f) Business Event
 - (g) Organizational Unit
 - (h) Accounting period (prior, current, etc.)
- (6) Database Access Security and Relevant Data Restrictions: The proposed system shall provide the ability to restrict access to the application database(s) from outside the application programs; and it shall provide the ability to limit access to data relevant to the particular user, as well as their role (e.g., only see data for the user's agency).

5.7.5.3.6.1 Threat Assessment

The proposed system must include a process for performing periodic assessments of potential vulnerabilities or threats to the system(s), applications, and databases. These assessments will include but not necessarily be limited to: reasonability, cost effectiveness, risk, impact, resources, services and time:

- (1) System, applications, and database shall not be deployed until all critical, high, and medium vulnerabilities are remediated. Assessment will be based on reporting from a "Nessus" based full intrusive scan and/or assessment performed via the State Security Office.
- (2) Provide the ability to install all security patches in compliance with State Security Policies.

5.7.5.4 Configuration Management/Version Control

Configuration management is a process that begins during the project development cycle and continues through Operations. A project that has clearly implemented a successful configuration management process adds to the value of the system once it reaches maintenance. This section describes Contractor requirements to control the versions of software and hardware to operate and support the MMIS. This applies to operating systems, applications, networks and all devices within IT Enterprise. Configuration management includes:

- (1) Software version control
- (2) Hardware and "Off-the-Shelf" Software Version Control
- (3) Documentation and User Manual Version Control

5.7.5.4.1 Software Version Control

Version control shall be under the jurisdiction of a Contractor team that is separate from the design, coding, and testing teams. At a minimum, the Contractor must provide detailed descriptions of the following that are consistent with system change control requirements:

- (1) Tools (Use Case and Case Tools and configuration management tools) and business processes to control software development, including check in/check out procedures and a responsibility audit trail.

- (2) Business processes and procedures for controlling the migration of code from design through coding, acceptance, unit, and integration testing, as well as promotion into production.
- (3) Organizational structure to control all system development and maintenance.
- (4) Structure and maintenance of non-production environments (i.e. User Acceptance Test, System Training, and other environments), including the timing of the promotion of changes to the non-production environments.
- (5) Software development management process including the migration of code from design to production. This description shall include diagrams and other graphical devices to communicate the processes.
- (6) Provide access for the State's MMIS Configuration Manager to the configuration management tool used to control software development.

5.7.5.4.2 Hardware and "Off the Shelf" Software Version Control

Periodically new hardware and software versions become available. The Contractor must maintain awareness of these developments and conform to the following requirements.

- (1) Upon State approval, desktop software supplied for State use must be upgraded within one year of the release of a newer version of the software.
- (2) When new or upgraded operating system, server, database management, or other support software becomes available, the Contractor shall work with the State to determine the impact of implementation of the new version and the need for software redesign or hardware replacement. If required, the Contractor shall develop an upgrade plan, including cost and savings estimates. The State shall review and approve the plan for implementation or return the plan for adjustment.

5.7.5.4.3 Documentation and User Manual Version Control

The Contractor must maintain the currency of all forms of system documentation, system user manuals, training manuals, and other such materials that require updating as procedures, operations, or system functionality changes. The Contractor will also maintain historical document version archives for all documentation.

5.7.5.5 Documentation Requirements

The systems, including MMIS, POS/PRO-DUR, DW/DSS, AVS, and EVS, must have accurate, complete, and current documentation in both hardcopy and electronic formats. The documentation requirements are an integral part of the System Development Life Cycle (SDLC) as well as the ongoing operational requirements of the system. The system must be sufficiently documented to provide for uninterrupted operation, support system security requirements, and validate software changes made according to management controls and priorities.

The Contractor shall publish updated versions of all documentation affected by changes to systems functionality resulting from new development, modification, defect resolution, or other sources. Draft versions of documentation will be shared with the State during DDI and final

versions published prior to deliverable or system acceptance. During operations, updated versions of documentation will be made available to DHSS no later than the date that the attendant system changes are implemented in the production environment.

Electronic versions of documentation will be accessible from the user's desktop, including hypertext cross-references. The preferred format is PDF format or HTML format if access is provided via a browser. Documentation must be available at critical milestones during the project development and any modifications made during the operations phase of the Contractor. The Contractor is responsible for preparing and printing documentation and revisions, in final form, prior to State sign off on the system and operation, and for system and operational changes made during the operations phase of the contract.

Documentation requirements are defined in two areas:

- (1) User Documentation
- (2) System Documentation

Documentation must be organized in a format that facilitates updating; and must include system and subsystem narratives that can be understood by non-technical personnel. Hardcopy documentation must be bound in three-ring binders on 8 ½ x 11-inch pages, have a table of contents, and be indexed. Each page should be numbered within each section, and a revision date should be included on each page. Revisions to the manuals must be published with a guide for inserting revised pages into existing documents. A special copy of the revision pages must be provided using Microsoft Word revision functions that strike-through deleted text and underline new text so that reviewers can easily identify the changes that are made. Four (4) copies of all documentation and updates must be provided to the State.

The requirements listed below are intended to define the information to be provided in the documentation, rather than specific manuals to be provided. DHSS's intent is to have integrated documentation available to users on-line with hyperlinks from one section of the documentation to other related sections of the documentation, i.e., capability to move from the user documentation to associated sections of the system documentation and operations documentation. The integrated documentation will allow for updating information once, which will update all documentation that uses the updated information and will facilitate updating associated documentation. In addition, the Contractor will utilize appropriate sections of the documentation for training activities.

The Contractor will consult with the State regarding standards for labeling documentation as State of Alaska property, including, definition of disclaimers, right of use Statements, and other proprietary notices.

5.7.5.5.1 User Documentation

The purpose of the user documentation is to provide information on how to access inputs, reports, and screens used in the systems as well as to view samples of the inputs, reports, and screens. User documentation must be written for each function in a procedural, step-by-step format. User documentation must adhere to the following guidelines:

- (1) Be available on-line via the MMIS and facilitate updating.
- (2) Have instructions for sequential functions (for example, balancing instructions must follow the actual flow of the process).
- (3) Definitions of codes used in various sections must be consistent.
- (4) Mnemonics used must be identified and consistent with screens, reports, and the data dictionary.
- (5) Abbreviations must be consistent.
- (6) Field names for the same fields on different records must be consistent.
- (7) Conform to standards approved by the State.

The contents of the user documentation must include:

- (8) Error message descriptions for all fields incurring edits, and the steps necessary to correct such errors.
- (9) Tables of valid values for data fields (for example, provider types and claims types), including codes and descriptions in English, presented on screens and reports.
- (10) Illustrations of screens used in the subsystem, with all data elements on the screens identified by number; and all calculated or generated fields on the screens described clearly.
- (11) Instructions for requesting reports or other outputs with examples of input documents and/or screens.
- (12) Instructions for file maintenance, with descriptions of code values and data element numbers for reference to the data dictionary.
- (13) In the claims processing function user documentation, a detailed pricing logic for all claims processed by the system and detailed descriptions of each edit and audit.

5.7.5.5.2 Operating Procedures

The purpose of the operating procedures is to detail the manual operations of the Contractor and the interface between the manual operations and the system. Operating procedures must be written in a procedural, step by step format and must meet the following criteria:

- (1) Instructions for sequential functions must follow the flow of actual activity.
- (2) Include all procedures for all systems manual operations including mailroom, cycle balancing, production control, and file updates.
- (3) Have consistent definitions of codes throughout.
- (4) Identify mnemonics used in operating procedures consistent with screens, reports, and the data dictionary.
- (5) Use consistent abbreviations throughout.
- (6) Clearly depict in the instructions for accessing on-line screens which data and files are changed.

- (7) Contain any internal reports used for balancing which are not system outputs.

5.7.5.5.3 System Documentation

The systems documentation must meet or exceed the following standards:

- (1) Be available and updated on electronic media.
- (2) Be organized in a format which facilitates updating; revisions must be clearly identified and dated.
- (3) Include function and sub-function narratives that are understandable by non-technical personnel.

5.7.5.5.3.1 Detailed System Design (DSD)

The DSD serves three (3) purposes:

- (1) Provides a detailed definition of the new MMIS, POS, DW/DSS, AVR, and EVS for State approval.
- (2) Serves as the specifications for Contractor staff to develop the new systems.
- (3) Becomes the earliest draft of the systems' documentation.

The DSD is critical to the development cycle. It must be delivered and approved by the State before system development. The DSD must be updated to reflect identified changes approved during development and testing and must be provided to the State for on-going review and approval.

The DSD must present a comprehensive and detailed design for all system and operations functions, showing all inputs, processes, programs, interfaces, program interrelationships, and outputs. The DSD must also include a cross-reference to the corresponding sections of Part 11 of the State Medicaid Manual. Specific requirements are provided below

5.7.5.5.3.1.1 System Overview

- (1) A narrative describing the entire system.
- (2) Architecture documentation showing multiple sets of hierarchic, multi-level charts that give a high, medium, and detailed view of the system, for both on-line and batch processes.
- (3) Business Process Models.
- (4) Data flow diagrams showing data stores and flows.
- (5) Entity Relationship Diagrams (ERD).
- (6) A description and flow charts showing the flow of major processes in the system.
- (7) A description of the operating environment. The nomenclature used in the overview shall correspond to nomenclature used in subsystem documentation. All functions must be referenced, and documentation must be consistent from the overview to the specific

functions and between functions. All data stores and flows must be referenced and documented.

- (8) Hardware/software platform configuration chart.

5.7.5.5.3.1.2 Functional Documentation

- (1) Function name and numeric identification.
- (2) Function narrative, including each functional area and feature of the function including use for the on-line system or in batch processing.
- (3) Flow charts, identifying each program, input, output, and file.
- (4) Job streams within functions identifying programs, input and output, controls, job stream flow, operation procedures, and error and recovery procedures.
- (5) For all forms, screens, tapes and other inputs: input definitions, including names, descriptions, sources, examples, and contents definitions cross-referencing each field to its data element name and number -or- describing how the field is calculated.
- (6) For all screens, reports, and other outputs: output definitions, including names, numbers, sources, destinations, examples, and content definitions; electronic media specifications, file descriptions, and record layouts must be included for all data stored on electronic media.
- (7) Identification and listing of all Contractor internal control reports.

5.7.5.5.3.1.3 Program Documentation

- (1) Program narratives including process specifications, purpose, use in on-line system or in batch processing, and relationships between the programs and modules.
- (2) A list of input and output files and reports, including retention.
- (3) File/database layouts.
- (4) File/database names and dispositions.
- (5) Specifics of all updates and manipulations.
- (6) Comments identifying changes to the program by date, author, and reason.
- (7) Detailed program logic descriptions and edit logic or decision tables, including, at a minimum, the sources of all input data, each process, all editing criteria, all decision points and associated criteria, interactions and destination links with other programs, and all outputs.
- (8) Listings of edits and audits applied to each input item, including detailed edit logic, claim and provider types affected, related State policies, edit disposition and hierarchy, suspense and override data, and corresponding error messages.
- (9) Detailed pricing logic for all claims processed by the system.
- (10) For all files, including intermediate and work files: file descriptions and record layouts, with reference to file names and numbers; data element names, numbers, number of

occurrences, length, and type; record names, numbers, and lengths; and file maintenance data, such as number of records, file space, and others.

- (11) Lists, by identifying name, of all files, inputs and outputs with cross-references to the programs in which they are used.

5.7.5.5.3.2 Production Control Documentation

The purpose of the production control documentation is to describe the operation of the system, and must include the following:

- (1) Job streams within subsystems identifying programs, input and output, controls, job stream flow, operating procedures, and error and recovery procedures.
- (2) For all forms, screens, tapes and other inputs, input definitions including names, descriptions, sources, and examples.
- (3) For all reports, tapes, and other outputs, output definitions, including names, numbers, sources, destinations, and examples.
- (4) Contain operations run documentation with schedules and dependencies.
- (5) Support State monitoring activities and any annual system performance review requirements on an ongoing basis.

5.7.5.5.3.3 Data Element Dictionary

The purpose of the data element dictionary is to define each data element used in the system, identify where and how the element is used, and to provide the values of each data element. The data element dictionary must include:

- (1) A unique data element number.
- (2) A standard data element name.
- (3) A narrative description and definition of the data element.
- (4) A table of values for each data element.
- (5) The source of each data element.
- (6) Table listings for all table elements.
- (7) Capability to generate each of the following at any time: a sorted list of all data names used to reference the data element in programs, a sorted list of programs using the data element, describing the use of input, internal, or output; and a list of files containing the data element. Multiple sorted formats should be available that include data element name, number, and other key element information.
- (8) Descriptions of naming conventions used to create data element names.
- (9) DED must meet State approved documentation standards and approved conventions.
- (10) A cross-reference to the State Medicaid Manual.

5.7.5.5.3.4 Table Description

The purpose of the table descriptions documentation is describe each table used in the system, the elements included in the table, and the values of the elements. The table descriptions documentation must include:

- (1) A description of all tables used in the system which includes at a minimum, for each subsystem:
 - (a) A listing of elements, their values, a written description of the element, and to which subsystems they apply.
 - (b) Cross-reference listings or matrices of related elements or values, showing allowable relationships or exclusions (e.g., Provider Type/Provider Specialty cross-reference).
 - (c) A business rules repository, if appropriate.
 - (d) A table of contents, by function, table and element.
- (2) Each table within the manual shall contain code sets identified by value, description and in which function(s) the code sets apply.
- (3) Each table within the manual shall be listed in alphabetical order by title as approved by the State.
- (4) Updates to the MMIS tables descriptions shall reflect changes identified during the acceptance test process. Updated pages shall be provided to the State for review and approval.

5.7.5.6 Disaster Recovery and Backup

The systems must be protected against hardware and software failures, human error, natural disasters, and other emergencies that could interrupt services. This plan must address recovery of business functions, business units, business processes, human resources, and the technology infrastructure. The plan should clearly communicate all aspects of the recovery and testing processes and contain enough detail so that someone, other than the primary guardian, is able to perform the recovery process.

5.7.5.6.1 Business Continuity Plan

This plan defines how to maintain the business function when automated services are lost. This process is distinctly different than disaster recovery. Generally, disaster recovery relates directly to recovery of the automated functions, such as data, a servers, networks, applications, etc. Continuity deals directly with maintaining the business functions of the operating unit and the services provided to their customers or users in the event of loss of IT functions. Contingency activities would be the creation of paper forms for automated entry systems, creation of secondary hot site locations for automated services, and personnel sharing/training schemes (cross training) for the event of loss of core personnel.

The Contractor must develop a business continuity plan that includes the following:

- (1) Identification of the core business processes involved in the MMIS.
- (2) For each core business process.

- (a) Identification of potential system failures for the process.
- (b) Risk analysis.
- (c) Impact analysis.
- (d) Definition of minimum acceptable levels of outputs.
- (3) Documentation of contingency plans.
- (4) Definition of triggers for activating contingency plans.
- (5) Discussion of establishment of a business resumption team.
- (6) Maintenance of updated disaster recovery plans and procedures.
- (7) Plan for replacement of personnel to include:
 - (a) Replacement in the event of loss of personnel during DDI or during operations.
 - (b) Replacement in the event of inability by personnel to meet performance standards.
 - (c) Allocation of additional resources in the event of the Contractor's inability to meet performance standards.
 - (d) Replacement/addition of personnel with specific qualifications.
 - (e) Time frames necessary for replacement.
 - (f) Vendor's capability of providing replacements/additions with comparable experience.
 - (g) Methods for ensuring timely productivity from replacements/additions on the Alaska project.

5.7.5.6.2 Disaster Recovery Plan

Disaster recovery documentation and procedures must be approved by DHSS and be in place before system operation is initiated. Each aspect of the disaster recovery plan must be detailed as to both Contractor and State responsibilities and must satisfy all requirements for federal certification.

The system, including communications, must include appropriate checkpoint/restart capabilities and other features necessary to ensure reliability and recovery. The Contractor will be required to prepare and maintain a disaster recovery plan and provide DHSS with up-to-date copies at least once a year during the term of the contract. The Disaster Recovery plan must be submitted to DHSS for approval prior to the systems implementation and whenever changes are required. The plan will at a minimum encompass the following:

- (1) Checkpoint/restart capabilities.
- (2) Retention and storage of backup files and software.
- (3) Hardware backup for the main processor(s).
- (4) Network backup for telecommunications.
- (5) Contractor provided telecommunications equipment.
- (6) Uninterruptible Power Source (UPS) at both the primary and alternate sites with the capacity to support the system and its components.

Specific items to be addressed in the Disaster Recovery plan are:

- (7) The continued processing of Alaska transactions (claims, eligibility, provider file, and other transaction types), assuming the loss of the Contractor's primary processing site. This shall include interim support for the State online component of the MMIS and how quickly recovery can be accomplished.
- (8) Back-up procedures and support to accommodate the loss of online communication between the Contractor's processing site and the State.
- (9) A detailed file back-up plan and procedures, including the off-site storage of crucial transaction and master files; the plan and procedures shall include a detailed frequency schedule for backing up critical files. The off-site storage facility shall provide security of the data stored there, including protections against unauthorized access or disclosure of the information, fire, sabotage, and environmental considerations.
- (10) The maintenance of current system documentation and source program libraries at an off-site location.
- (11) Organizational charts, current contact names and corresponding emergency contact phone numbers, and backup contacts and contact information to each of the lead contacts.

At a minimum, three types of situations could arise and must be addressed by the Contractor within their plan to ensure ongoing operations.

- (12) The first type is a major disaster where the central computer installation and resident software are destroyed or damaged. The Contractor must identify and provide alternative facilities and backup to ensure continuation of operations as a part of a comprehensive disaster recovery plan. The disaster recovery plan must be invoked within four (4) hours of a major disaster.
- (13) The second type is system or application dependent problems resulting from network failure, software error, or operational errors where one or several days' processing is invalid, making data on the MMIS also invalid. The Contractor must provide a plan that addresses the restoration of program and data integrity.
- (14) The third type is caused by system down time. The Contractor must maximize system availability at the local level. Down time, caused by the failure of one or more components of the system application software must be resolved and the restoration of services implemented within four (4) hours of the failure.

In addition, differences in the level of backup and recovery abilities exist for the DW/DSS, Eligibility Verification System, and the POS/PRO-DUR System. These are addressed as follows:

- (15) The Contractor must provide back up for the DW/DSS that will enable complete recovery of the hardware and software environment within two (2) calendar days.
- (16) The Contractor must maximize the Eligibility Verification System and POS/PRO-DUR System availability. Down time, caused by the failure of one or more components of any of the application software, operating system, hardware, or any other component supplied and/or controlled by the Contractor, must be resolved and the restoration of services implemented within 30 minutes of the failure. Should the restoration of these systems require the restoration of the MMIS because of the Contractor's architectural solution, the Contractor should not construe this requirement to indicate that the MMIS restoration

requirement is also 30 minutes. Instead, in such a situation, if there is a failure of the MMIS, the back up procedures that apply to the MMIS will prevail for the MMIS; the Eligibility Verification System and POS/PRO-DUR System components may utilize the most recent back up copy of any needed data that existed on the MMIS, not to exceed one day in age.

5.7.5.6.3 Back-Up Requirements

System back-up and processing shall include the following:

- (1) **Weekly Back-up:** The Contractor must establish and maintain on a weekly basis an adequate and secure back-up for all computer software and operating programs, databases and systems, operations, and user documentation (in magnetic and non-magnetic form). The back-ups must be maintained at a secure off-site location in an organized and controlled manner.
- (2) **Daily Back-up:** The Contractor must establish and maintain periodically each day an adequate and secure back-up for all computer software and operating programs, databases and systems, operations, and user documentation (in magnetic and non-magnetic form) that can be changed on a daily basis. The backups must be maintained at a secure off-site location in an organized and controlled manner.
- (3) **Off-Site Storage:** The Contractor must provide for off-site storage of back-up operating instructions, procedures, reference files, system documentation, programs, procedures, and operational files. This must begin during the phase-in period. Procedures must be specified for updating off-site materials. The disaster planning document must be in place before operations are assumed. All proposed off-site procedures, locations, and protocols must be approved in advance by DHSS.
- (4) **Back-up Processing:** The Contractor must provide for a back-up processing capability at a remote site(s) from the Contractor's primary site(s) such that normal payment processing, as well as other system and DHSS services deemed necessary by DHSS, can continue in the event of a disaster or major hardware problem at the primary site(s).
- (5) **Hot Site Back-up Processing Capability:** The Contractor must provide documentation defining back-up processing capacity and availability. Included shall be a prioritized listing of all of the Contractor's back-up processing that must be performed at the back-up processing facility in the event of an inoperable condition at the primary site. Estimated back-up processing capacity utilization shall be included for each back-up processing item listed. Documentation shall include written agreements with the management of the back-up processing facility. Agreements shall identify duties and responsibilities of all parties involved as well as specify the level of back-up service to be provided to the Alaska systems.
- (6) **Hot Site Back-up Processing Demonstration:** The Contractor must demonstrate the back-up processing capability for all critical system components at a remote site once during the first year of the contract period and no less often than every two (2) calendar years in accordance with 45CFR 95.21(f). The demonstration at the remote site will be performed for all administrative, manual, input, processing, and output procedures functions, and include:

- (a) The processing of one daily and one weekly payment processing cycle, at a minimum, and a test of all on-line transactions including the real-time interface with DSS, and a test of query and report capability
- (b) Verification of the results against the corresponding procedures and production runs conducted at the primary site

A report summarizing the hot site processing test results must be provided to DHSS within 30 calendar days of completion of the test.

Back-up demonstrations shall be performed at no additional cost to DHSS. In the event the Contractor's test is deemed by DHSS to be unsuccessful, the Contractor will continue to perform the test until satisfactory.

5.7.5.7 Records Retention

The Contractor will be required to assume control of the current Contractor's existing hard copy files for records retention. The retention schedule and media are provided in the following table.

Document	Retention Requirements	
	Documents Turned Over from Current Contractor	Documents To Be Retained from New Contract
SURS Case Review Reports and Files	Image the hardcopy and store imaged documents Destroy hardcopies prior to 1994	Hardcopy to be stored at DHSS Image when files are retired
Microfilm	Store all microfilm	Imaged documents will replace microfilm
Microfiche	Store all microfiche	Electronic reports will replace microfiche
Hardcopy Claims, Attachments, Prior Authorizations, Pend Sheets	Destroy hardcopy documents prior to 2001 Retain hardcopy documents for two years	Retain hardcopy for 2 years Retain imaged copies in permanent storage
EMC Claims	Store electronic media	Store electronic media and provide imaged copy
Provider Correspondence	Destroy hardcopy documents prior to 2001 Retain hardcopy documents for two years	Retain hardcopy for 2 years Retain imaged copies in permanent storage

Document	Retention Requirements	
	Documents Turned Over from Current Contractor	Documents To Be Retained from New Contract
Provider and Beneficiary Publications and Training Materials	Retain two most current versions in hardcopy	Retain most current version in hardcopy Retain all historical copies in electronic format
Work Orders, DHSS Correspondence, File Updates	Retain hardcopy documents	Retain hardcopy documents
Provider Appeals	Archive hardcopy documents over 4 years old	Retain hard copies over 4 years Retain imaged copies in permanent storage
Provider Agreements	Image the hardcopy and store imaged documents Retain hardcopies	Store hardcopies Image and store imaged copies
Systems Library	Store CD copies of system and documentation	Store electronically

It will be the Contractor's responsibility to comply with all standard federal data retention requirements for the medical assistance programs, as well as any other retention requirements that are applicable. Public law requires a three-year retention after the end of the contract on certain documents.

The Contractor must identify the off-site storage facility and submit a detailed plan for the storage of contract material for DHSS approval.

5.7.5.8 Location of Activities

During the DDI and operations phases of the contract functions related to system processing and computer operations may be performed at a site selected by the Contractor and approved by DHSS. The following key functions have historically been performed in Alaska and will continue to be at the discretion of the State. The Contractor may propose alternatives to the Alaska location that demonstrate cost and resource efficiency:

- (1) Claims receipt and control
- (2) Prior authorization, other than those portions of the pharmacy prior authorization which can be done through the POS help desk
- (3) Provider relations
- (4) Provider enrollment

- (5) Provider training (Locations outside of Anchorage are specified in Section 5.5.4—
Provider Function)
- (6) Project management
- (7) Claims resolution
- (8) Utilization Review (UR) & Quality Assurance (QA)
- (9) Ad-Hoc programming support in Anchorage & Juneau
- (10) Contract monitoring
- (11) Third Party Liability (TPL)
- (12) Bank account reconciliation
- (13) Case management
- (14) Claims payment
- (15) Recipient functions including buy-in, eligibility, and lock-in
- (16) Retrospective Drug Utilization Review (DUR).
- (17) Payment Error Rate Measurement (PERM)
- (18) Managed care

Except for managed care, more detailed information on these functions can be found in the Detailed Systems Design (DSD) and the User Manuals located in the procurement library. The actual location of activities and any changes must be coordinated with and receive the approval of DHSS.

5.7.5.9 Facility Requirements

The Contractor will provide fully equipped office space for its ongoing operations in Anchorage, Alaska. The Contractor must insure adequate office space and parking for Contractor staff, and must provide a break room for Contractor staff including the normal amenities, such as a coffee machine, vending machines, microwave oven, refrigerator, etc. All utilities, including gas, water, and electric, as well as adequate janitorial services will be the Contractor's responsibility.

The Contractor will be required to supply separately lockable office space in the Contractor's Anchorage facility for use by ten (10) DHSS staff. This office space must be fully equipped with furniture, telephone service, ten (10) personal computers with access to the system, and access to a printer and copier. Reserved parking spaces must be provided to accommodate DHSS staff who will be using the space.

5.7.5.10 Equipment Requirements

The Contractor will be responsible for submitting to DHSS for approval a comprehensive plan identifying the approach, the equipment, and software to be supplied to DHSS for the support of their daily operations.

The Contractor will be responsible for supplying all equipment for its staff to operate the MMIS.

All equipment must meet DHSS approval and must be compatible with DHSS hardware and software used in connection with the MMIS. The Contractor must develop equipment test criteria for approval by DHSS.

The Contractor must supply personal computers for Contractor staff with MMIS and network access, and must provide sufficient office space and office furniture to accommodate the computers and any required additional hardware. The Contractor must provide a detailed plan for installing equipment, furniture, and software, and a detailed equipment and materials listing for DHSS approval.

5.7.5.11 Equipment Ownership

All equipment and furniture purchased by the Contractor and paid for with funds provided by the State of Alaska during the term of the contract will become State property. Items purchased by the Contractor solely with Contractor funds may be purchased by the State at the end of the contract for the salvage or reasonable value at the discretion of DHSS.

5.7.5.12 Audit Requirements

This subset defines the procedures used to reaffirm and identify the functions, processes, or activities within the IT Enterprise are functioning as documented and designed. This subset relies heavily on documented processes. It will help ensure that there is a clear understanding to the predictability of the IT Enterprise and the functions or activities and to affirm compliance the activities defined in the other categories.

Annually, the Contractor shall pay for and be subject to an audit of the claims payment process controls to be conducted by a third party. A Statement on Auditing Standards (SAS) 70 Report shall be provided to the DHSS Contract Administrator. SAS 70 provides guidance on the factors an independent auditor should consider when auditing the financial Statements of an entity that uses a service organization to process certain transactions.

The third party auditor should consider the effect of the Contractor on the internal control of the State and the availability of evidence to:

- (1) Obtain the necessary understanding of the Contractor's internal control in order to plan an audit.
- (2) Assess control risk at the Contractor's site.
- (3) Perform substantive tests.

5.8 Operations

Following successful implementation of the system the Contractor will be responsible for ongoing operations. During the course of the contract this will include:

- (1) Continuation of the management and operational activities described in 5.7 that were employed during Takeover and DDI phases.

- (2) Maintenance and enhancement of the functional requirements defined in 5.6.
- (3) Incorporation of maintenance and operation efficiencies made possible by improved technology.
- (4) Commitment and flexibility to support changes in the Alaska medical assistance programs and the service delivery system, and support cost savings initiatives.
- (5) Achieving CMS functional and reporting requirements at all times.

5.9 Turnover

Upon termination of the contract, the Contractor will be required to provide support in turning over the MMIS operations to DHSS or its designated agent. All assistance, including the cost of hardware, software, or staffing will be borne by the Contractor as part of the annual fixed operations fee.

5.9.1 DHSS Objectives

Turnover of the MMIS is an integral part of the MMIS contract. The turnover of operations, whether to DHSS or to another Contractor, must be smooth, timely, and without any adverse impact on the users of MMIS services. The proposers must describe their approach to turnover of operations at the termination of the contract. The proposed approach must address the staff proposed, the main tasks for Turnover, and a proposed schedule. DHSS will require the Contractor to develop a comprehensive Turnover Plan within twelve (12) months of the implementation of the contract and update it once every year during the life of the contract.

5.9.2 Turnover Tasks

The Contractor must identify in its work plan all the Turnover tasks proposed for a smooth and timely transition, and its approach to accomplishing those tasks on time.

5.9.3 DHSS Responsibilities

- (1) Notify the Contractor at least twelve (12) months prior to the termination of the contract that DHSS wants to transfer or replace the system. For a termination prior to the full term of the contract, DHSS notification will be sixty (60) days or less.
- (2) Review and approve the Turnover Plan.
- (3) Provide DHSS staff time for training.
- (4) Coordinate the availability of new Contractor staff to be trained for Takeover.
- (5) Review and approve the proposed staffing plan for Turnover.
- (6) Coordinate the turnover of hardware, software, and data to the new Contractor.
- (7) Review and approve the post-turnover staffing proposed by the Contractor.
- (8) Monitor the Turnover Phase of the contract.

5.9.4 Contractor Responsibilities

- (1) Within thirty (30) days after receipt of the notification of intent to transfer or replace, provide a Turnover Plan to DHSS. The plan shall include at a minimum:
 - (a) Approach to Turnover
 - (b) Schedule for Turnover
 - (c) Staffing for Turnover
 - (d) State staffing requirements
 - (e) Tasks and subtasks associated with Turnover
- (2) Within forty-five (45) days after receipt of the notification of intent to transfer or replace, provide a comprehensive MMIS requirements document to DHSS. This document will include Statements regarding overall staffing, equipment, facility, and hardware and software. The intent of this document is to prepare DHSS or its agent with adequate resources to manage the operations upon termination of the contract.
- (3) Provide the current Contractor organization chart for the Alaska medical assistance programs operations.
- (4) Provide a data transfer plan.
- (5) Provide a software transfer plan.
- (6) Prepare training materials.
- (7) Train State and Contractor staff.
- (8) Provide guided visits to the facility for State and Contractor staff.
- (9) Provide a plan to transfer all current and archived documents.
- (10) Transfer all system, user, and operations documentation.
- (11) Transfer all provider-related documents and manuals.
- (12) Provide a list of Subcontractors.
- (13) Provide a list of hardware, telecommunications, and software resources currently used to manage the operations.
- (14) Provide a list of staff, by labor category, required to manage the operations.
- (15) Provide a list of proprietary software, if any, with appropriate descriptions.
- (16) Provide a complete turnover results report at the end of the Turnover Phase.
- (17) Provide post-turnover support.

5.9.5 Milestones

- (1) DHSS approval of the Turnover Plan.
- (2) Completion of training for DHSS and Contractor staff.
- (3) Completion of transfer of data and software for initial test.
- (4) Transfer of all documentation.

5.9.6 Deliverables

- (1) Turnover plan.
- (2) MMIS staffing requirements.
- (3) MMIS training materials.
- (4) MMIS operational requirements.
- (5) List of all MMIS hardware and software.
- (6) File/data transfer plan.
- (7) Documents transfer plan.

6 PROPOSAL FORMAT AND CONTENT

6.1 Proposal Format and Content

The State discourages overly lengthy and costly proposals; therefore, brochures or other presentations, beyond that sufficient to present a complete and effective proposal, are not desired. Elaborate artwork or expensive paper is not necessary or desired. Audio and/or videotapes are not allowed. Offeror proposals including audio or videotapes will be deemed non-responsive and rejected.

In order for the PEC to evaluate proposals fairly and completely, Offerors should follow the format set out below to provide all requested information. The use of tabs to identify sections and/or subsections is encouraged.

Format and content requirements for technical proposals are presented in Section 6.2. Format and content requirements for cost proposals are presented in 6.3. Cost proposal documents must be submitted separately from the technical proposal document.

6.2 Technical Proposals

Technical proposals must be submitted in the following format:

- Section I: Introduction
- Section II: Understanding of the Alaska MMIS Project
- Section III: Management Plan for the Project
- Section IV: Scope of Work - Methodology for the Alaska Project
- Section V: Experience and Qualifications
- Section VI: Appendices

The format and content requirements for each section of the technical proposal are described below. The technical proposal shall include complete responses to all required items listed under each heading. Without providing overly lengthy descriptions, the proposal must provide clear descriptions and/or responses so that the PEC members can adequately evaluate the Offeror's response and intent. Offerors are advised to follow the defined format and to clearly identify the location of topics in their proposal. The evaluation of technical proposals will follow the submission format.

Each technical proposal (including all copies) shall use 8.5 x 11-inch paper, be clearly page numbered on the bottom of each page and submitted in three-ring binders. Sections, Appendices, and Exhibits may be independently page numbered instead of consecutive pagination throughout the entire proposal (for example, if Section I and Section II are 25 and 30 pages respectively: I-1 through I-25, and II-1 through II-30). A type size of eleven (11) points or larger shall be used.

An original and fifteen copies of the technical proposal are required. The format of the electronic copy to be put on compact disk was referenced in SECTION ONE (1).

6.2.1 Introduction

Proposals must confirm that the Offeror will comply with all provisions in this RFP, and if applicable, provide notice that the firm qualifies as an Alaskan bidder. Proposals must be signed by a company officer empowered to bind the company. An Offeror's failure to include these items in the proposal may cause the proposal to be determined to be non-responsive, and the proposal may be rejected.

The introduction must contain the following subsections:

- Transmittal Letter
- Executive Summary
- Proposal Cross Reference

The requirements for each of these subsections are described below.

6.2.1.1 Transmittal Letter

The transmittal letter shall be submitted on official business letterhead by the prime Contractor. The original of the transmittal letter, including original signature of an individual authorized to bind the Offeror to the provisions of the RFP, shall be submitted within the original version of the technical proposal. A copy of the letter shall be included in each technical proposal. All transmittal letters shall include the following:

- (1) The complete name and address of the firm and the name, mailing address, e-mail address, and telephone number of the person the State should contact regarding the proposal.
- (2) A statement that the Offeror accepts the contract terms and conditions contained in this RFP, including the Attached Contract. Exceptions to any the RFP language, requirements, or conditions must be reflected in this Statement. All exceptions must be identified and fully described in a separate attachment to the proposal and include any suggested alternatives and language. DHSS reserves the right to reject proposals as non-responsive based on exceptions taken by an Offeror and is not bound to accept or negotiate any suggested alternatives.
- (3) A statement that the Offeror complies with the State Procurement Code (AS 36.30) and all applicable local, State, and Federal laws, codes, and regulations.
- (4) A statement that the Offeror does not restrict the rights of the State or otherwise qualify their proposal.
- (5) A statement declaring onsite staffing in Alaska, as well as other system development support completed and managed at the Offeror's central offices or other locations, will be as approved by the State.

- (6) A statement that no attempt has been made or will be made by the Offeror or its Sub-Contractor(s) to induce any other firm or person to submit or not to submit a proposal in response to this RFP.
- (7) A statement that cost or pricing information has not been included in this letter, nor in the entire technical proposal.
- (8) A statement that the Offeror certifies that in connection with this procurement:
 - (a) The prices proposed have been arrived at independently, without consultation, communication, or agreement, as to any matter relating to such prices with any other Offeror or with any competitor for the purpose of restricting competition.
 - (b) Unless otherwise required by law, the prices quoted have not been knowingly disclosed by the Offeror prior to award, directly or indirectly, to any other Offeror or to any competitor.

(This requirement is also to be fulfilled by other parties in the case of a joint venture or the use of Sub-Contractors. Each party must certify separately for its own organization.)
- (9) A statement identifying all amendments to this RFP issued by DHSS and received by the Offeror. If no amendments have been received, a Statement to that effect should be included.
- (10) A statement indicating whether or not the Offeror, Sub-Contractor, or any individuals proposed to work on the project have a possible conflict of interest (e.g., employed by the State of Alaska) and, if so, the nature of that conflict.
- (11) A statement that the Offeror agrees to obtain and provide the required performance bonds described in this RFP. A commitment letter for the first performance bond is required to be included with the proposal.
- (12) A statement indicating that the Offeror commits to producing a turnover plan when instructed to do so and to fully cooperating in implementing a turnover when required.
- (13) If a proposal with Sub-Contractors is submitted, the Offeror must submit a statement indicating that the Offeror will perform at least 45% of the amount of work for the entire project. This percentage is measured in terms of the total price of the contract. The Offeror must provide the following information concerning each prospective Sub-Contractor in an appendix to the proposal:
 - (a) Complete name of the Sub-Contractor
 - (b) Complete address of the Sub-Contractor
 - (c) Type of work the Sub-Contractor will be performing
 - (d) Percentage of work the Sub-Contractor will be providing
 - (e) Evidence that the Sub-Contractor presently holds a valid Alaska business license
 - (f) A Statement that clearly verifies that the Sub-Contractor is committed to render the services required by the contract
 - (g) A general description of the scope of work to be performed by the Sub-Contractor

- (h) The Sub-Contractor's assertion that it does not discriminate in its employment practices.
- (i) This appendix must be signed by an individual authorized to legally bind the Sub-Contractor.
- (14) A statement indicating the preferences for which the Offeror qualifies (if any). If affirmative, an affidavit certifying that the Offeror is eligible to receive these preferences must appear in an appendix.
- (15) A statement that identifies whether or not the concept of this proposal's prime Contractor is as a joint venture. If it is a joint venture, a copy of the joint venture agreement must be included in the appendix which identifies the principles involved, and their rights and responsibilities regarding performance and payment.

6.2.1.2 Executive Summary

The Executive Summary shall condense and highlight the contents of the technical proposal in such a way as to provide the PEC with a broad understanding of its contents. The Executive Summary is limited to twenty-five (25) pages and shall include the following:

- (1) A clear and concise summary of understanding of the Alaska project, including proposed approach to operational takeover, development of the new Alaska MMIS system, and Contractor needs;
- (2) A clear and concise summary of the proposed methodology that will be followed to address the Offeror's Statement of Work responsibilities during the Operational Takeover (Phase I), DDI (Phase II), and Operations (Phase III);
- (3) A summary description of proposed system capabilities that will be used or modified to address Alaska system needs, including listing sources for the base system or systems for each subsystem, and appropriate MMIS certification data, if any;
- (4) A brief description of corporate capabilities, planned roles of any proposed Sub-Contractor(s) and overall staffing approach; and
- (5) A brief description of the major benefits offered by this proposal.

6.2.1.3 Proposal Cross Reference

A proposal cross-reference must be included in an appendix to the Offeror's proposal. The proposal cross-reference will be used by the PEC to aid in the evaluation of the proposal. The Offeror is expected to use the format in Attachment I. The Offeror should make an entry for every item included on Attachment I to indicate where the information is found in the proposal that satisfies the requirement.

6.2.2 Understanding of the Alaska MMIS Project

Offerors must provide comprehensive narrative Statements that illustrate their understanding of the requirements of the project and the project schedule.

This section shall describe the Offeror's understanding of the scope of the Alaska MMIS project and the medical assistance programs to be supported by the Offeror. Background information regarding Alaska medical assistance programs is presented in Section 4. This methodology section shall contain the following subsections:

6.2.2.1 Outline of the Approach for Takeover of the Legacy System

This subsection of the proposal shall include a description of the proposed approach to accomplishing Phase 1 of the project, takeover of the current fiscal agent operations. This should address how the Offeror will accomplish the activities presented in the Takeover section of the RFP. The description should also identify risks and mitigation strategies.

6.2.2.2 Outline of Proposed Solution and Approach

Provide an outline of the proposed system solution and approach to meeting the requirements for the Alaska system. DHSS encourages a modular solution if it provides necessary flexibility, integrity, and congruity of processes. The overview will be accompanied by one or more charts depicting all major automated and manual processes and the required internal and external interfaces.

6.2.2.3 System Proposed for Transfer to Alaska

Include a narrative of the system being proposed for transfer to Alaska, including an overview of its functions and capabilities. If applicable, the source and location of any transfer system should also be identified along with current status of CMS certification of the MMIS portion of the transfer system.

6.2.2.4 Changes to Proposed System

If the Offeror intends to install an existing system, provide a list of key proposed changes that will be incorporated in the proposed transfer system to make the system comply with the functional and technological requirements of this RFP. Provide an overview of the changes required, including an estimated total percent of system changes, enhancements or additions. Also, identify proposed changes by required system function to enable the PEC to clearly understand the scope of such changes.

6.2.2.5 MITA Architecture

The State intends to acquire a system that is aligned with the CMS Medicaid Information Technology Architecture (MITA) and has the capability and corporate planning, support, and vision to achieve successive MITA maturity levels. The State understands that MITA is an evolving set of standards that is not fully developed and is not requesting "full adherence" to all specifications nor highest maturity levels. However, the State is requiring Offerors to identify their proposed systems' alignment with MITA principals and their corporate vision for addressing MITA requirements.

MITA enabling guidelines, processes and tools provide states a framework for the continuous improvement of service delivery and business process based on efficient technology utilization.

MITA depicts this evolution as a progression of maturity levels that reflect the State's ability to execute business functions in the rapidly changing health care environment.

The State will use MITA as a tool to assist the State in the strategic application of technology and enhancements that provide value and contribute to a continuous improvement in the Medicaid program's maturity. The State's is interested, however, in purchasing a system that will (a) enhance its maturity in most or all areas, and (b) serve as both a foundation and a catalyst for the State to continuously improve the efficiency of its business and service delivery capabilities.

The Offeror must identify, using the format in the MITA Baseline Attachment B, how the offered solution aligns with the MITA business process maturity levels and technical capabilities. This MITA baseline should reflect the system and processes capabilities as proposed to meet Alaska's RFP requirements.

6.2.3 Management Plan for the Project

Offerors must provide comprehensive narrative Statements that set out the management plan they intend to follow and illustrate how the plan will serve to accomplish the work and meet the State's project schedule.

The approaches used to plan and manage the MMIS project are critical for successful completion of MMIS implementation. The proposal will present the Offeror's comprehensive approach to project management that will be employed throughout all phases of the project, including planning, development of work plans, determination of resource requirements, quality assurance, risk assessment and mitigation, change management, monitoring, and reporting. This must also describe the tools and organizational structure that will be used to control and manage the project. RFP Sections 5.5.1 and 5.5.2 include requirements that should be addressed in this comprehensive approach.

Specific requirements for the comprehensive approach to project management are presented below. In addition, the proposal must address how project management tasks and responsibilities will change as the project moves through each Phase; including takeover of the legacy MMIS, DDI of the new system, operations, and turnover.

At a minimum, the Offeror's proposal should explain how the Offeror intends to complete or address the following project management issues/approaches during the life of the contract:

- (1) Project management approach for successfully completing all phases of the project within the budget and defined schedule; include maintenance of milestone and deliverable timelines.
- (2) Approach to requirements definition.
- (3) Approach to resource planning and establishing the scope of responsibilities for each Key position listed in Section 3.11 as well as lead functional area (subsystem) experts who will be participating on the project. This should clarify how the workload related to all activities performed during DDI is distributed.

- (4) Approach for change management control and reporting.
- (5) Approach to test planning and management.
- (6) Approach for issue and risk identification, tracking, and reporting procedures, including an automated tracking and management system.
- (7) Approach to internal quality control.
- (8) Approach for scope management.
- (9) Approach for completing and presenting deliverables, conducting walkthroughs, and obtaining client sign-off.
- (10) Description of how the Detailed Implementation Plan and other reporting will be maintained.
- (11) Approach to client interface and completing required status reporting.
- (12) Approach to interfacing with the incumbent Contractor and transition planning.
- (13) Process for identifying privacy and security requirements and ensuring they are maintained.
- (14) Authority of the project manager and other key staff.
- (15) Work hours, time estimating and reporting methods.
- (16) Approach to coordinating activities and tasks between on-site and off-site staff in the most efficient manner.
- (17) Approach to meeting the contract performance standards.

6.2.4 Scope of Work - Methodology for the Alaska Project

Offerors must provide comprehensive narrative Statements that set out the methodology they intend to employ and illustrate how their methodology will serve to accomplish the work and meet the State's project schedule.

In this section the proposal will present the approaches and methods that will be used to accomplish the scope of work introduced in Sections 5.1 – 5.3 and described in detail for each phase of the project.

6.2.4.1 Phase I – Operational Takeover

This subsection of the proposal will depict the Offeror's and each Sub-Contractor's project team organization charts, proposed personnel, and the number and type of FTEs proposed. Each activity and task identified in Section 5.4 (Phase I – Operational Takeover Phase) will be addressed individually.

The Offeror shall organize and present responses to each activity, task, and subtask in this phase as follows:

- (1) A narrative overview of the Offeror's approach to completing each activity, task, and subtask for this phase.

- (2) A work plan detailing each activity, task, and subtask, including, at a minimum:
 - (a) Description of each activity, task, and subtask;
 - (b) Start Date;
 - (c) End Date;
 - (d) Offeror Resource Requirements: Person hours of effort by labor category associated with each task and subtask (no subtask will exceed 80 person hours of effort);
 - (e) DHSS Resource Requirements: Offerors should assume that individual State staff members will be available for a maximum of forty percent (40%) of the normal State work hours during the Operational Takeover phase;
 - (f) Milestones;
 - (g) Deliverables;
 - (h) Location where activity, task, or subtask will be performed;
 - (i) A Gantt chart; and
 - (j) A discussion of how the work plan will provide for handling potential and actual problems.
- (3) Organization charts and staffing plan for the Operational Takeover phase showing staffing levels and positions, including, at a minimum:
 - (a) Key personnel, identified in Section 3.11 of this RFP;
 - (b) Job descriptions for each position on the organization chart, including the following:
 - (1) Position title;
 - (2) Required qualifications;
 - (3) Prior experience; and
 - (4) Responsibilities related to the project.
 - (c) Staffing matrix indicating the staffing levels on the project by labor category, start and end dates, and the physical location of each staff;
 - (d) A description of additional corporate support available for this phase of the project; and
 - (e) Any assumptions and constraints in developing or completing the work plan.
- (4) Description of the facility and equipment planned for takeover in Alaska during the Operational Takeover phase, including, at a minimum:
 - (a) Layout and total square footage of the facility;
 - (b) Number of Offeror's staff to occupy the facility;
 - (c) Furniture and office equipment to be installed at the facility; and
 - (d) LAN architecture and all telecommunications linkages.

- (5) A list of any proprietary software and commercial off-the-shelf (COTS) software to be purchased for State use in the Operational Takeover phase, including identification of those software packages for which license fees will be paid.
- (6) Identification and description of all deliverables, with due dates for draft and final deliverables.
- (7) Delineation and description of DHSS and Offeror responsibilities, with names and titles of key personnel responsible for each activity.
- (8) Any assumptions and constraints.

6.2.4.2 Phase II – DDI

This subsection of the proposal will contain the Offeror's and each Sub-Contractor's project team organization charts, proposed personnel, and the number and type of FTEs proposed. Each activity and task identified in Sections 5.5.3 – 5.5.11, Phase II – DDI Phase, will be addressed individually.

The State recognizes that Data Warehouse/Decision Support System functionality will be the primary vehicle for meeting the program planning, management, and reporting requirements of DHSS. Proposals should address this reporting component as a design and development effort that is performed in parallel to the design and development of core MMIS functionality. The MMIS must be interoperable with the Data Warehouse/Decision Support System. The Project Management Approach must explain how the required parallel development efforts will be accomplished, including assignment of expert staff, requirements assessment, assessment of affordability versus scalability, and development of comprehensive solution for approval by the State.

The Offeror shall organize its proposal and present an initial DDI Project Plan response to each activity, task, and subtask in this phase as follows:

- (1) A narrative overview of the Offeror's approach to completing each activity, task, and subtask for this phase.
- (2) A Project Implementation Plan (PIP) maintained in MS Project or a similar accepted industry established tool, detailing each activity, task, and subtask, including, at a minimum:
 - (a) Description of each activity, task, and subtask;
 - (b) Start Date;
 - (c) End Date;
 - (d) Offeror Resource Requirements: Person hours of effort by labor category associated with each task and subtask (no subtask will exceed 80 person hours of effort);
 - (e) DHSS Resource Requirements;
 - (f) Milestones;
 - (g) Deliverables;

- (h) Location where activity, task, or subtask will be performed;
 - (i) A Gantt chart; and
 - (j) A discussion of how the work plan will provide for handling potential and actual problems.
- (3) Organization charts and staffing plan for the DDI phase showing staffing levels and positions, including, at a minimum:
 - (a) Key personnel, identified in Section 3.11 of this RFP;
 - (b) Job descriptions for each position on the organization chart, including the following:
 - (1) Position title;
 - (2) Required qualifications;
 - (3) Prior experience; and
 - (4) Responsibilities related to the project.
 - (c) Staffing matrix indicating the staffing levels on the project by labor category, start and end dates, and the physical location of each staff;
 - (d) A description of additional corporate support available for this phase of the project; and
 - (e) Any assumptions and constraints in developing or completing the work plan.
- (4) Description of the equipment planned for installation at the State supplied facility in Alaska during the DDI phase, including, at a minimum:
 - (a) Number of Offeror's staff to occupy the facility (full time equivalents and key staff);
 - (b) Furniture and office equipment to be installed at the facility; and
 - (c) LAN architecture and all telecommunications linkages.
- (5) A list of any proprietary software and COTS software to be purchased for State use in the DDI phase, including identification of those software packages for which license fees will be paid.
- (6) Identification and description of all deliverables, with due dates for draft and final deliverables.
- (7) Project Definition including delineation and description of DHSS and Offeror responsibilities, with names and titles of key personnel responsible for each activity. The Project Definition Document deliverable will confirm the parameters of responsibility that exist for the Contractor and the State with respect to information exchange and completing tasks. The object of this document is to eliminate gaps that may develop if each organization assumes work is being completed by the other. This document will present the Contractor's description of the individual tasks involved in completing each activity specifically designated as "Contractor's Responsibilities" in the RFP. To reduce confusion the State has included in the bidders library a Project Management Office Operations Manual that describes the State of Alaska - DHSS resources dedicated to the

project. In addition, the manual presents project management concepts and approaches that the State sees as key to the successful execution of the project.

(8) Any assumptions and constraints.

6.2.4.3 Functional Requirements

Functional requirements include the existing business processes, as well as the enhanced business process capabilities that will be supported through successful DDI, and will be conducted and supported throughout the Operations Phase of the project. This subsection of the proposal must provide a description of how all functional requirements presented in the RFP Sections 5.6.2 – 5.6.21 will be provided by the proposed system or by on-going operational functions performed by the Contractor.

Proposals should demonstrate that the Offeror has assessed these requirements, compared their purpose and scope to existing capabilities of the proposed system, and developed recommendations for modifications or enhancements that will support implementation. Narrative should elaborate understanding of requirements and educate evaluators about how these requirements can be achieved through the proposed system. Repetitive and non-informative “yes or no” responses are not encouraged.

The proposal must:

- (1) Include a description of the Offeror’s methodology for assessing the gap between the proposed system capabilities for supporting functionality and the requirements presented in Sections 5.6.2 – 5.6.21.
- (2) Include descriptions of how the proposed solution meets or exceeds each requirement in Sections 5.6.2 – 5.6.21. In order to minimize repetition and to help clarify capabilities, individual responses may address multiple requirements. However, such responses must clearly identify the individual requirements that are included, and it must be evident in the text how each requirement is addressed.
 - (a) Include explanations of any assumptions and/or constraints related to each function and how these impact compliance with the requirements.
 - (b) In cases where requirements are not met, present a summary of system modification or enhancement that will need to be completed.
 - (c) For each functional area, provide high-level process and data flow diagrams and identification of documented interfaces, inputs, and outputs.
 - (d) Provide a description of the delineation of responsibilities between the State and the Offeror within each functional area.

Only Offerors that are reasonably susceptible for award will be asked to demonstrate the functionality of their proposed solution(s). These scripted demonstrations will be scheduled during the proposal evaluation period. A more detailed description of the demonstration requirements and evaluation criteria and weighting are included in the Software Demonstration Script, Attachment L.

6.2.4.4 Management and Operational Requirements

Include descriptions of the approaches, automated and manual tools, and processes that will be performed by the Contractor to ensure effective system control, reliability, documentation, and recovery. Proposals must explain how the operational functions presented in Section 5.7 will be implemented during DDI and employed through the Operations Phase of the project. These functions include:

- (1) Contractor internal quality control.
- (2) Contract monitoring.
- (3) Change management.
- (4) Data processing policies, procedures, and standards.
- (5) System reliability and ability to meet production, access, and navigation.
- (6) Security and Confidentiality.
- (7) Configuration Management and Version Control.
- (8) Documentation Requirements.
- (9) Records Retention.
- (10) Disaster Recovery and Back-up.
- (11) Location of Activities.
- (12) Facility and Equipment Requirements.

6.2.4.5 Phase III Operations

Following successful implementation of the system with the functional requirements above, the Contractor will be responsible for ongoing operation of the system. This includes continuation of the management and maintenance activities that are implemented during the DDI Phase. The proposal must describe how these functions will be accomplished during ongoing operations. The proposal must address:

- (1) General requirements responsibilities presented in Sections 5.6.1 and 5.8, including:
 - (a) Meeting CMS functional and reporting requirements at all times.
 - (b) Maintaining all capabilities implemented as a result of this procurement.
 - (c) Incorporating maintenance and operational efficiencies made possible by improved technology.
 - (d) Provide flexibility in approaches to reimbursement methodologies and the infrastructure to support them.
 - (e) Provide flexibility to support changes in the Alaska medical assistance programs and the service delivery system.

- (2) Identification of any processes or procedures initiated and utilized during DDI that will be modified to support ongoing operations, including a summary of the modification that will be required.
- (3) Organization charts and staffing plan for the Operations phase showing staffing levels and positions, including, at a minimum:
 - (a) Key personnel, identified in Section 3.11 of this RFP.
 - (b) Job descriptions for each position on the organization chart, including position title, required qualifications, prior experience, and responsibilities of the position.
 - (c) Staffing matrix indicating the staffing levels on the project by labor category, start and end dates, and the physical location of each staff.

6.2.4.6 Phase IV Turnover

The Offeror shall present the approach that will be used to provide support in turning over MMIS operations to the State or its designated agent. Requirements are contained in Section 5.9. The proposal must address:

- (1) Approach to Turnover;
- (2) Major tasks associated with Turnover; and
- (3) Proposed schedule and types and numbers of staff.

6.2.5 Experience and Qualifications

Offerors must provide an organizational chart specific to the personnel assigned to accomplish the work called for in this RFP, illustrate the lines of authority, and designate the individual responsible and accountable for the completion of each component and deliverable of the RFP.

Offerors must provide reference names and phone numbers for similar projects the Offeror's firm has completed.

Proposals must include proof of the Offeror's capability to fulfill the performance requirements of the State and suitable evidence of financial ability to perform. This proof must be submitted in an appendix to the proposal.

Such evidence must include at least three business letters of recommendation and a list of four or more references, including at least three customers and one lending institution.

Proposals must include evidence of the Offeror's experience in working with State medical assistance programs, federal medical assistance programs, and private sector vendors in the operation of health and medical mechanized claims payment information systems. Proposals shall also describe the Offeror's experience in working on the DDI of health and medical information systems.

Offerors must provide evidence within their proposal that they meet the minimum requirements specified in **Section 2.7 – Minimum Requirements**, or their proposal will be found non-responsive and will be rejected.

The following subsections must be included in the Offeror's proposal:

- (1) Corporate Capabilities
- (2) Resumes

The requirements for each of these subsections are described below.

6.2.5.1 Corporate Capabilities

This subsection must describe the Offeror's and each Sub-Contractor's (if any) company background, size and resources, details of relevant experience, financial Statements, and a list of all current or recent Medicaid or related projects. The specific role of each proposed Sub-Contractor must be described. At a minimum, the background information must include:

- (1) Name of the Offeror or Sub-Contractor (clearly identified as such)
- (2) Date established
- (3) Ownership (whether public company, partnership, subsidiary, etc.)
- (4) Federal employer identification number (FEIN)
- (5) Primary line of business
- (6) Total number of employees
- (7) Number of employees engaged in MMIS and DSS development and operations
- (8) Number of employees engaged in computer system development
- (9) Company's current computer hardware and software resources
- (10) Financial Statements for the legal contracting entity and Sub-Contractors for the last three years, including:
 - (a) Balance sheets
 - (b) Statement of income
 - (c) Statement of changes in financial position
 - (d) Auditor's reports
 - (e) Notes to financial statements
 - (f) Summary of significant accounting policies
- (11) Details of corporate experience (including Sub-Contractors) by separate project within the last five years relevant to the proposed fiscal agent contract, including:
 - (a) Experience with large scale data processing system takeover and operation
 - (b) Experience with large scale data processing system enhancement and modifications

- (c) Experience with relational database and client/server platforms
 - (d) Experience with IE/CASE tools and Information Re-engineering.
 - (e) Experience with messaging and interface software systems
 - (f) Experience with MMIS systems and MMIS operations
 - (g) Experience with healthcare providers
 - (h) Experience as a fiscal agent or an intermediary
 - (i) Experience with Medicaid programs
 - (j) Experience in medical policy management, utilization review, and case management activities
 - (k) Experience in performing prior authorization activities
 - (l) Experience with TPL operations
- (12) For every project referenced above, the Offeror must provide, at a minimum:
- (a) Title of the project
 - (b) Name of client organization
 - (c) Client reference, title, and current telephone number
 - (d) Start and end dates of the contract
 - (e) Total contract value in dollars
 - (f) FTE staff hours
 - (g) Brief description and scope of the project
 - (h) Hardware and software platform used
 - (i) Whether the project was a new development or a takeover

6.2.5.2 Resumes

Individual resumes must be supplied for key personnel proposed for the Takeover and DDI phases of the project and for each person named in the proposal. Each resume must show employment history for relevant or related experience, educational qualifications, names of employers, and at least three references with names and current telephone numbers. A suggested format for resumes is presented below. Resumes shall be limited to no more than 5 pages for each resume:

- (1) Part I: Identification Information - Provide the name and current position of the proposed person.
- (2) Part II: Education - Provide information about the educational background of the person proposed.
- (3) Part III: Experience - Provide a short description of the experience of the person, including job titles, major responsibilities, and number of years in most recent to least recent order. Highlight relevant experience that demonstrates the person meets or

exceeds minimum requirements for the position. Specifically describe management level experience by staff or project type managed, responsibilities, and number of years as a manager. Experience of particular relevance for this project includes:

- (a) System design and development (including MMIS, DW/DSS, and other systems)
 - (b) Claims processing operations
 - (c) Provider relations
 - (d) Medical review
 - (e) Managed care programs
 - (f) Medicaid policy development
 - (g) Management of large-scale data processing systems or operations
 - (h) Management and delivery of large scale software development projects
 - (i) Software testing and methodologies as appropriate
- (4) Part IV: Qualifications for Proposed Position - List the specific activities the proposed person will perform during each phase of the Alaska project. For each activity, list prior positions/ contracts in which the proposed person has performed these or related activities, whether it was an MMIS project, and indicate the position held and the name of the employer. Also indicate the dates during which the employee held the position indicated.
- (5) Part V: References - Include three references (name, title, employer or corporation, address, e-mail address, and current phone number) for the proposed person who can give information on the individual's experience and competence in the areas indicated.
- (6) Part VI. Employment Evidence - Include a Statement or other evidence of employment or commitment to join the Offeror's (or Sub-Contractor's) organization.

6.2.6 Appendices

The following appendices must be included in the Offeror's appendix section:

- (1) Proposal Cross Reference;
- (2) Alaska Business License & Other Required Licenses;
- (3) Corporate Experience Evidence;
- (4) Offeror's and Sub-Contractor's Key Staff Experience Evidence;
- (5) Sub-Contractor Information, if applicable;
- (6) Preferences Certification(s), if applicable;
- (7) Division of Vocational Rehabilitation Certification Letter(s), if applicable;
- (8) Joint Venture Agreement Information, if applicable;
- (9) MITA Baseline Business Process Maturity Levels and Technical Capabilities; and
- (10) List of contract objections, if applicable.

6.3 Cost Proposal

Cost proposals must include an itemized list of all direct and indirect costs associated with the performance of the contract, including, but not limited to, personnel wages at various hourly rates, direct expenses, payroll, supplies, overhead assigned to each person working on the project, percentage of each person's time devoted to the project, and profit.

The cost proposal format consists of four (4) pricing schedules. The formats are included in Attachment H of this RFP and are made up of the following:

6.3.1 Pricing Schedule A – Takeover and Legacy Operations, DDI, MMIS Operations, and Turnover Pricing

In Pricing Schedule A, the Offeror will be required to list all costs for legacy takeover, legacy operations, DDI, and system operations and turnover. Schedule A must include the total costs for all four (4) phases of the Alaska MMIS project. Line 1 of the cost proposal must include the total takeover costs; line 2 must include the total cost for takeover operations for a two-year period; line 3 must include the total cost for DDI; and line 4 must include the total cost for new system operations and renewals for Phase III, including the cost for turnover in Phase IV.

6.3.2 Pricing Schedule B - Operations Labor Rates

In Pricing Schedule B, the Offeror must list all job titles proposed for the operation of the MMIS in its entirety. For each job title, the Offeror must provide an hourly rate per full-time equivalent (FTE). This rate must cover the Contractor's total cost for supporting each listed resource category. If necessary, the Offeror should include additional lines to accommodate job categories and hourly rates.

6.3.3 Pricing Schedule C - Change Order Billing Price

In Pricing Schedule C, the Offeror must provide an hourly rate, by labor category, for additional FTEs for system enhancements. This hourly rate, per FTE, will cover the Contractor's total cost for supporting each FTE category.

6.3.4 Pricing Schedule D - Software and Training Price

In Pricing Schedule D, the Offeror must provide costs for proprietary software and COTS software to be purchased for State use, software license fees for proprietary and COTS software, and training costs. These costs should also be **included** in the hourly rates provided on Pricing Schedule A.

The costs for software shown on Schedule D must include only the purchase cost and ongoing license fees for the software and should not include costs for system modifications, interface with the MMIS and DW/DSS, and conversion of data.

6.4 Evaluation Criteria

All proposals will be reviewed to determine if they are responsive. They will then be evaluated using the criteria set out in Section SEVEN.

An evaluation may not be based on discrimination due to the race, religion, color, national origin, sex, age, marital status, pregnancy, parenthood, disability, or political affiliation of the Offeror.

A proposal shall be evaluated to determine whether the Offeror responds to the provisions, including goals and financial incentives, established in the Request for Proposals in order to eliminate and prevent discrimination in State contracting because of race, religion, color, national origin, sex, age, marital status, pregnancy, parenthood, or disability.

7 EVALUATION CRITERIA AND CONTRACTOR SELECTION

**THE TOTAL NUMBER OF POINTS USED
TO SCORE THIS PROPOSAL IS 10,000**

7.1 Evaluation of Proposals

Each proposal passing the minimum requirements will be evaluated using the weighting factors outlined in Attachment M and the Proposal Evaluation Criteria and the requirements described in detail within this RFP.

PEC members will review requirements for each component and then review and score each responsive proposal. PEC members will perform an independent review of each written proposal against the appropriate requirement to determine whether the written technical proposal adequately and completely addresses each requirement. PEC members will independently score RFP requirements, using the Proposal Evaluation Form in Attachment J. After this process, group discussions will take place. Individual PEC members may revise their own individual scores based upon group discussions. Individual PEC member scores for each requirement will be tabulated by the Procurement Officer.

7.1.1 Reasonably Susceptible for Award

The Procurement Officer will determine whether Offeror proposals are reasonably susceptible for award, based solely upon total technical proposal scores from the PEC evaluation and the total cost proposal scores, including appropriate preferences. If the range between the highest ranked proposal score and the second ranked proposal score is less than 1,000 points, (the total demonstration score), then the two proposals are reasonably susceptible for award. However, if the range between the highest ranked proposal and the third ranked proposal is greater than 1,000 points, based upon the total technical score and the total cost proposal, including preferences; then the third ranked proposal is not reasonably susceptible for award.

EXAMPLE

Reasonably Susceptible for Award

[STEP 1]

Procurement Officer determines total technical proposal score from PEC scores; reviews cost proposals and converts cost to points (Section 2.11.2); and determines the number of points available for preferences (Section 2.11.3). Proposals are then sub-totaled and ranked from highest to lowest.

Total number of points available – 10,000 Points

Total number of points available for technical proposals, cost proposals, and preferences – 9,000 Points

Offeror #1 – highest ranked proposal - 8,700 points
Offeror #3 – second ranked proposal - 8,300 points
Offeror #2 – third ranked proposal - 7,200 points

[STEP 2]

The range between Offeror #1 and Offeror #3 technical and cost proposal scores (with preferences) is less than 1,000 points; thus these two proposals are considered to be reasonably susceptible for award. The range between Offeror #1 and Offeror #2 scores is greater than 1,000 points; thus Offeror #2 proposal is not considered to be reasonably susceptible for award. Offeror #1 and Offeror #3 will be given the opportunity for a scripted demonstration.

7.1.2 Scripted Demonstrations

Scripted demonstrations will be scored by PEC members and tabulated by the Procurement Officer, using the procedures outlined in Attachment L, the Offeror Demonstration Scripts Manual. For scripted demonstrations, the functional requirements may carry different weights, further described in Attachment L. PEC member demonstration scores will be tabulated by the Procurement Officer to arrive at a proposal demonstration score. These scores will be added to the total technical and cost proposal scores, applying appropriate preferences, to arrive at the highest ranked proposal.

Failure to comply with the exact requirements of the demonstrations may result in the immediate disqualification of the Offeror.

7.2 Federal/State Approvals

The State will issue a NOIA to all Offerors who submitted proposals. The contract award, however, will not be final until Federal and State approval is obtained. The State will make every effort to obtain and expedite Federal approval. The State reserves the right to not award a contract if Federal approval does not include enhanced FFP.

After Federal and State approval, the contractor will initiate project work in accordance with the schedule negotiated with the State. Failure to begin work will result in the State beginning negotiations with the next highest ranked offer.

7.3 Evaluation Factors and Weighting Factors

Per 2 AAC 12.260 Evaluation of Proposals, evaluation of proposals will be based only on the evaluation factors set out in the Request for Proposals. The relative importance or weighting values of each evaluation factor is described in Attachment M. Table 7.1, below, lists evaluation criteria and weighting factors.

Table 7-1 Proposal Evaluation Criteria and Weighting Factors		
<i>Technical Proposal</i>	Score	Weight
Introduction and Understanding of the Alaska Project	205	2.05%
Management Plan for the Project	540	5.4%
Scope of Work		
<u>Operational Takeover - Phase 1</u> (6.2.4.1) - Using presentation criteria in this section, documentation of how the following requirements will be met	310	3.1%
<u>DDI - Phase II</u> (6.2.4.2) - Using presentation criteria in this section, documentation of how the following requirements will be met	895	8.95%
<u>Operations Phase III</u> (6.2.4.5) - Using presentation criteria in this section, documentation of how the following requirements will be met	300	3.0%
<u>Turnover Phase IV</u> (6.2.4.6)	100	1.0%
<u>Functional Requirements</u> (6.2.4.3) - Using presentation criteria in this section, documentation of how the following requirements will be met	1,500	15.0%
<u>Operations Management Requirements</u> (6.2.4.4) - Using presentation criteria in this section, documentation of how the following requirements will be met	650	6.5%
Experience and Qualifications	500	5.0%
<i>Overall Proposal</i>		
Technical Evaluation Score Total	5,000	50.0%
Cost Proposal Score Total	3,000	30.0%
Alaska Offerors Preference	1,000	10.0%
Scripted Demonstration Score Total	1,000	10.0%
Total Possible Proposal Score	10,000	100%

7.4 Evaluation Requirements for Technical Proposals (50%)

DHSS places high emphasis on the functionality of the MMIS system. Alaska is interested in an MMIS solution that will be technically sound for many years to come, is aligned with MITA, is HIPAA compliant, will provide easy access to system resources through a Graphical User Interface (GUI), and will provide a DW/DSS that allows easy availability of data and information with standardized and ad hoc query tools. Strong management skills, corporate background and past experience, project staff qualifications, and the collective corporate and staff experience in the DDI and operation of large scale healthcare systems will be evaluation criteria. Technical proposals will be evaluated based upon requirements for components in the RFP.

Table 7.1 lists the four major components of the technical evaluation, the cost proposal weighting, scripted demonstrations, and points for the Alaska Offeror preference. The maximum score for the technical evaluation will be 5,000 points or 50% of the total points awarded. Points for the technical proposal are listed in Table 7.1 and in Attachment M.

7.4.1 Introduction and Understanding of the Alaska MMIS Project (2.05%)

The proposal criteria to be evaluated are outlined in Sections 6.2.1, 6.2.2, and 6.2.6 of this RFP. The PEC will review the Offeror's executive summary, overall completeness and quality of the proposal including the transmittal letter, appendices, and general qualifications of the Offeror. The PEC will also include a review of subcontracting or joint venture arrangements and how these may affect the overall contract.

The outline of the proposed solution and approach, system proposed for transfer to Alaska, and the changes to the proposed system will be evaluated for coherence and understanding and reasonableness of approach. The MITA Assessment prepared by the Offeror using the forms included in Attachment B will also be evaluated.

7.4.2 Management Plan for the Project (5.4%)

The proposal criteria to be evaluated are defined in Sections 6.2.3. The Offeror's approach and commitment to quality control in all phases of the contract and project management and problem resolution are critical success factors in the management of a large Medicaid operation.

The PEC will evaluate the Offeror's approach to project management and the tools and structure that will control the project during all phases of the Alaska MMIS Project. The PEC will also evaluate the Offeror's work plan and approach to all phases. Evaluation will also address requirements definition, resource planning, change management, test planning and management, issue and risk mitigation, quality control, scope management, communication strategy with the State, and contract performance standards.

7.4.3 Scope of Work - Methodology Used for the Alaska MMIS Project (37.55%)

The PEC will evaluate the approaches and methods proposed to accomplish the scope of work described for each of the following six evaluation areas, for the scope of work:

7.4.3.1 Phase I – Operational Takeover (3.1%)

Proposal information to be evaluated is described in 6.2.4.1. The PEC will evaluate the Offeror's approach and methods for accomplishing the work from information within Section 5.4, including the Takeover Implementation component, Requirements Analysis, Takeover Documentation, Takeover DW/ DSS, Takeover Testing, Provider and Recipient Services Support Services Takeover, HIPAA Takeover, Takeover Operational Readiness and Operability Testing, Takeover Implementation, Post-Takeover Implementation, and the Takeover Maintenance Component.

7.4.3.2 Phase II – DDI (8.95%)

Proposal information to be evaluated is described in Section 6.2.4.2, based upon the DDI information described in Section 5.5, including Project Initiation, Requirements Analysis,

System Design, DW/DSS Development and Implementation, MMIS Development and Testing, Conversion, Acceptance Testing, Implementation, and Post-DDI Implementation Evaluation.

7.4.3.3 Functional Requirements (15%)

Proposal information and requirements to be evaluated are described in Sections 6.2.4.3, based upon requirement information in Section 5.6 of the RFP. The system proposed for transfer to Alaska and the proposed changes to the system will be evaluated to determine how well the proposed solution meets and exceeds functional requirements listed within the RFP. Functional requirements include the existing business processes, as well as the enhanced business process capabilities that will be supported through successful DDI, and will be conducted and supported throughout the Operations Phase of the project.

7.4.3.4 Operations Management Requirements (6.5%)

Proposal information to be evaluated is described in Section 6.2.4.4. Operations Management Requirements are described in Section 5.7 of the RFP. Based upon information within the Offeror's proposal, the operations approach, tools, and processes that will be employed during the project to ensure Performance Monitoring and Reporting, Internal Quality Assurance, Contract Monitoring, Change Management, documentation, security/confidentiality, and other operational requirements will be evaluated.

7.4.3.5 Operations Phase III (3%)

Proposal information to be evaluated is described in Section 6.2.4.5, based upon the Offeror's approach for maintaining high level performance to further the goals of Alaska, including incorporating operational and architectural efficiencies made possible by improved technology, flexibility in reimbursement methodologies, ability to support changes in medical programs and service delivery systems, and achieving Federal system and reporting requirements, as described in Section 5.8.

7.4.3.6 Phase IV – Turnover (1%)

Proposal information to be evaluated is described in Section 6.2.4.6, based upon Section 5.9, the Offeror's approach to turnover, including identification of tasks and scheduling.

7.4.4 Experience and Qualifications (5%)

Proposal information to be evaluated is described in Section 6.2.5. The PEC will review the Offeror's financial stability to ensure that the State of Alaska will be fully covered against any financial difficulties that the company may experience during any period of the contract. The experience and reputation of the Offeror in managing large projects of this nature and how the Offeror interfaces with its clients for status reporting and other contract issues is important.

Relevant experience in dealing with healthcare providers, provider groups, recipients, recipient advocacy groups, and many other organizations interested in the successful operation of the Alaska medical assistance programs will be evaluated. Experience in Medicaid, large healthcare delivery systems, managed care operations, and recent technological advancements in the arena

of healthcare systems will also be criteria in the evaluation of submitted proposals.

Resumes of all key staff and other named persons are a critical element for this criterion. Corporate and staff references may be verified and findings will be evaluated.

Reference checks may not be limited to only those references supplied by the Offeror. Site visits may also be incorporated in this evaluation.

7.5 Contract Cost (30%)

Overall, a minimum of 30% of the total evaluation points will be assigned to cost. The cost points may be affected by one or more of the preferences referenced under Section 2.11.

Converting Cost to Points

The lowest cost proposal will receive the maximum number of points allocated to cost. The procedure for allocation of cost to points on the other proposals will be determined using the method set out in Section 2.11.2.

7.6 Alaskan Offeror's Preference (10%)

If an Offeror qualifies for the Alaskan Bidder Preference, the Offeror will receive an Alaskan Offeror's Preference. The preference will be 10 percent of the total available points. This amount will be added to the overall evaluation score of each Alaskan Offeror.

7.7 Demonstration Scoring and Evaluation Factor (10%)

Attachment L outlines the evaluation criteria and scoring procedures for the scripted demonstrations.

**ATTACHMENT A
STANDARD AGREEMENT FORM FOR PROFESSIONAL SERVICES CONTRACT (FORM 02-093)**

STANDARD AGREEMENT FORM				
1. Agency Contract Number	2. ASPS Number	3. Financial Coding	4. Agency Assigned Encumbrance	
5. Vendor Number			6. Alaska Business License Number	
This contract is between the State of Alaska,				
7. Department of		Division		
8. Contractor				
Mailing Address	Street or P.O. Box	City	State	ZIP+4
9. ARTICLE 1. Appendices: Appendices referred to in this contract and attached to it are considered part of it. ARTICLE 2. Performance of Service: 2.1 Appendix A (General Provisions), Articles 1 through 14, governs the performance of services under this contract. 2.2 Appendix B sets forth the liability and insurance provisions of this contract. 2.3 Appendix C sets forth the services to be performed by the contractor. ARTICLE 3. Period of Performance: The period of performance for this contract begins _____, and ends _____. ARTICLE 4. Considerations: 4.1 In full consideration of the contractor's performance under this contract, the State shall pay the contractor a sum not to exceed \$ _____ in accordance with the provisions of Appendix D. 4.2 When billing the State, the contractor shall refer to the Authority Number or the Agency Contract Number and send the billing to:				
10. Department of		Attention: Division of		
Mailing Address		Attention:		
11. CONTRACTOR				
Name of Firm		13. CERTIFICATION: I certify that the facts herein and on supporting documents are correct, that this voucher constitutes a legal charge against funds and appropriations cited, that sufficient funds are encumbered to pay this obligation, or that there is a sufficient balance in the appropriation cited to cover this obligation. I am aware that to knowingly make or allow false entries or alternations on a public record, or knowingly destroy, mutilate, suppress, conceal, remove or otherwise impair the variety, legibility or availability of a public record constitutes tampering with public records punishable under AS 11.56.815-.820. Other disciplinary action may be taken up to and including dismissal.		
Signature of Authorized Representative	Date			
Typed or Printed Name of Authorized Representative				
Title	Employer ID No. (EIN) or SSN			
12. CONTRACTING AGENCY				
Department/Division		Signature of Head of Contracting Agency or Designee		Date
Date		Typed or Printed Name Title		
Signature of Project Director				
Typed or Printed Name of Project Director				
Title				

NOTICE: This contract has no effect until signed by the head of contracting agency or designee.

APPENDIX A GENERAL PROVISIONS

A.1 Structure

- A.1.1** This agreement between the State Contracting Agency and the Contractor is comprised of a Cover Sheet bearing the signatures of the parties, this Appendix A (General Provisions) and the additional Appendices referenced in the Cover Sheet and/or attached hereto. Each Appendix may contain one or more Exhibits or Schedules. The Cover Sheet, Appendices, Exhibits, Schedules, the RFP and the Proposal are referred to collectively herein as the **“Agreement”**.
- A.1.2** In the event of any conflict, discrepancy or inconsistency within the provisions of this Appendix A and the other provisions of this Agreement, the following priority of control shall prevail: (a) this Appendix A, unless another Appendix or amendment to this Agreement expressly and specifically notes the deviations from the terms of this Appendix A and such deviation shall be approved in writing by the State’s Department of Law; (b) the other Appendices; (c) the Exhibits, (d) the Schedules, (e) the RFP, and (f) the Contractor’s Proposal; provided, however, that in the event the Contractor’s Proposal, exceeds the requirements of the RFP, the State, in its sole discretion, may enforce the Contractor’s language as provided in the Contractor’s Proposal.
- A.1.3** In the event of any conflict, discrepancy or inconsistency within the Contractor’s Proposal, the terms most favorable to the State, as determined by the State Contracting Agency, shall apply. In the event of any conflict, discrepancy or inconsistency between the provisions in the RFP and the Contractor’s Proposal, the terms most favorable to the State, as determined by the State Contracting Agency, shall apply.

A.2 Definitions and Construction

- A.2.1** Capitalized terms shall have the meanings ascribed to them in Appendix H and elsewhere in this Agreement. If any capitalized term is used herein without definition, such term shall have the meaning ascribed to it in the RFP.
- A.2.2** The words “hereby,” “herein,” “hereunder” and words of similar import refer to this Agreement as a whole (including all Appendices, Exhibits and Schedules hereto) and not merely to the specific article, section, paragraph or clause in which such word appears. The definitions given for terms in this Agreement shall apply equally to both the singular and plural forms of the terms defined. Whenever the context may require, any pronoun shall include the corresponding masculine, feminine and neuter forms. The words “include,” “includes” and “including” shall be deemed to be followed by the phrase “without limitation.”
- A.2.3** With regard to all dates and time periods set forth or referred to in this Agreement, time is of the essence.

- A.2.4 For purposes of this Agreement, (a) “days” means calendar days, unless specifically defined as “business days”, however, if the due date falls on a weekend or holiday, the due date will be the next full business day in Juneau, Alaska, and (b) all times stated are Alaska Standard Time, unless otherwise noted.
- A.2.5 Unless otherwise specifically provided in a later Appendix, the Services, Deliverables and all work on the Project shall be provided in the State of Alaska at the locations designated by the Project Director. The price specified herein includes the costs associated with the transportation and delivery of each Deliverable to the locations in the State of Alaska designated by the Project Director and any associated insurance costs. The Contractor shall arrange for such transportation and insurance and pay the costs as they are incurred.

A.3 Books and Records; Inspection; Accounting Procedures

- A.3.1 The Contractor hereby agrees to the conditions of all applicable state and federal regulations, which are incorporated herein by this reference, regarding retention and access requirements relating to all financial and programmatic records, supporting documents, statistical records, and other records of this Agreement. In addition, the Contractor shall maintain complete and accurate books and records to substantiate all fees, charges, expenses and other amounts invoiced under this Agreement. Such books and records shall be retained by the Contractor and the Contractor Agents for six years after the expiration or termination of this Agreement.
- A.3.2 All such books and records shall be subject at reasonable times and upon prior notice to examination, inspection, copying, or audit by the State Contracting Agency, its auditors (including internal audit staff and external auditors) and inspectors or by federal officials authorized by law, rule, regulation or contract, when applicable. During the term of this Agreement, access to these books and records will be provided in Juneau, Alaska. The Contractor shall be responsible for any audit exceptions or disallowed costs incurred by the Contractor or any Contractor Agents.
- A.3.3 The Contractor shall also provide to the State Contracting Agency access, upon prior notice and during regular business hours, to all facilities used to perform Services or provide Deliverables pursuant to this Agreement and to any personnel of the Contractor or a Contractor Agent engaged in providing such Services and Deliverables.
- A.3.4 As part of the Services, the Contractor shall provide, upon the Project Director’s request, a copy of those portions of the Contractor’s (and any Contractor Agent’s) internal audit reports relating to the Services or Deliverables.
- A.3.5 The Contractor shall establish and maintain, and shall ensure that each Contractor Agent shall establish and maintain, an accounting system with procedures and practices in accordance with generally accepted accounting principles. Such accounting systems shall maintain records pertaining to the Services, Deliverables

and all other costs and expenditures made under this Agreement, and the costs properly applicable to the Agreement shall be readily ascertainable therefrom.

- A.3.6 The Contractor shall ensure that each Contractor Agent maintains the appropriate books and records and affords the State Contracting Agency and federal officials the rights of access, examination, inspection and audit set forth in this Section A.3.

A.4 Reports and Meetings

- A.4.1 The Contractor shall make written progress and other reports in the manner and at the times the State Contract Agency reasonably requires. All such reports shall be produced in formats and at a level of detail approved by the Project Director. In addition, the Contractor will implement the automated performance monitoring system described in Section 5.7.1 of the RFP.
- A.4.2 The Contractor shall participate in the meetings described in the RFP and in this Section in person, except that such meetings may be conducted by telephone conference call, videoconference, and/or web conference in the State Contracting Agency's sole discretion.
- A.4.3 The Contractor Project Manager and other Key Personnel shall attend weekly status meetings with the Project Director or his or her designee and other members of the State Contracting Agency's Project team during the Project. These weekly status meetings shall follow a preset agenda jointly prepared by the Contractor Project Manager and the Project Director, but will also allow both Contractor and the State Contracting Agency to discuss other issues that may concern either party. The parties will also conduct Contract Performance Review meetings as provided in Section 5.7.1 of the RFP.

A.5 Term of the Agreement

The term of this Agreement shall commence on the Effective Date and, unless terminated pursuant to Section A.6 or Section A.7, shall expire when the Contractor's performance hereunder is completed and all Deliverables have been accepted.

A.6 Termination for Cause

- A.6.1 The State Contracting Agency may, subject to Section A.6.2, by written notice of default to the Contractor, terminate this Agreement in whole or in part if the Contractor fails to:
- (a) Deliver the Deliverables or to perform the Services within the time specified in this Agreement or any extension;
 - (b) Make progress, so as to endanger performance of this Agreement; or

(c) Perform any of the other provisions of this Agreement.

- A.6.2 The State Contracting Agency's right to terminate this Agreement under Section A.6.1(b) and A.6.1(c) above, may be exercised if the Contractor does not cure such failure within 10 days (or more if authorized in writing by the Project Director) after receipt of the notice from the Project Director specifying the failure.
- A.6.3 If the State Contracting Agency terminates this Agreement, in whole or in part, it may acquire, under the terms and in the manner the Project Director considers appropriate, deliverables or services similar to those terminated, and the Contractor will be liable to the State Contracting Agency for any excess costs for those deliverables or services. However, the Contractor shall continue the work not terminated.
- A.6.4 If this Agreement is terminated by the State Contracting Agency pursuant to this Section A.6, the State Contracting Agency may require the Contractor to transfer title and deliver to the State Contracting Agency, as directed by the Project Director, any (a) completed supplies, materials and other work product, and (b) partially completed supplies, materials and other work product, including parts, tools, fixtures, plans, drawings, specifications, information, and contract rights (collectively referred to as "**Work in Progress**") that the Contractor has specifically produced or acquired for the terminated portion of this Agreement. Upon direction of the Project Director, the Contractor shall also protect and preserve property in its possession in which the State has an interest.
- A.6.5 The State Contracting Agency shall pay the contract price for completed work delivered and accepted. The Contractor and Project Director shall agree on the amount of payment for Work in Progress delivered and accepted and for the protection and preservation of the property. Failure to agree will be a dispute under the disputes section of this Appendix.
- A.6.6 If, after termination pursuant to this Section A.6, it is determined that the Contractor was not in default, or that the default was excusable, the rights and obligations of the parties shall be the same as if the termination had been issued for the convenience of the State Contracting Agency pursuant to Section A.7.
- A.6.7 The rights and remedies of the State Contracting Agency in this Section are in addition to any other rights and remedies provided by law or under this Agreement.

A.7 Termination for Convenience

- A.7.1 The State Contracting Agency may terminate this Agreement, in whole or, from time to time, in part, if the Project Director determines that a termination is in the State's interest. The Project Director shall terminate by delivering to the Contractor a notice of termination specifying the extent of termination and the effective date.

A.7.2 After receipt of a notice of termination, and except as directed by the Project Director, the Contractor shall immediately proceed with the following obligations, regardless of any delay in determining or adjusting any amounts due under this Section A.7:

- (a) Stop work as specified in the notice.
- (b) Place no further subcontracts or orders (referred to as subcontracts in this Section A.7) for materials, services, or facilities, except as necessary to complete the continued portion of this Agreement.
- (c) Terminate all subcontracts to the extent they relate to the work terminated.
- (d) Assign to the State Contracting Agency, as directed by the Project Director, all right, title, and interest of the Contractor under the subcontracts terminated, in which case the State Contracting Agency shall have the right to settle or to pay any termination settlement proposal arising out of those terminations.
- (e) With approval or ratification to the extent required by the Project Director, settle all outstanding liabilities and termination settlement proposals arising from the termination of subcontracts; the approval or ratification will be final for purposes of this Section A.7.
- (f) As directed by the Project Director, transfer title and deliver to the State Contracting Agency the Work in Progress.
- (g) Complete performance of the work not terminated.
- (h) Take any action that may be necessary, or that the Project Director may direct, for the protection and preservation of the property related to this Agreement that is in the possession of the Contractor and in which the State has or may acquire an interest.

A.7.3 The State Contracting Agency's sole and exclusive liability to the Contractor for termination of this Agreement pursuant to this Section A.7 shall be the payment to the Contractor of the fees specified herein for Deliverables provided and accepted and Services satisfactorily rendered through the final day on which the Contractor provides Deliverables and performs the Services. The final day of performance shall be specified in the notice of termination from the Project Director or, if not specified therein, shall be the date of such termination notice.

A.8 Governing Law; Disputes

A.8.1 This Agreement shall be governed by the law of the State of Alaska, excluding any conflicts or choice-of-law rule or principle that might otherwise refer construction or interpretation of this Agreement to the substantive law of another jurisdiction.

- A.8.2 Except for the right of either party to apply to a court of competent jurisdiction for a temporary restraining order or other provisional remedy to preserve the status quo or prevent irreparable harm, the parties agree to attempt in good faith to promptly resolve any dispute or claim arising out of or relating to this Agreement, including payment disputes, through negotiations between senior management of the parties. If the dispute cannot be resolved within 30 calendar days of initiating such negotiations, either party may pursue its available legal and equitable remedies.
- A.8.3 Any dispute or claim arising out of or related to this Agreement which is not disposed of by mutual agreement of the parties pursuant to Section A.8.2 shall be decided in accordance with AS 36.30.620-632.
- A.8.4 The Contractor irrevocably consents and agrees (a) to submit itself to the personal jurisdiction of Superior Court of the State of Alaska in the event any dispute or claim arises out of this Agreement or any of the transactions contemplated by this Agreement, (b) that it will not attempt to deny or defeat the personal jurisdiction of such court by motion or other request for leave from such court, (c) that, except as provided in Section A.8.3, it will not bring any action, suit or proceeding relating to this Agreement or any of the transactions contemplated by this Agreement in any court or forum other than the Superior Court of the State of Alaska, and (d) that, except as provided in Section A.8.3, all disputes or claims arising out of this Agreement or any of the transactions contemplated by this Agreement shall be resolved in the courts of the State of Alaska.
- A.8.5 The Contractor acknowledges that the timely and complete performance of its obligations pursuant to this Agreement is critical to the discharge by the State of important public functions. Accordingly, in the event of a dispute between the Contractor and the State Contracting Agency, the Contractor shall continue to perform its obligations under this Agreement in good faith during the resolution of such dispute. For the avoidance of doubt, the provisions of this Section A.8.5 shall not be deemed to obligate the Contractor to begin work on a Change Request prior agreement of the parties on the scope of such Change Request.

A.9 Equal Employment Opportunity

- A.9.1 The Contractor shall not discriminate against any employee or applicant for employment because of race, color, religion, national origin, ancestry, physical handicap, age, sex, marital status, changes in marital status, pregnancy or parenthood when the reasonable demands of the position(s) do not require distinction on the basis of age, physical handicap, sex, marital status, changes in marital status, pregnancy, or parenthood. The Contractor shall take affirmative action to insure that the applicants are considered for employment and that employees are treated during employment without unlawful regard to their race, color, religion, national origin, ancestry, physical handicap, age, sex, marital status, changes in marital status, pregnancy or parenthood. This action must include, but need not be limited to, the following: employment, upgrading,

demotion, transfer, recruitment or recruitment advertising, layoff or termination, rates of pay or other forms of compensation, and selection for training including apprenticeship. The Contractor shall post in conspicuous places, available to employees and applicants for employment, notices setting out the provisions of this Section.

- A.9.2 The Contractor shall state, in all solicitations or advertisements for employees to work on State of Alaska contract jobs, that it is an equal opportunity employer and that all qualified applicants will receive consideration for employment without regard to race, color, religion, national origin, ancestry, physical handicap, age, sex, marital status, changes in marital status, pregnancy or parenthood.
- A.9.3 The Contractor shall send to each labor union, or representative of workers with which the Contractor has a collective bargaining agreement or other contract or understanding, a notice advising the labor union or workers' compensation representative of the Contractor's commitments under this Section and post copies of the notice in conspicuous places available to all employees and applicants for employment.
- A.9.4 The Contractor shall include the provisions of this Section in every contract, and shall require the inclusion of those provisions in every contract entered into by any of its Contractor Agents, so that those provisions will be binding upon each such Contractor Agent.
- A.9.5 The Contractor shall cooperate fully with State efforts which seek to deal with the problem of unlawful discrimination, and with all other State efforts to guarantee fair employment practices under this Agreement, and promptly comply with all requests and directions from the State Commission for Human Rights or any of its officers or agents relating to prevention of discriminatory employment practices.
- A.9.6 Full cooperation in Section A.9.5 includes, but is not limited to, being a witness in any proceeding involving questions of unlawful discrimination if that is requested by any official or agency of the State of Alaska; permitting employees of the Contractor to be witnesses or complainants in any proceeding involving questions of unlawful discrimination, if that is requested by any official or agency of the State of Alaska; participating in meetings; submitting periodic reports on the equal employment aspects of present and future employment; assisting inspection of the Contractor's facilities; and promptly complying with all State directives considered essential by any office or agency of the State of Alaska to insure compliance with all federal and State laws, regulations, and policies pertaining to the prevention of discriminatory employment practices.
- A.9.7 The Contractor's failure to perform the obligations set forth in this Section A.9 (Equal Employment Opportunity) shall constitute a material breach of this Agreement by Contractor.

A.10 No Assignment or Delegation

The Contractor shall not assign its rights or, except as provided in Section A.11 (Subcontractors), delegate its obligations under this Agreement, whether by operation of law or otherwise, in whole or in part, without the prior written consent of the Agency Head. Any attempted assignment or delegation in violation of this Section shall be void.

A.11 Subcontractors

- A.11.1 The Contractor may engage subcontractors at no additional cost to the State Contracting Agency; provided, however, that (a) if the subcontractors are not expressly referenced in an Appendix or Contractor's Proposal, the Contractor must receive the prior written approval of the Project Director for each subcontract; (b) the subcontractor will be bound by confidentiality and data protection provisions no less onerous than those to which the Contractor is subject under the Agreement; (c) the Contractor will remain the State Contracting Agency's sole point of contact and sole contracting party; (d) the subcontractor shall appoint a management level employee who shall be responsible for the subcontracted activities and for responding to any requests from the Project Director, including requests for status updates, and (e) all subcontractor employees will be subject to the same provisions of the Agreement as employees of the Contractor.
- A.11.2 Prior to amending, modifying, or otherwise supplementing any subcontract, the Contractor shall notify Project Director of the proposed amendment, modification, or supplement and shall obtain the Project Director's written approval thereof.
- A.11.3 The Contractor shall make all payments it is contractually required to make to all subcontractors in accordance with the respective agreements between the Contractor and its subcontractors such that no subcontractor shall be in a position to enforce any liens and/or other rights against the State Contracting Agency or any Deliverable or any part thereof. The Contractor shall protect and keep free all Deliverables from any and all claims, liens, charges or encumbrances of the nature of mechanics, labor or materialmen liens or otherwise arising out of or in connection with the performance by the Contractor of this Agreement or any performance by any subcontractor, and to promptly have any such lien released by bond or otherwise.
- A.11.4 No subcontract shall release the Contractor from its responsibility for its obligations under this Agreement. The Contractor shall be responsible for the work and activities of each of its subcontractors, including their compliance with the terms of this Agreement. Any breach of this Agreement by a subcontractor performing services pursuant to this Agreement shall be deemed a breach by the Contractor. The Contractor's use of subcontractors shall in no way increase the Contractor's rights or diminish the Contractor's liabilities to the State Contracting Agency with respect to this Agreement. The Contractor shall be liable for any delays caused by any subcontractor as if such delays were caused by the Contractor.

A.11.5 The terms of this Agreement shall in all events be binding upon the Contractor regardless of and without regard to the existence of any inconsistent terms in any agreement between the Contractor and any subcontractor whether or not and without regard to the fact that the State Contracting Agency may have directly or indirectly had notice of any such inconsistent term.

A.12 No Additional Work or Material

A.12.1 No claim for additional services, not specifically provided in this Agreement, performed or furnished by the Contractor, will be allowed, nor may the Contractor do any work or furnish any material not covered by this Agreement unless the work or material is ordered in writing by the Project Director in accordance with the provisions set forth in this Agreement.

A.12.2 The Contractor shall be deemed to have satisfied itself before entering into this Agreement as to the quantities and nature of the work, equipment, facilities and materials necessary for the performance of the Services and completion of the Deliverables, the accommodation, equipment and facilities it may require; and in general shall for itself have obtained all necessary information as to risks, contingencies, expenses and other circumstances which might have influenced its decision to enter into this Agreement, and to have satisfied itself as to the correctness and sufficiency of the terms and conditions of this Agreement.

A.13 Independent Contractor

The Contractor, and any Contractor Agents, act in an independent capacity. Nothing contained herein shall be deemed to create an employment, agency, joint venture or partnership relationship between the parties hereto or any of their employees, agents, officers, directors or other representatives, or any other legal arrangement that would impose liability upon the State for the act or failure to act of the Contractor. The Contractor is not granted hereby, and shall not hold itself out as having, any right or authority to enter into any contract, incur any liabilities, create any obligation or responsibility or make any representation or warranty, express or implied, on behalf of or in the name of the State, or to otherwise bind the State in any manner.

A.14 Payment of Taxes

As a condition to the State Contracting Agency's performance of this Agreement, the Contractor shall pay all federal, state, and local taxes and duties incurred by the Contractor in the performance of its obligations hereunder and shall require their payment by any Contractor Agent or any other persons or entities in performing work under this Agreement.

A.15 Waivers and Amendments

A.15.1 No waiver of any provision of, or consent or approval required by, this Agreement, nor any consent to or approval of any departure herefrom, shall be

effective unless it is in writing and signed by the Project Director. Such waiver, consent or approval shall be effective only in the specific instance and for the purpose for which given. Neither the failure of the State Contracting Agency to enforce, nor the delay of the State Contracting Agency in enforcing, any condition, provision or part of this Agreement at any time shall be construed as a waiver of that condition, provision or part or forfeit any rights to future enforcement thereof. No action taken pursuant to this Agreement, including any investigation by or on behalf of the State Contracting Agency, shall be deemed to constitute a waiver by the State Contracting Agency of compliance by the Contractor with any representation, warranty, covenant or agreement contained herein.

- A.15.2 This Agreement may not be amended, modified, altered or supplemented other than by means of a written instrument duly executed and delivered by the parties hereto; provided, however, that if any amendment, modification, alteration or supplement is required by the State Contracting Agency in order to comply with applicable law or to receive the maximum amount of FFP or other federal funding available for the Project, the State Contracting Agency may make such amendment, modification, alteration or supplement by written notice to the Contractor.

A.16 Officials Not to Benefit

The Contractor shall comply with all applicable federal or state laws regulating ethical dealings with public officers and employees. In particular, and without limitation of the foregoing, the Contractor shall not pay any salaries, commissions, fees or make any payments or rebates to any employee of the State of Alaska, or to any designee of such employee, or favor any employee of the State of Alaska, or any designee of such employee, with gifts, gratuities or entertainment of significant cost or value or with services or goods sold at less than full market value. The Contractor agrees that its obligation to the State under this Section shall also be binding upon all Contractor Agents. The Contractor further agrees to insert the provisions of this Section in each contract or subcontract with a Contractor Agent performing work pursuant to this Agreement.

A.17 No Contingent Fees

The Contractor warrants that no person or agency has been employed or retained to solicit or secure this Agreement upon an agreement or understanding for a commission, percentage, contingent fee, brokerage or other fee that is contingent upon the success that a person or concern has in securing a contract with the State, except employees or agencies maintained by the Contractor for the purpose of securing business in the ordinary course. For the breach or violation of this warranty, the State Contracting Agency may terminate this Agreement without liability or in its discretion deduct from the contract price or consideration the full amount of the commission, percentage, contingent fee or brokerage or otherwise

recover the full amount of the contingent fee.

A.18 Civil Rights of Clients

- A.18.1 The Contractor shall comply with Title VI and VII of the Civil Rights Act of 1964, the Age Discrimination in Employment Act of 1967, Section 594 of the Rehabilitation Act of 1973, the Food Stamp Act of 1977, Alaska Statute 18,80.200-280, and pertinent portions of the Code of Federal Regulation (CFR) for implementation of the foregoing.
- A.18.2 The Contractor shall make no distinction or discriminate against the client, recipient, applicant or beneficiary of the State Contracting Agency's federally assisted programs on the basis of race, color, age, national origin, sex, political belief, religious creed, or handicap. No client, recipient, applicant or beneficiary of these federally assisted programs shall be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the State Contracting Agency has responsibility.
- A.18.3 Distinction on the ground of race, color, age, national origin, sex, political belief, religious creed, or handicap includes:
- (a) Any type of segregation, separate or different treatment, or other discrimination on that ground;
 - (b) The imposition of any admission, enrollment, quota, eligibility, or other requirement or condition which individuals must meet in order to be provided any service or other benefit under the program or to be afforded an opportunity to participate in the program if the race, color, age, national origin, sex, political belief, religious creed, or handicap of individuals is considered in determining whether they meet any such requirement or condition;
 - (c) The use of membership in a group as a basis for the selection of individuals for any purpose if in selecting members of the group there is discrimination on the grounds of race, color, age, national origin, sex, political belief, religious creed, or handicap; and
 - (d) The assignment of personnel to provide services, or on the basis of race, color, age, national origin, sex, political belief, religious creed, or handicap of the individual to be served.
- A.18.4 In making a determination of whether a contractor is illegally discriminating in the provision of benefits or services, consideration shall be given to the purpose of the service as expressly stated in any federal statute, state statute, or local statute or ordinance adopted by an elected general purpose legislative body. In making such a determination it shall be acknowledged that certain federal, state or local funding is legally designated for specific groups by age, sex, handicap, income, or other specific and legal eligibility criteria. For example, programs for the aging,

blind, disabled and youth provide services legally only for those groups. Also, institutions may legally serve a special age, sex, or handicap group depending upon their protective treatment, or rehabilitative needs and funding sources to provide the services.

A.19 Fixed Price Contract

- A.19.1 The Contractor shall provide the State Contracting Agency with the Services and the Deliverables at the times specified in the RFP, the Proposal and this Agreement.
- A.19.2 Subject to Section F.1, \$[insert amount] shall be the maximum amount paid to Contractor pursuant to this Agreement (**“Maximum Amount”**).
- A.19.3 The price specified herein is fixed and not subject to measurement or recalculation should the quantities of work and/or materials differ from any estimates made at the time of contracting. Such price shall be inclusive of all works and expenditure, whether separately or specifically mentioned or described in the RFP, which are either necessary to carry out the Project and bring it to successful completion or which may become necessary to overcome difficulties in the Project before its completion.
- A.19.4 The State Contracting Agency shall have no obligation to make any payment to the Contractor pursuant to this Agreement for any Deliverables or Services with respect to which the Contractor is in breach of this Agreement until and unless such breach is cured or waived by the State Contracting Agency in accordance with the terms of this Agreement.

A.20 Title and Risk of Loss

- A.20.1 Title to all property (whether tangible or intangible, real or personal) furnished by the State Contracting Agency to the Contractor in connection with the Agreement shall remain in the State Contracting Agency.
- A.20.2 Title to all property (whether tangible or intangible, real or personal) purchased by the Contractor or a Contractor Agent, for which the Contractor has been reimbursed by the State Contracting Agency under this Agreement, shall pass to and vest in the State Contracting Agency upon acceptance of the Deliverable in which such property is included. Title to any Deliverable shall pass to the State Contracting Agency only on acceptance of the Deliverable. All risk of loss, regardless of the cause, shall remain with the Contractor until title to the Deliverable passes to the State Contracting Agency.
- A.20.3 All property referenced in Sections A.20.1 and A.20.2 (collectively, **“Property”**) shall, unless otherwise approved in writing by the Project Director, be used by the Contractor only for the performance of its obligations under and subject to the terms of this Agreement.

A.20.4 The Contractor shall protect and be responsible for any loss, destruction, or damage to Property which results from or is caused by Contractor's willful misconduct or negligent acts or omissions or from the failure on the part of the Contractor to maintain and administer that Property in accordance with sound management practices. The Contractor shall ensure that the Property is returned to the State Contracting Agency in like condition to that in which it was furnished to the Contractor, reasonable wear and tear excepted. Upon the loss of, destruction of, or damage to any of the Property, the Contractor shall notify the Project Director thereof and shall take all reasonable steps to protect that Property from further damage.

A.20.5 The Contractor shall deliver to the State Contracting Agency or its designee all Property within thirty (30) days of the earlier of completion or termination of this Agreement.

A.21 HIPAA Business Associate Agreement Requirements

The Contractor shall comply with all applicable provisions of the Privacy, Security, and Transactions Standards and any other administrative simplification standards promulgated under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The Contractor shall execute a Business Associate Agreement in the form of Exhibit A-1.

A.22 Other General Provisions

A.22.1 If any covenant or provision hereof is determined by a court of competent jurisdiction to be void or unenforceable in whole or in part, it shall not be deemed to affect or impair the validity of any other covenant or provision, each of which is hereby declared to be separate and distinct. If any provision of this Agreement is so broad as to be unenforceable, such provision shall be interpreted to be only so broad as is enforceable. If any provision of this Agreement is declared invalid or unenforceable for any reason other than overbreadth, the offending provision will be modified so as to maintain the essential benefits of the bargain between the parties hereto to the maximum extent possible, consistent with applicable law and public policy.

A.22.2 This Agreement (and each amendment, modification and waiver in respect of it) may be executed in counterparts, and each such counterpart hereof shall be deemed to be an original instrument, but all such counterparts together shall constitute but one instrument. Delivery of an executed counterpart of a signature page of this Agreement (and each amendment, modification and waiver in respect of it) by facsimile or other electronic transmission (such as an email of a PDF file) shall be effective as delivery of a manually executed original counterpart of each such instrument.

A.22.3 Except as expressly provided herein, the parties' respective rights under the various provisions of this Agreement shall be construed as cumulative, and no one of them is exclusive of the other or exclusive of any rights allowed by law.

A.22.4 The Contractor shall, at the request of the State Contracting Agency, execute, acknowledge, deliver, file and record, and cause to be executed, acknowledged, delivered, filed and recorded, such further certificates, amendments, instruments, and documents and to do, and cause to be done, all such other acts and things, as may be required by applicable law, or as may, in the reasonable opinion of Project Director, be necessary or advisable to carry out the purposes of this Agreement.

A.22.5 Except for the provisions of Appendix B (Indemnification) this Agreement is for the sole benefit of the parties hereto and not for the benefit of any third party.

A.23 Entire Agreement

A.23.1 This Agreement, together with the RFP and the Contractor's Proposal referenced herein, contains the entire agreement between the parties with respect to the transactions contemplated by this Agreement and supersedes all prior agreements or understandings, whether written or oral, between the parties with respect to the subject matter hereof.

* * *

APPENDIX B INDEMNITIES AND INSURANCE

B.1 Indemnification Obligations

The Contractor shall indemnify the State Contracting Agency, and each of its current, future and former officials, employees, representatives and agents (the “**State Indemnified Parties**”), and defend and save each of them harmless, from and against any and all losses, damages, liabilities, costs and expenses (including attorneys’ fees and expenses) (collectively, “**Losses**”) in connection with any and all suits, proceedings, investigations, claims or demands (collectively, “**Claims**”) arising from or occurring as a result of: (a) the breach by the Contractor of any term or provisions of this Agreement, including the inaccuracy, untruthfulness or breach of any representation or warranty made by the Contractor in this Agreement, (b) the negligence or willful misconduct on the part of the Contractor or the Contractor Agents in performing any obligations under this Agreement; (c) bodily injury or death to persons or physical damage to personal or real property attributable to the acts or omissions of the Contractor or the Contractor Agents in performing any obligations under this Agreement; and (d) the use by the State in accordance with the terms of this Agreement of any Deliverable or Service developed and/or provided by the Contractor to the State pursuant to this Agreement, including any Claim that the use of such Deliverable or Service infringes, violates or misappropriates a third party’s patents, copyrights, trade secrets, trademarks or other intellectual property rights; provided, however, that in each case (items (a) through (d) above) the Contractor shall not be obligated to indemnify the State Indemnified Parties for any Losses to the extent that such Losses arise as a result of gross negligence or willful misconduct on the part of the State Contracting Agency.

B.2 Indemnification Procedures

- B.2.1 If any Claim is commenced or threatened against a State Indemnified Party, written notice shall be given to the Contractor by the State Contracting Agency. Such notice shall be given as promptly as practicable. After such notice, if the Contractor acknowledges in writing to the State Contracting Agency that Section B.1 applies with respect to such Claim, then the Contractor shall be entitled to take control of the defense and investigation of the Claim and to employ and engage attorneys of its choice that are reasonably acceptable to the State Contracting Agency to handle and defend and/or settle the same, at the Contractor’s sole cost and expense. The Contractor shall deliver written notice of its election of taking such control of the Claim to the State Contracting Agency not fewer than ten (10) days prior to the date on which a response to such Claim is due or such lesser period as is reasonable given the nature of the Claim and the notice and response time permitted by law or the facts and circumstances. The State Contracting Agency shall cooperate in all reasonable respects and at the Contractor’s cost and expense with the Contractor and its attorneys in the investigation, trial and defense or settlement of such Claim and any appeal arising

therefrom. The State Contracting Agency may participate in such investigation, trial and defense or settlement of such Claim and any appeal arising therefrom, through its own attorneys or otherwise, at its own cost and expense. No settlement of a Claim by the Contractor shall be entered into without the consent of the State Indemnified Parties unless (a) the only form of relief in such settlement is the payment of money, (b) such settlement will not have any adverse effect on any other Claims that have been or may be made against the State Indemnified Parties, and (c) such settlement includes an unconditional release of each State Indemnified Party of all liability on Claims that are the subject of such proceeding.

- B.2.2 After notice to the State Contracting Agency of the Contractor's election to assume full control of the defense of any such Claim, the Contractor shall not be liable for any legal expenses incurred thereafter in connection with the defense of that Claim by the State Indemnified Parties. If the Contractor does not promptly assume full control over and diligently pursue the defense of a Claim as provided in this Appendix, each State Indemnified Party shall have the right to defend, settle or otherwise resolve the Claim in such manner as he, she or it may deem appropriate, at the cost and expense of the Contractor.

B.3 Insurance

- B.3.1 During the term of this Agreement the Contractor and each Contractor Agent shall maintain and keep in force, at its own expense, the following minimum insurance coverage and minimum limits:
- (a) Workers' Compensation Insurance: The Contractor and each Contractor Agent shall provide and maintain coverage as required by AS 23.30.045, and; where applicable, any other statutory obligations including but not limited to Federal Longshore and Harbor Workers' Compensation Act (USL&H) and Jones Act requirements. The policy must waive subrogation against the State.
 - (b) Commercial General Liability Insurance: covering all business premises and operations used by the Contractor and the Contractor Agents in the performance of Services under this Agreement with minimum coverage limits of \$1,000,000 combined single limit per occurrence.
 - (c) Commercial Automobile Liability Insurance: covering all vehicles used by the Contractor and the Contractor Agents in the performance of Services under this Agreement with minimum coverage limits of \$300,000 combined single limit per occurrence.
- B.3.2 Where specific limits are shown in Section B.3.1, it is understood that they shall be the minimum acceptable limits. If the Contractor's or a Contractor Agent's policy contains higher limits, the State shall be entitled to coverage to the extent of such higher limits.

B.3.3 Certificates of insurance shall be furnished to the Project Director prior to beginning work and must provide for a 30-day prior notice of cancellation, nonrenewal or material change of conditions. No such cancellation, nonrenewal or material modification shall affect the Contractor's obligation to maintain the insurance coverage required by this Appendix. Failure to furnish satisfactory evidence of insurance or lapse of the policy is a material breach of this Agreement and shall be grounds for termination of this Agreement. All insurance policies shall comply with, and be issued by insurers licensed to transact the business of insurance under AS 21.

* * *

APPENDIX C CONTRACT ADMINISTRATION

C.1 Contractor Personnel

- C.1.1 The Contractor shall ensure that any personnel performing work under this Agreement, including personnel employed by any Contractor Agents, possess the appropriate qualifications and competence and are in all respects acceptable to the Project Director.
- C.1.2 The Contractor shall appoint an individual (the “**Contractor Project Manager**”), who shall serve, on a full-time basis, as the primary Contractor representative under this Agreement. The Contractor’s appointment of any Contractor Project Manager shall be subject to the Project Director’s prior approval. The Contractor Project Manager shall (a) be of a management level sufficient to assure timely responses from all Contractor personnel, (b) have overall responsibility for managing and coordinating the performance of the Contractor’s obligations under this Agreement, (c) be authorized to act for and on behalf of the Contractor with respect to all matters within the scope of this Agreement, and (d) work full-time during the DDI Phase from the locations in the State of Alaska designated by the Project Director. For purposes of this Appendix the Contractor Project Manager shall be deemed a member of the Key Personnel.
- C.1.3 The key personnel initially assigned by the Contractor to provide Services to the State Contracting Agency are identified the portion of the Proposal that responds to Section 3.11 of the RFP (each a “**Key Person**” and collectively, the “**Key Personnel**”). With respect to each Key Person, the parties agree as follows:
- (a) Unless otherwise agreed by the Project Director in writing, each Key Person shall be dedicated to the Customer account either on a full-time basis or on a percentage basis as specified in the portion of the Proposal that responds to Section 3.11 of the RFP.
 - (b) The State Contracting Agency shall have the right to evaluate each Key Person and to accept or reject any such Key Person based upon the background, experience and other qualifications indicated by the individual. The Contractor shall only assign an individual to a Key Personnel position who is approved by the Project Director.
 - (c) The Contractor shall not replace or reassign any Key Person, unless the Project Director consents to such replacement or reassignment or such Key Person (i) voluntarily resigns from the Contractor, (ii) is dismissed by the Contractor for misconduct (e.g., fraud, drug abuse, theft), (iii) fails to perform his or her duties and responsibilities pursuant to this Agreement, or (iv) dies or is unable to work due to illness or disability.
 - (d) The Contractor shall provide the period of overlap specified in the portion of the Proposal that responds to Section 3.11 of the RFP for all Key

Persons (or, if not specified in the Proposal, a six-month period of overlap) if the Key Person in a later phase of the Project is different from the comparable position in the earlier phase of the Project. For purposes of illustration only, if the systems operation manager is not the same person as the systems development manager and the Proposal call for a three-month period of overlap, the Contractor shall assure a three month overlap on their respective tenure on the Project, except in the circumstances described in Section (c)(i) through (c)(iv) above.

- C.1.4 In the event that any Key Person or any other employee of the Contractor or a Contractor Agent performing work under this Agreement is found to be unacceptable to the Project Director for any reason, the Project Director may notify the Contractor of such fact and the Contractor shall promptly remove said person and, if requested by the Project Director, provide a suitable, qualified replacement with the same or better level of skill, knowledge and experience within fifteen (15) days of the date of receipt of the Project Director's notice.
- C.1.5 The Contractor shall not hire on a full-time, part-time, or other basis during the period of this Agreement any managerial, professional or technical personnel of the State Contracting Agency that are or have been at any time during the term of this Agreement in the employ of the State Contracting Agency, except regularly retired employees, without the written consent of the Project Director. Further, the Contractor shall not knowingly engage on this Agreement on a full-time, part-time, or other basis during the period of this Agreement any retired employee who has not been retired for at least one year, without the prior written consent of the Project Director.

C.2 Conduct of Contractor Personnel

- C.2.1 While on site at any State facility, the Contractor and the Contractor Agents shall comply with the requests, standard rules and regulations of the State Contracting Agency regarding security, safety and health, storage of materials, personal and professional conduct (including the wearing of a particular identification badge or personal protective equipment, and adhering to facility regulations and general safety practices or procedures) generally applicable to such State facility. The Project Director may remove from and refuse entry and re-admission to a State facility any person who is, in the opinion of the Project Director, not conforming with these requirements.
- C.2.2 The Contractor shall ensure that no property in which the State has an interest, including hardware, equipment, software or other tangible or intangible materials, are removed from any State facility without the Project Director's prior written consent. The Contractor shall immediately notify the Project Director in writing of any known or suspected breach of security in relation to this Agreement and give the State Contracting Agency its full co-operation in any resulting investigation.
- C.2.3 The Contractor shall supply on request details (including name, social security

number, address and date of birth) of any person employed by Contractor or a Contractor Agent who might have access to a State facility under this Agreement.

- C.2.4 The Contractor and the State Contracting Agency shall each be solely responsible for the management, direction, control, supervision, and compensation of its own employees, respectively. Neither party shall be deemed a joint employer of the other's employees, each party being responsible for any and all claims by its employees, subject to Appendix B (Indemnification). Neither party's employees shall be deemed "leased" employees of the other for any purpose.

C.3 Standard of Care

When providing Deliverables and performing Services pursuant to this Agreement, the Contractor shall, and shall cause the Contractor Agents to, provide such Deliverables and perform such Services in a way that meets or exceeds the Contractor Standard of Care. As used herein, the term "**Contractor Standard of Care**" means the exercise of degree of skill, diligence and prudence which is expected from a skilled, experienced and nationally recognized and reputed contractor engaged in the same type of undertaking under similar circumstances and acting generally in accordance with applicable laws, rules, regulations, codes and industry standards.

C.4 Status Reports and Notice of Adverse Impact

- C.4.1 The Contractor shall provide the State Contracting Agency and its designated agents and representatives with written reports of the progress of the work required under this Agreement, any anticipated problems (resolved or unresolved), and any indication of delay in schedules or target dates specified herein. The status reports shall be provided by the Contractor in accordance with the schedule specified in the RFP or, if not specified in the RFP, on a weekly basis.
- C.4.2 The Contractor shall promptly notify the Project Director in writing of any factor, occurrence, condition or event coming to its attention that may adversely affect or delay proper and timely completion of the provision of Deliverables or Services specified in this Agreement and/or the ability of either party to perform its obligations specified herein. Any such notice shall be accompanied by a description of the Contractor's proposed remedy for the particular factor, occurrence, condition or event. The provision by the Contractor of any notice pursuant to this Section shall not relieve the Contractor of its obligations under this Agreement.

C.5 Agreements with Employees

The Contractor shall, and shall cause each Contractor Agent to, obtain and maintain in effect written agreements with each of its employees who provide Deliverables or perform Services pursuant to this Agreement. Such agreements shall contain terms sufficient for the Contractor to comply with all provisions of

this Agreement and to support all grants and assignments of rights and ownership hereunder. Such agreements also shall impose an obligation of confidence on such employees with respect to the State's confidential information that is no less onerous than the obligation of confidence set forth in this Agreement.

C.6 Change Control Procedures

- C.6.1 The State Contracting Agency and the Contractor acknowledge that during the term of this Agreement the software, systems, hardware and equipment required for the Alaska MMIS will undergo changes in order to meet the requirements of the RFP and the business needs of the State Contracting Agency. The change control provisions in this Appendix ("**Change Control Procedure**") shall apply to all Alaska MMIS changes and project phases. Additional specific provisions apply to each category of system changes as further described below.
- C.6.2 Each change shall be classified using one of the following four categories: (1) DDI Change, which shall be handled in accordance with Section C.7 below; (2) System Maintenance change, which shall be handled in accordance with Section C.8 below; (3) Enhancement Modification, which shall be handled in accordance with Section C.9 below; and (4) Additions, which shall require a written, executed amendment to this Agreement, as further described in Section C.10 below.
- C.6.3 For all changes (other than changes made during the DDI Phase in accordance with Section C.7.1), the administrative process for approval of change requests shall commence with the preparation of a change request by the party initiating the request ("**Change Request**"). Each Change Request shall, unless otherwise specified in the RFP, contain at a minimum the following:
- (a) if the Change Request is initiated by the State Contracting Agency, it shall include: (i) the category of the change using the classification system in Section C.6.2; (ii) a description of the requested change, including the business need; and (iii) known system and/or operational impacts; and
 - (b) if the Change Request is initiated by the Contractor, it shall include: (i) the category of the change using the classification system in Section C.6.2; (ii) a description of the requested change, including the business need; (iii) system and/or operational impacts; (iv) targeted dates for completion; (v) the effect the change will have on any then-current schedules; and (vi) the cost and resources required to implement the requested change.
- C.6.4 When either party receives a Change Request from the other, such party shall review the proposal and reject or accept the proposal in writing within a reasonable period of time, but in no event more than fifteen (15) days after receipt of the Change Request.
- C.6.5 Upon request by the State Contracting Agency, the Contractor shall provide the State Contracting Agency an impact statement ("**Impact Statement**") that sets forth in detail the following: (a) a written estimate of the increase or decrease in

cost (if any) of or resulting from making the change described in the proposed Change Request; (b) an estimate of the additional resources (if any) to be provided by each party to complete the change described in the proposed Change Request; (c) the new or changes to existing Services or Deliverables to be provided by the Contractor in connection with the change described in the proposed Change Request; (d) proposed time schedules or targets for implementation of the change described in the proposed Change Request; (e) reports, completion criteria, and testing methodology; and/or (f) such other information as may be reasonably requested by the State Contracting Agency. If a Change Request from the State Contracting Agency requires that the Contractor reduce or eliminate one or more elements of the Services or Deliverables or the functionality to be provided hereunder, then Contractor's Impact Statement shall include a calculation of the resources and expenses related to the elements of the Services or Deliverables or functionality being reduced or eliminated and the cost savings to the State Contracting Agency resulting from such reduction or elimination.

- C.6.6 If Change Request is rejected by the receiving party, the rejection shall include written reasons for such rejection. If the requesting party disagrees with the rejection, it may seek a remedy through the dispute resolution process set forth in this Agreement.
- C.6.7 If the Change Request is accepted by both parties, the parties shall mutually agree on the changes. Such changes shall be made only in a written Statement of Understanding ("SOU") which shall include (a) a description of the system or operational changes to be made, including a description of any new Services to be rendered or Deliverables to be provided, (b) the agreed upon cost or credit, (c) a payment schedule, (d) the resources, including time, materials and staff, required to complete the change, (e) an implementation schedule with a fixed date for completion, (f) the reports, completion criteria, and testing methodology, and (g) the specific remedies for a failure to complete the changes in a timely and satisfactory manner. If an Impact Statement has been prepared in connection with the Change Request, such Impact State will be attached to and form part of the SOU.
- C.6.8 The Contractor shall maintain an automated tracking system that meets the approval of the Project Director and RFP requirements to track all Change Requests, SOUs and contract amendments.
- C.6.9 Changes that are not otherwise included in the costs associated with relevant phases shall be made by the Contractor in accordance with the terms of the SOU; provided, however that the hourly rates for any work associated with a change shall in no event exceed the rates specified in Exhibit C-1. *[Note -- to be completed following review of Contractor's proposal]*.
- C.6.10 Notwithstanding the provisions contained above, if the parties agree in writing that a particular change is an emergency, the Contractor shall make the change

within a shorter agreed-upon timeframe, or on a specified date approved by the State Contracting Agency. At no time shall the Contractor proceed with any Change Request, emergency or otherwise, in the absence of an SOU that has been executed and delivered by the Project Director.

C.7 DDI Change

- C.7.1 All changes that are made to the Alaska MMIS during the DDI Phase that are for the purpose of meeting functional specifications and/or satisfying the requirements specified in the RFP are part of the design and development process and included in the cost, tasks, deliverables, approvals and project implementation schedule of the DDI Phase. Costs associated with these changes during the DDI Phase are included in the DDI Phase costs. No additional costs shall be charged to the State Contracting Agency for these changes made during the DDI Phase.
- C.7.2 If a party requests changes to the functional specifications and/or requirements specified in the RFP during the DDI Phase, the party initiating such request shall prepare a Change Request, and such Change Request shall be subject to the change control provisions for Enhancement Modifications set forth in Section C.9 below, with payments to the Contractor, if any, made in accordance with Section C.9.3.

C.8 System Maintenance

- C.8.1 Contractor shall perform equipment, hardware, software and system maintenance and support to ensure that the Alaska MMIS continuously meets all functional specifications and requirements specified in the RFP (“**System Maintenance**”). System Maintenance shall be provided by the Contractor at the direction of the State Contracting Agency during the term of this Agreement. System Maintenance may result from a determination by the State Contracting Agency or by the Contractor that a deficiency exists within the operational Alaska MMIS, or that continued or improved efficiency can be maintained or achieved through the activity. Examples of various types of maintenance can include: correction of deficiencies and errors; activities to meet ongoing CMS certification requirements; file maintenance activities for updates to tables and databases; changes to edit disposition parameters for established edit or audit criteria; changes to parameters of reports; updated or new data values.
- C.8.2 All costs associated with System Maintenance are included in the Operational Phase fixed costs. No additional costs shall be charged to the State Contracting Agency for System Maintenance.
- C.8.3 If the Contractor considers that any maintenance change requested by the State Contracting Agency constitutes a change the functional specifications and/or requirements specified in the RFP, the Contractor shall so advise the State Contracting Agency in writing within fifteen (15) days of receiving the request. If the Project Director agrees with the Contractor on classification of this work order, he/she will re-classify the work order as an Enhancement Modification

under Section C.9. If the Project Director denies the Contractor's request for reclassification of the work order, the Contractor may seek remedy through the dispute resolution process set forth in this Agreement.

- C.8.4 In the event that any software maintenance release or software upgrade supplied by the Contractor during the term of this Agreement has the effect of preventing the Alaska MMIS or any part thereof from satisfying or performing in accordance with the functional requirements of the RFP or otherwise adversely affects the functionality or features of the Alaska MMIS or any part thereof, then the Contractor shall promptly retrofit or take such other corrective action as may be necessary to ensure that the Alaska MMIS or any such affected part, as modified to include each such software maintenance release or software upgrade, shall satisfy, and perform in accordance with, the functional requirements of the RFP and restore all pre-existing functionality and features as well as provide any new features and functionality provided by any of the foregoing modifications, in each case without any additional charge to the State Contracting Agency.

C.9 Enhancement Modifications

- C.9.1 It is anticipated by the parties that during the term of this Agreement the State Contracting Agency will request changes the functional specifications and/or requirements specified in the RFP that are not System Maintenance changes ("**Enhancement Modifications**"). Examples of Enhancement Modifications can include: new capabilities not specified in the RFP; new edits and audits not defined in the RFP nor offered in the proposed system; certain changes to established report, screen, or tape formats, new data elements, or report items; or a new input form or interface.
- C.9.2 The Contractor is required to dedicate four (4) Full Time Equivalent ("**FTE**") staff with a minimum of 150 hours each, or a total of 600 hours of effort, per month for each month during the term of this Agreement to be used for the State Contracting Agency's anticipated Enhancement Modification requirements. This cost is included in the Operations Phase fixed cost. Any unused hours remaining at the end of a calendar month will be added to the hours for the next calendar month and will be carried forward and accumulate for subsequent calendar months and contract years. At the expiration or termination of this Agreement, the Contractor shall reimburse the State Contracting Agency for all accumulated and unused hours at the hourly rate specified in Exhibit [__] for a system analyst engaged in system modification work. The required dedicated FTE hours for a given period plus all accumulated and unused FTE hours for such period are referred to collectively herein as the "**Enhancement Hours.**" The Contractor shall keep an accurate record of the number of Enhancement Hours expended in each month during the term of this Agreement and make written reports of accrued Enhancement Hours in such manner and at such times as the Project Director may reasonably require.

C.9.3 If the State Contracting Agency requests an Enhancement Modification (including an enhancement requested during the DDI Phase pursuant to Section C.7.2), and the work required to complete the Enhancement Modification will result in the State Contracting Agency exceeding the then-available Enhancement Hours, then (a) the Contractor shall specifically and conspicuously state the number of additional FTE hours required to complete the Enhancement Modification in the text of the SOU, (b) the Contractor shall be reimbursed for the Enhancement Modification upon its completion and acceptance by the State Contracting Agency according to the level of effort stated in the SOU that is in excess of the then-available Enhancement Hours, and (c) any such reimbursement shall be made at the hourly rates specified in the SOU; provided, however that such hourly rates shall in no event exceed the rates specified in Exhibit C-1.

C.10 Additions

C.10.1 Notwithstanding any other provision of this Agreement to the contrary, if an enhancement, modification or change to the Alaska MMIS will result in an increase to the total overall cost to be paid by the State Contracting Agency to the Contractor of more than \$100,000.00 or add more than 60 days, either in delay to the implementation of the system in the DDI Phase or cumulative work hours in Operations Phase, a contract amendment shall be required, and no work shall commence until the contract amendment is executed by both parties. Contract amendments will be subject to the requirements of AS 36.30.400.

C.11 Inspection, Evaluation, and Approval

The Contractor will be responsible for the completion of all work set out in this Agreement. All work is subject to inspection, evaluation, approval and acceptance by the Project Director. The State Contracting Agency may employ all reasonable means to ensure that the work is progressing and being performed in compliance with this Agreement.

C.12 Deliverable Review and Acceptance

C.12.1 The provisions of this Section C.12 shall apply to all Deliverables (including Deliverables provided pursuant to a Change Request), except to the extent the RFP or another Appendix or the Change Request contains express deviations from the terms of this Section.

C.12.2 Each of the Deliverables shall be accompanied by a Deliverable Transmittal Document, signed and dated by the Contractor Project Manager and the Contractor Quality Manager, where applicable. The Deliverable Transmittal Document will be the mechanism for communication concerning the status of that Deliverable. The Deliverable Transmittal Document shall (a) set forth the nature and condition of the Deliverable, (b) reference to all RFP requirements the Deliverable is intended to satisfy, and (c) specify the medium of delivery and the date of delivery. The medium of the Deliverable Transmittal Document (e.g. paper, fax, electronic) shall be approved in advance by the Project Director.

- C.12.3 The countersignature of the Project Director on a Deliverable Transmittal Document will be required for acceptance of each Deliverable, unless otherwise provided in this Appendix.
- C.12.4 For Deliverables that are comprised of reports, documents, templates, studies, strategies, operating models, technical designs, technical architectures, specifications or documentation for software (but not the software itself) the Contractor shall deliver, and the State Contracting Agency shall evaluate, the proposed final version of such Deliverable. The time period for evaluation of such Deliverable, if not otherwise specified in the RFP, shall be ten (10) days from the date of its receipt by the State Contracting Agency. In the event that the Deliverable contains errors and/or requires corrections, the State Contracting Agency shall specify the errors and corrections needed and the Contractor shall deliver an amended version of such Deliverable within ten (10) days following receipt of notice of such need for corrections from the State Contracting Agency.
- C.12.5 For Deliverables that are comprised of software objects, software programs, source code or object code the Contractor shall deliver, and the State Contracting Agency shall evaluate, the proposed final versions of each such Deliverable. The time period for evaluation of such Deliverable, if not otherwise specified in the RFP, shall be ten (10) days from the date of receipt by the State Contracting Agency of the applicable Deliverable Transmittal Document. If the State Contracting Agency identifies Errors in any Deliverable, then the Contractor shall correct such Errors within ten (10) business days following receipt of notice of such Errors from the State Contracting Agency and the State Contracting Agency shall thereafter submit a written acceptance or rejection to the Contractor concerning such Error correction within ten (10) business days of delivery of a requested Error correction.
- C.12.6 As used in this Agreement, the term “**Error**” means any defect, deficiency, failure or malfunction in a Deliverable that causes (i) a deficiency of its functionality or performance, including compatibility, or (ii) a failure to conform to the applicable specifications, requirements, acceptance criteria and user documentation.
- C.12.7 Acceptance of a Deliverable shall be in writing and shall not be withheld if a Deliverable (a) conforms all applicable requirements (including all applicable RFP requirements, quality standards, acceptance criteria, legal requirements and industry standards), and (b) performs in accordance with all applicable specifications.
- C.12.8 The failure of a Deliverable to meet its specifications and otherwise satisfy all other applicable acceptance criteria by the third submission (i.e., the initial submission to the State Contracting Agency plus two re-tries under Sections C.12.4 or C.12.5 above) or any subsequent set of acceptance tests shall, at the election of the State Contracting Agency, constitute a material breach of this Agreement by the Contractor. The Project schedule shall not change as a result of

time required by the Contractor to correct Errors, unless otherwise agreed in writing by the Project Director.

C.12.9 By submitting a Deliverable, the Contractor represents that, to the best of its knowledge, it has performed the associated tasks in a manner that will, in concert with other tasks, meet the specifications and objectives stated or referred to in the RFP and this Agreement. By unconditionally giving acceptance for a Deliverable, the State Contracting Agency represents only that it has reviewed the Deliverable and detected no Errors of sufficient gravity to defeat or substantially threaten the attainment of those objectives and to warrant the withholding of acceptance for the work completed.

C.13 System Acceptance

C.13.1 The foregoing notwithstanding, (a) final acceptance testing of a given Deliverable shall require completion, installation and acceptance of all relevant or material dependencies and other necessary items, and (b) acceptance of a given Deliverable based on stand-alone or unit testing or testing in a non-production environment shall be subject to the Contractor's obligation to correct as described herein any latent defects and other failure(s) to meet its specifications or other applicable acceptance criteria that are discovered in subsequent end-to-end or integration testing, production testing or other testing.

C.13.2 If the State Contracting Agency has made payment for a Deliverable that subsequently is determined to have a latent defect or is otherwise subsequently determined to have failed to meet its specifications or other acceptance criteria in subsequent end-to-end or integration testing, production testing, scale testing or other testing, the State Contracting Agency shall, in addition to its other remedies, have a right of set-off against its payment obligations for Services rendered or Deliverables provided subsequent to such Deliverables until the latent defect or other failure to meet specifications or acceptance criteria is corrected by the Contractor.

C.13.3 The State Contracting Agency shall not be deemed to have waived any rights to accept or reject a particular Deliverable or Service under this Section in the event it fails to deliver any of the notices described herein. Notwithstanding the foregoing, in the event the State Contracting Agency fails to deliver any of the notices described herein, the Contractor shall send the State Contracting Agency's Project Director a written notice that the Contractor has not received the State Contracting Agency's formal acceptance or rejection of a particular Deliverable within the time frame(s) specified in this Section. Such notice shall specifically reference this Section, describe the Deliverable at issue and conspicuously note the failure of the State Contracting Agency to accept or reject such Deliverable within the period specified herein. If the State Contracting Agency does not respond to such notice within ten (10) business days following receipt of such notice, then the State Contracting Agency shall be deemed to have accepted the particular Deliverable or Service specified in the Contractor's notice.

C.13.4 In the event of an early termination of this Agreement, the Contractor shall provide the State Contracting Agency with all partially or wholly completed Deliverables and other work-in-progress with respect to the terminated work within thirty (30) days after the termination date.

* * *

APPENDIX D PROPRIETARY RIGHTS; CONFIDENTIALITY; DATA

D.1 License to Alaska MMIS

D.1.1

Pursuant to 45 CFR § 95.617 Software and ownership rights, the State will have all ownership rights in software or modifications thereof and associated documentation designed, developed or installed with Federal financial participation under this subpart. The Federal Department of Health and Human Services reserves a royalty-free, nonexclusive, and irrevocable license to reproduce, publish, or otherwise use and to authorize others to use for Federal Government purposes, such software, modifications, and documentation. Proprietary operating/vendor software packages which are provided at established catalog or market prices and sold or leased to the general public shall not be subject to the ownership provisions as described above. FFP is not available for proprietary applications software developed specifically for the public assistance programs covered under this subpart

Pursuant to 45 CFR § 92.34 Copyrights, the Federal awarding agency reserves a royalty-free, nonexclusive, and irrevocable license to reproduce, publish or otherwise use, and to authorize others to use, for Federal Government purposes: (a) The copyright in any work developed under a grant, subgrant, or contract under a grant or subgrant; and (b) Any rights of copyright to which a grantee, subgrantee or a contractor purchases ownership with grant support. The license granted to the State in this Section D.1.1 shall be limited to Use solely in connection with the State's Medicaid program (including the installation, integration, testing, deployment, maintenance and operation of the Alaska MMIS).

D.1.2 The license to the Alaska MMIS set forth in Section D.1.1 above shall include, but not be limited to:

- (a) All Alaska MMIS software and supporting programs in their most current version, including the most current versions of source and object code;
- (b) All job control language (JCL) or other system instructions for operating the Alaska MMIS, in their most current version;
- (c) All data files in their most current version;
- (d) User and operational manuals and other documentation in their most current version;
- (e) System and program documentation describing the most current version of the Alaska MMIS;
- (f) Training programs (including related materials) for State staff for the operation and use of the Alaska MMIS in their most current version;

- (g) Any and all performance-enhancing operational plans and products in their most current version;
- (h) Training programs (including related materials) for providers and other billing agencies for claims submission, including both paper and electronic media claims (EMC), and use of the recipient Eligibility Verification System, Electronic Claims Capture, and Prospective Drug Utilization Review (DUR) criteria; and
- (i) All specialized or specially modified operating system software and specially developed programs, including utilities, software, electronic claims submission packages, and documentation, which are required for, or used in the operation of, the Alaska MMIS but which may not be considered as being developed or modified under this Agreement.

D.1.3 The Contractor shall provide two sets of all system and program documentation and related user manuals that are used in conjunction with the Alaska MMIS. Such documentation shall be provided in electronic format (compatible with Microsoft Corporation's then-generally available Office products) and in written format in accordance with the terms of the RFP and this Agreement. Upgrades and revisions to such documentation shall be provided while the Contractor is providing Services therefor. There shall be no additional charge for the documentation or updates thereto, in whatever form provided. The Contractor's documentation shall be comprehensive, well structured and indexed for easy reference.

D.2 Contractor Materials

- D21 All designs, specifications, software, procedures, files, data and documentation (a) that were owned by or licensed to the Contractor as of the Effective Date and were developed or licensed without the use of any funds provided by the State or Federal government, (b) of which the Contractor acquired ownership or license rights after the Effective Date without the use of any funds provided by the State or the Federal government and which are not Developed Materials, and (c) that were developed by or on behalf of the Contractor after the Effective Date without the use of any funds provided by the State or Federal government and which are not Developed Materials (items (a) through (c) collectively, the "**Contractor Materials**") shall be and shall remain the property of Contractor. The Contractor Materials are licensed pursuant to Section D.2.2 below and are not part of the materials licensed pursuant to Section D.1.1 above or part of the Developed Materials (as hereinafter defined).
- D22 The Contractor hereby grants to the State and the United States Department of Health and Human Services a non-exclusive, royalty-free, irrevocable and perpetual license to Use the Contractor Materials. For the avoidance of doubt, the license to the Contractor Materials set forth in this Section permits the State to authorize one or more third parties (including any successor contractors) to Use the Contractor Materials solely in conjunction with the State's Medicaid program

(including the installation, integration, testing, deployment, maintenance and operation of the Alaska MMIS); provided that any such third party must acknowledge in writing to the State that: (a) it will maintain all Contractor Materials as confidential; (b) all Contractor Materials are proprietary to Contractor; and (c) the Contractor Materials will only be used in connection with State's Medicaid program (including the installation, integration, testing, deployment, maintenance and operation of the Alaska MMIS).

D.3 Third Party Materials

- D31 All designs, specifications, software, procedures, files, data and documentation licensed from a third party that will be used in connection with the Alaska MMIS (collectively, "**Third Party Materials**") shall be and shall remain the property of their respective third party licensors. The Contractor shall be responsible for negotiating and obtaining the required rights and licenses to the Third Party Materials used in connection with the Alaska MMIS, which rights and licenses shall include all of the rights set forth in Section D.1. In the event Contractor is unable to negotiate and obtain all of the rights specified in Section D.1 to a particular item of Third Party Materials, the Contractor shall so notify the Project Director in writing of its inability to obtain for the State such rights and the cost and viability of any other designs, specifications, software, procedures, files, data and documentation that can perform the requisite functions and with respect to which the Contractor has the ability to obtain such rights.
- D32 The Contractor shall not introduce any Third Party Materials into the Alaska MMIS unless (a) such Third Party Materials are provided at established catalog or market prices and sold or leased to the general public, (b) the Contractor has provided the State with a complete and correct copy of all license terms applicable to such Third Party Materials, including all price and payment provisions related thereto, and (c) the State has approved such license terms in writing. The Contractor shall not, without the State's written permission, modify any Third Party Materials in any manner for use in the Alaska MMIS.
- D33 With respect to any such State-approved Third Party Materials, unless otherwise agreed by the State in writing, Contractor shall (a) pay all license, maintenance, support and other fees for the Third Party Materials during the term of this Contract, and (b) verify in writing that the State and its designees have the right to obtain or renew the licenses for the Third Party Materials and purchase ongoing maintenance and support for such Third Party Materials, in each case on commercially reasonable terms.
- D34 Unless otherwise mutually agreed to in writing, the Contractor shall, during the term of this Agreement, maintain any and all Third-Party Materials that are software products at their most current version or no more than one version back from the most current version and no additional charge.
- D35 If the State is not named as the licensee under the applicable license agreement for any Third Party Materials that are be used in connection with the Alaska MMIS

then, upon expiration or termination of this Agreement for any reason, the Contractor shall do one of the following at its option and expense: (a) transfer and assign to the State the licenses for the Third Party Materials being used in the Alaska MMIS as of the effective date of such expiration or termination, (b) grant the State a non-exclusive, royalty-free, and irrevocable sublicense to Use such Third Party Materials in connection with the State's Medicaid program (including the installation, integration, testing, deployment, maintenance and operation of the Alaska MMIS), or (c) obtain from the third party licensor a license for the State to Use such Third Party Materials on the terms set forth in Section D.1 above in connection with the State's Medicaid program (including the installation, integration, testing, deployment, maintenance and operation of the Alaska MMIS).

D.4 Developed Materials

- D41 The parties agree that, as between the State and the Contractor, the State shall own all right, title and interest in and to all designs, specifications, software, procedures, files, data and documentation that are designed, developed, installed, enhanced or improved with any funds provided by the State or the Federal government pursuant to this Agreement ("**Developed Materials**"). The Developed Materials shall be deemed "works made for hire" for copyright purposes, with all copyrights in such Developed Materials owned exclusively by the State.
- D42 To the extent that all or any part of the Developed Materials do not qualify as a work made for hire under applicable law, the Contractor shall assign, and cause the Contractor Agents to assign, to the State all right, title, and interest in and to such Developed Materials. Title to the Developed Materials shall vest in the State as such Developed Materials are created. To the maximum extent permitted by law, the Contractor waives, and shall cause its Contractor Agents to waive, all moral rights in the Developed Materials.
- D43 The State hereby grants to the Contractor a non-exclusive, royalty-free, irrevocable and perpetual license to reproduce and otherwise use (and authorize others to reproduce and otherwise use) the Developed Materials for any purpose; provided that such license is at all times subject to the nondisclosure and confidentiality provisions of this Agreement. For the avoidance of doubt, the license set forth in this Section does not apply to any State Data and no rights or licenses with respect to the State Data are granted herein.

D.5 Records of Materials Used in the Alaska MMIS; Delivery of Materials

- D5.1 The Contractor, as part of the Services provided hereunder, shall compile and, as changes are made, update a list of the Contractor Materials, Third Party Materials and Developed Materials in use in the Alaska MMIS. The Contractor shall provide the State Contracting Agency with a copy of such list (a) at contract initiation and on a quarterly basis during the term of this Contract, and (b) within

five (5) business days of receipt of the State Contracting Agency's written request.

- D52 Contractor agrees to deliver to the State Contracting Agency a usable, then-current copy of (a) the object code for all Contractor Materials, Developed Materials and Third Party Materials, (b) the source code for all Contractor Materials and Developed Materials, (c) the source code for all Third Party Materials if such source code was made available to the Contractor by the third party licensor, (d) the State Data, and (e) any other designs, specifications, software, procedures, files, data and documentation constituting the Alaska MMIS in each case (i) on the date of expiration or termination of this Agreement, and (ii) within fifteen (15) days from the receipt of a written request by the State Contracting Agency. Such requests may be made by the State Contracting Agency at any time prior to the expiration of this Agreement and for a period of three years thereafter.

D.6 State Data

- D61 All State Data is and shall remain the exclusive property of the State Contracting Agency. As used herein, the term "**State Data**" means (a) all data, fields, formats and files that are (i) provided by the State to the Contractor or a Contractor Agent or otherwise made available to the Contractor or a Contractor Agent in connection with this Agreement, (ii) migrated into, posted on or inputted into the Alaska MMIS, or (ii) collected, processed, stored, transferred, created, displayed, analyzed or reported in the operation of the Alaska MMIS, and (b) all reports, compilations, aggregations, abstracts, summaries and analyses of any of the foregoing.
- D62 The Contractor shall not, and shall ensure that the Contractor Agents do not (a) use the State Data for any purpose other than in connection with the State's Medicaid program (including the development, maintenance and/or operation of the Alaska MMIS), (b) disclose, sell, assign, lease, or otherwise provide any State Data to any third party without the prior written approval of the Project Director, or (c) commercially exploit the State Data in any way.
- D63 All files containing State Data shall be returned to the State Contracting Agency by the Contractor at the expiration or termination of this Agreement or upon demand by the Project Director. In addition, the Contractor shall ensure that the media upon which such files are stored are prominently marked or inscribed so as to evidence the ownership of the State Data by the State Contracting Agency.

D.7 Nondisclosure and Confidentiality

- D7.1 Contractor agrees that all Confidential Information shall be used only for purposes of providing the Deliverables and performing the Services specified herein, and for no other purpose. The Contractor shall hold as confidential and will use the same level of care (including both facility physical security and electronic security) to prevent unauthorized access by, storage, disclosure,

publication, dissemination to and/or use by third parties of, the Confidential Information as it employs to avoid unauthorized access, storage, disclosure, publication, dissemination or use of its own information of a similar nature, but in no event less than reasonable care. The concept of a “reasonable care” shall include compliance by the Contractor with all applicable federal and state law, including the Social Security Act and HIPAA.

- D.72 If Confidential Information is required to be disclosed by the Contractor by law, regulation, governmental or regulatory authority, such Confidential Information may be disclosed pursuant to such requirement so long as the Contractor provides the State with written notice of the disclosure, to the extent such notice is permitted by law, within a reasonable time after receipt of notice of the required disclosure and, upon request of the State, shall seek to obtain confidential treatment of such information.
- D.73 The Contractor shall promptly notify the Project Director in writing if it becomes aware of any storage, disclosure, loss, unauthorized access to or use of the Confidential Information in violation of this Agreement. The Contractor shall be responsible to ensure that the Contractor Agents comply with this Section D.7.
- D.74 The obligations under the parties under this Section D.7 shall survive for a period of twenty-four (24) months after the last of (a) acceptance of the final Deliverable tendered pursuant to this Agreement, (b) complete performance of the last of the Services specified in this Agreement, and (c) the termination of this Agreement.

D.8 Press Releases

Press releases or other similar public communication by the Contractor relating to this Agreement shall be approved in advance by the Project Director, which approval shall not be unreasonably withheld.

* * *

APPENDIX E REPRESENTATIONS AND WARRANTIES; COVENANTS

E.1 General Representations and Warranties

E.1.1 The Contractor represents and warrants to the State Contracting Agency as of the Effective Date and as of the date of receipt of each payment from the State Contracting Agency, as follows:

- (a) The Contractor (i) is a corporation, duly organized, validly existing and in good standing under the laws of its jurisdiction of incorporation, and (ii) has full power to own, lease, license and operate its properties and assets, to conduct its business as currently conducted and to enter into this Agreement and to consummate the transactions contemplated hereby;
- (b) This Agreement has been duly authorized, executed and delivered by the Contractor and constitutes a valid and binding agreement of the Contractor, enforceable against the Contractor in accordance with its terms, except as such enforcement may be affected by bankruptcy or other insolvency laws;
- (c) Neither the execution and delivery of this Agreement by the Contractor, nor the consummation by the Contractor of the transactions contemplated hereby, shall result in the breach of any term or provision of, or constitute a default under, any charter provision or bylaw, agreement, order, law, rule or regulation to which the Contractor is a party or that is otherwise applicable to the Contractor;
- (d) There is no action, suit, proceeding or investigation pending or, to the Contractor's knowledge, threatened, that questions the validity of this Agreement or the Contractor's right to enter into this Agreement or to consummate any of the transactions contemplated herein;
- (e) The Contractor has all requisite knowledge, know-how, skill, expertise and experience to satisfy its obligations in a timely manner in accordance with the terms of this Agreement;
- (f) The Contractor has the financial and management capacity and capabilities to satisfy its obligations in a timely manner in accordance with the terms of this Agreement and in particular (i) the Contractor has the financial stability to carry out at least six months of Services without reimbursement for the Services; and (ii) Contractor has the financial resources to fund the capital expenditures required under the Agreement without advances by the State Contracting Agency or assignment of any payments by the State Contracting Agency to a financing source;
- (g) Neither the Contractor nor any of its Principals is (i) presently debarred, suspended, proposed for debarment, or declared ineligible for the award of

contracts by any Federal or State agency or excluded in any fashion for any reason from participation in the Medicare, Medicaid or any other federally-funded health program, (ii) in default on any contractual obligation to the State of Alaska, (iii) a party to any agreement, undertaking or contract with the State of Alaska that has been terminated by the State for material breach, or (iv) controlled, directly or indirectly, by a person or entity that is so excluded, in default or the subject of termination. As used in this Section, the term **“Principals”** means the Contractor’s officers, directors, owners and partners and persons having primary management or supervisory responsibilities within a business entity (*e.g.*, general manager; plant manager; head of a subsidiary, division, or business segment and similar positions).

- E.12 The Contractor shall obtain representations and warranties from each Contractor Agent in the form set forth in Section E.1.1. above, *mutatis mutandis*, which representations and warranties shall be made by the Contractor Agent for the benefit of the State Contracting Agency as of the effective date of the applicable subcontract and as of the date of receipt of each payment from the Contractor.

E.2 Services Warranty

- E.21 Notwithstanding inspection and acceptance by the State Contracting Agency or any provision concerning the conclusiveness thereof, Contractor represents and warrants to the State Contracting Agency that all Services performed under this Agreement will, at the time of acceptance, be free from defects in workmanship and conform to the requirements of this Agreement.
- E.22 **“Acceptance,”** as used in this Section E.2, means the act of an authorized representative of the State Contracting Agency by which the State Contracting Agency approves specific services, as partial or complete performance of this Agreement.
- E.23 The Contractor shall immediately correct or re-perform Services which are not in compliance with this Appendix. If the Contractor is required to correct or reperform, it shall be at no cost to the State Contracting Agency, and any Services corrected or reperfomed by the Contractor shall be subject to this Section E.2 to the same extent as work initially performed. If the Contractor fails or refuses to correct or reperform, the Project Director may, by contract or otherwise, correct or replace with similar services and charge to the Contractor the cost occasioned to the State Contracting Agency thereby, or make an equitable adjustment in the contract price.

E.3 Covenants and Undertakings

- E.3.1 In the performance of its obligations hereunder, the Contractor shall comply with all applicable laws, ordinances, rules and regulations, including those laws, ordinances, rules and regulations applicable to the provision of the Services and the delivery of the Deliverables to the State.

- E32 The Contractor shall timely obtain and maintain all necessary approvals, licenses and permits from any public governmental or regulatory body, agency or authority applicable to its business and the performance of its obligations hereunder.
- E33 The Contractor shall not provide any Services or deliver any Deliverable in a manner that infringes, or constitutes an infringement or misappropriation of, any patent, trade secret, copyright, trademark, trade dress or other third-party intellectual property rights.
- E34 The Contractor shall be responsible for ensuring that the Alaska MMIS is, and during the term of this Agreement shall remain, in compliance with HIPAA. Without limitation of the foregoing, Contractor shall originate, develop, prepare, license and acquire, maintain and operate any Deliverable hereunder in a manner that ensures that the use of such Deliverable as part of the Alaska MMIS shall be fully compliant with HIPAA, including the Privacy, Security and Transactions Standards and any other administrative simplification standards promulgated thereunder.
- E35 The Contractor shall not insert, or permit or authorize the insertion, into any Deliverable of any software virus, worm, sniffer, time bomb, drop dead device, logic bomb, Trojan horse, trap door, back door or other computer instructions, software code, intentional devices or techniques that would have the effect of disabling, damaging or otherwise shutting down or permitting unauthorized access to all or any portion of the Alaska MMIS or that can or is designed to threaten, infect, vandalize, defraud, disrupt, damage, steal, take over or be used to take over operation of, allow or enable or be used to allow or enable unauthorized access to or use of, bi-pass, disable, or shut down all or any part of the Alaska MMIS or any component or part thereof, including its firewalls, security or user passwords or other similar protections, data or databases, hardware or software. The Contractor agrees to correct as soon as possible any Deliverables not in compliance with this covenant brought to its attention at any time.
- E36 Any written commitment by the Contractor within the scope of this Agreement shall be binding upon Contractor. Failure of the Contractor to fulfill such a commitment may constitute a material breach and shall render Contractor liable for damages under the terms of this Agreement. For purposes of this Section, a commitment by Contractor includes: (a) purchase prices, charges, discounts, and options committed to remain in force over a specified period of time; and (b) any warranty or representation made by the Contractor in the Proposal or contained in any Contractor publications, written materials, schedules, charts, diagrams, tables, descriptions, other written representations, and any other communication medium accompanying or referred to in the Proposal or used to effect the sale to the State Contracting Agency.

* * *

APPENDIX F PAYMENT PROVISIONS

F.1 All Payments Subject to Contract Funding

- F.1.1 The parties acknowledge and agree that all payments to the Contractor specified in this Agreement are expressly subject to (a) the availability of federal and State funding, and, once the initial funding has been granted all future payments are further subject to such funding not being revoked, rescinded, reduced or withheld during the term of this Agreement, (b) the State's annual legislative appropriation, (c) approval by the CMS, and (d) approval by the Agency Head or the Agency Head's designate. If funding to make payments in accordance with the provisions of this Agreement is not forthcoming from the federal government and/or the State for the Agreement, or is not allocated or allotted to the State Contracting Agency by the federal government and/or the State for this Agreement for periodic payment in the current or any future fiscal period, then the obligations of the State Contracting Agency to make payments after the effective date of such nonallocation or nonfunding, as provided in the notice, will cease and terminate.
- F.1.2 If funding, to make payments in accordance with the provisions of this Agreement, is delayed or is reduced from the federal government and/or the State for the Agreement, or is not allocated or allotted in full to State Contracting Agency by the federal government and/or the State for this Agreement for periodic payment in the current or any future fiscal period, then the obligations of State Contracting Agency to make payments will be delayed or be reduced accordingly or State Contracting Agency shall have the right to terminate the Agreement as provided in Section A.7. If such funding is reduced, State Contracting Agency in its sole discretion shall determine which aspects of the Agreement shall proceed and which Services shall be performed, with Contractor's charges for such Services and for associated Deliverables determined in accordance with those in the Proposal. In these situations, State Contracting Agency will pay Contractor for Services and Deliverables and certain of its costs in accordance with the terms of Section A.7. Any obligation to pay by State Contracting Agency will not extend beyond the end of State Contracting Agency's then-current funding period.
- F.1.3 Contractor expressly agrees that no penalty or damages shall be applied to, or shall accrue to, State Contracting Agency in the event that the necessary funding to pay under the terms of this Agreement is not available, not allocated, not allotted, delayed or reduced.

F.2 Payments

- F.2.1 During the Takeover Phase, the State Contracting Agency shall pay to the Contractor the milestones payments specified in Exhibit F-1 upon completion and acceptance of the applicable Deliverables as set forth in Exhibit F-1 (each, a **"Takeover Milestone Payment"**). Such payment of the Takeover Milestone

Payments shall represent payment in full for all Services rendered and Deliverables provided by the Contractor in the Takeover Phase.

- F22 During the DDI Phase, the State Contracting Agency shall pay to the Contractor the milestone payments specified in Exhibit F-2 upon completion and acceptance of the applicable Deliverables as set forth in Exhibit F-2 (each, a “**DDI Milestone Payment**”). Such payment of the DDI Milestone Payments shall represent payment in full for all Services rendered and Deliverables provided by the Contractor in the DDI Phase. [Note -- Exhibits F-1 and F2 to be completed following review of Contractor’s proposal].
- F23 During the Operations Phase and Turnover Phase, the State Contracting Agency shall pay to the Contractor the fixed operating charges as set forth in Exhibit F-2 (“**Fixed Charges**”). Such payment of the Fixed Charges shall represent payment in full for all Services rendered and Deliverables provided by the Contractor in the Operations Phase and Turnover Phase.
- F24 The State Contracting Agency shall pay each invoice submitted to it under this Agreement within thirty (30) days of receipt of a proper invoice prepared in accordance with this Appendix. All payments made pursuant to this Appendix are subject to the terms and conditions of this Appendix, including Section F.3 hereof.
- F25 Contractor shall pay Contractor’s out-of-pocket expenses incurred in connection with providing the Services and shall be responsible for payment of all expenses related to salaries, benefits, employment taxes, insurance and travel.
- F26 The State Contracting Agency shall not be liable for the payment of any interest, penalties or other charges associated with overdue payments due under this Agreement.

F.3 Invoicing and Holdbacks

- F31 During the Takeover Phase, the Contractor shall invoice the State Contracting Agency for the Takeover Milestone Payments and DDI Milestone Payments upon completion and acceptance of the applicable Deliverables.
- F32 During the Takeover Phase, the amount payable to the Contractor shall equal eighty percent (80%) of the amount of the applicable Takeover Milestone Payment, and the State Contracting Agency shall hold back twenty percent (20%) of each such Takeover Milestone Payment (the “**Takeover Withheld Amount**”). The Takeover Withheld Amount shall be disbursed to the Contractor in installments as follows: (a) seventy-five percent (75%) of the Takeover Withheld Amount shall be paid within seven (7) days of date that the State Contracting Agency authorizes implementation of takeover operations, and (b) the remaining twenty-five percent (25%) of the Takeover Withheld Amount shall be paid within seven (7) days of the date that the State Contracting Agency notifies the Contractor that the State Contracting Agency is satisfied that all components of

the Takeover Phase are successfully operating; provided, however, that all payments of Takeover Withheld Amounts shall be net of any Delay Credits or Performance Credits to which the State Contracting Agency is entitled under the terms of this Agreement.

- F33 During the DDI Phase, the amount payable to the Contractor shall equal eighty percent (80%) of the amount of the applicable DDI Milestone Payment, and the State Contracting Agency shall hold back twenty percent (20%) of each such DDI Milestone Payment (the **“DDI Withheld Amount”**). The DDI Withheld Amount shall be disbursed to the Contractor in installments as follows: (a) seventy-five percent (75%) of the DDI Withheld Amount shall be paid within seven (7) days of the Operations Start Date, and (b) the remaining twenty-five percent (25%) of the DDI Withheld Amount shall be paid within seven (7) days of the date that the State Contracting Agency is notified by DHHS of certification for the Alaska MMIS; provided, however, that all payments of DDI Withheld Amounts shall be net of any Delay Credits or Performance Credits to which the State Contracting Agency is entitled under the terms of this Agreement.
- F34 During the Operations Phase and Turnover Phase, the Contractor shall invoice the State Contracting Agency on a monthly installment basis in arrears for the approved Fixed Charges by the 10th day of the billing month. The invoice shall separate Medicaid and other State-only fees as required.
- F35 All invoices submitted must meet with the approval of the Project Director or his or her designee prior to payment. Contractor shall only submit invoices for Services or Deliverables as permitted by this Section F.3. Incorrect or incomplete invoices will be returned by the State Contracting Agency to Contractor for correction and reissue. Invoices must reference this Agreement and provide detailed information and in a format as requested by the State Contracting Agency.

F.4 Taxes

The Fixed Charges, Takeover Milestone Payments and DDI Milestone Payments are inclusive of all applicable income, sales, use, gross-receipts, excise, personal property, real property, intangibles or other similar taxes. The Contractor shall be solely responsible for remitting all the applicable taxes to the appropriate taxing authority in each jurisdiction.

F.5 Credits Against Amounts Owed

- F5.1 If the Contractor fails to provide a fully tested and accepted Deliverable on the due date specified in the milestone schedule set forth in Exhibit F-1 during the DDI Phase, the State Contracting Agency shall receive a credit (each, a **“Delay Credit”**) in an amount equal to one percent (1%) of the Takeover Milestone Payment or DDI Milestone Payment associated with such Deliverable for each seven (7) day period following the Deliverable due date.

- F52 If the Contractor fails to provide the Services in accordance with the Service Levels during the Operations Phase and Turnover Phase, the State Contracting Agency shall be entitled to a credit in an amount calculated as provided in Exhibit F-3 (“**Performance Credit**”), and the Contractor shall apply the resulting Performance Credits against the Fixed Charges or any other amounts owed to the Contractor hereunder. *[Note -- Exhibit F-3 to be completed following review of Contractor’s proposal]*.
- F53 The State Contracting Agency may, notwithstanding any other provision of this Agreement, deduct the amount of any credits to which it is entitled under this Section from any amounts otherwise due to the Contractor.
- F54 The parties agree that the Delay Credits (in the case of delays in the delivery of the Deliverables in the DDI Phase) and the Performance Credits (in the case of failures to provide Services in accordance with Services Levels in the Operations Phase) are a fair estimate of the damages that the State Contracting Agency will incur for each event for which a Performance Credit or Delay Credit is granted in this Agreement, that the actual damages incurred by the State Contracting Agency in each such event would be difficult and costly to determine, and that the Performance Credits and Delay Credits are liquidated damages and not a penalty.

F.6 Erroneous Payments

- F61 Contractor shall have the sole responsibility during the term of this Agreement for ensuring that erroneous payments (including overpayments, underpayments and duplicate payments) from the Alaska MMIS and all manually priced claims are promptly identified, reported to the Project Director and corrected. If an overpayment, underpayment or duplicate payment is made, and the payment is attributable to acts or omissions of the Contractor, the Contractor shall be liable to the State Contracting Agency for the difference between the amount paid erroneously and the amount that should have been paid using the correct guidelines and any Claims from beneficiaries relating to the failure to make appropriate payments.
- F62 The Contractor shall (a) reimburse the State Contracting Agency for any overpayment or duplicate payment, or (b) make a correcting payment to account for any underpayment, in each case within sixty (60) days of discovery of the erroneous payment.

F.7 Most Favored Customer

Contractor agrees all the prices, terms, rates, warranties, and benefits granted by Contractor are comparable to or better than the terms, prices, warranties and benefits, being offered by Contractor to any present customer meeting similar qualifications or requirements as the State Contracting Agency. Except as otherwise herein provided, if Contractor shall, during the term of this Agreement, enter into arrangements with any other customer providing greater benefits or more favorable terms, Contractor shall be obligated to provide the same to the

State Contracting Agency.

F.8 No Additional Payments

No payment beyond what is expressly set forth in this Appendix will be made to the Contractor for Services rendered and Deliverables provided pursuant to this Agreement except as expressly provided in Section C.6 (Change Control Procedures).

F.9 Additional Damages

Substantial failure of the Contractor to provide the Deliverables and/or render the Services specified in this Agreement may cause the State Contracting Agency to terminate this Agreement. In such event, the State Contracting Agency shall be entitled to reimbursement from the Contractor of all payments made (based on the identified portion of unacceptable work received) and may seek associated damages.

F.10 Limitation of the State's Liability

F.10.1 IN NO EVENT SHALL THE STATE CONTRACTING AGENCY'S AGGREGATE LIABILITY TO THE CONTRACTOR UNDER THIS AGREEMENT, REGARDLESS OF THE PHASE OF THE PROJECT OR THE FORM OF ACTION, WHETHER IN CONTRACT, TORT, NEGLIGENCE, STRICT LIABILITY OR BY STATUTE OR OTHERWISE, FOR ANY CLAIM RELATED TO OR ARISING UNDER THIS AGREEMENT, EXCEED THE MAXIMUM AMOUNT.

F.10.2 THE STATE CONTRACTING AGENCY SHALL NOT BE LIABLE, REGARDLESS OF THE FORM OF ACTION, WHETHER IN CONTRACT, TORT, NEGLIGENCE, STRICT LIABILITY OR BY STATUTE OR OTHERWISE, FOR ANY CLAIM RELATED TO OR ARISING UNDER THIS AGREEMENT FOR CONSEQUENTIAL, INCIDENTAL, INDIRECT, PUNITIVE OR SPECIAL DAMAGES.

* * *

APPENDIX G SCOPE OF WORK

G.1 Purpose

G.1.1 The State Contracting Agency is seeking to take advantage of recent technological advancements and replace its current Medicaid Management Information System with a system that meets all the requirements presented in the RFP. The State Contracting Agency is entering into this Agreement to obtain a fully functioning and operational Alaska MMIS.

G.2 Overview of Obligations

G.2.1 The Contractor shall (a) support the State's current MMIS system and operations until the implementation of the new Alaska MMIS by performing operational takeover services as described in the RFP; (b) design, develop, integrate, install, test, deploy, maintain and operate of the Alaska MMIS in a way that will meet all the functional and operational requirements described in RFP; (c) provide the Deliverables and perform the Services specified in this Appendix and elsewhere in this Agreement; (d) ensure that the Alaska MMIS meets all applicable regulatory requirements and can be certified by CMS for enhanced federal funding; and (e) participate in a collaborative transition to turn the Alaska MMIS over to the State or its designee at the expiration or termination of this Agreement, in each case as described in greater detail in this Appendix.

G.3 Project Phases and Tasks

G.3.1 The Services to be rendered and the Deliverables to be provided by Contractor pursuant to this Agreement are divided into phases as follows:

- (a) **"Takeover Phase"** pursuant to which the Contractor shall (i) develop a plan for the transition of the systems and software of the legacy MMIS system from the State's existing vendor to the Contractor, (ii) execute the transition plan approved by the State Contracting Agency, and (iii) operate the legacy MMIS system in the period prior to the Operations Transition Date;
- (b) **"DDI Phase"** pursuant to which the Contractor shall be responsible for the design, development, implementation, integration, testing and deployment of the systems and software required for the new Alaska MMIS;
- (c) **"Operations Phase"** pursuant to which the Contractor shall be responsible for the operation, maintenance and support of the systems and software for the new Alaska MMIS; and

- (d) **“Turnover Phase”** pursuant to which the Contractor shall be responsible for certain transition and turnover obligations to ensure that the Alaska MMIS can be operated independently by the State Contracting Agency or its designee without the assistance of the Contractor.

G32 Exhibit G-1 lists the tasks in duration as well as actual performance dates for this Agreement. Exhibit G-2 lists the performance schedule for the Transition Phase and DDI Phase. Exhibit G-3 outlines the scope of work to be performed by the Contractor in the Transition Phase and DDI Phase; however, the RFP and Proposal must be used to provide a detailed description of each obligation. [Note -- Exhibits to be completed following review of Contractor's Proposal]

G.4 Performance Bonds

G41 The Contractor shall deliver to the Project Director (a) a performance bond on terms acceptable to the State Contracting Agency covering the Contractor's obligations under the Takeover Phase, (b) a separate performance bond on terms acceptable to the State Contracting Agency covering the Contractor's obligations under the DDI Phase, and (c) a separate performance bond on terms acceptable to the State Contracting Agency covering the Contractor's obligations under the Operations Phase and Turnover Phase, as set forth in this Section.

G42 Each performance bond specified in this Section (each, a **“Performance Bond”**) shall be issued to the State Contracting Agency as security for the due performance and observance by the Contractor of all of the terms and conditions of this Agreement. If the Contractor shall fail to perform and observe any of this Agreement, then the State Contracting Agency shall be entitled to demand payment of the entire guaranteed amount under the then-applicable Performance Bond. In the event the amounts payable to the Contractor are increased from time to time pursuant to the Change Control Procedure, the State Contracting Agency shall be entitled to require that the applicable Performance Bond be increased accordingly. If any part of the Performance Bond shall be enforced by the State Contracting Agency, the Contractor shall on demand by the Project Director forthwith furnish a further Performance Bond for the amount so forfeited.

G43 The Contractor shall, within seven (7) days of the Effective Date, obtain a Performance Bond in the face amount equal to thirty percent (30%) of the aggregate amounts payable in the Takeover Phase (including planning, implantation and operation components) to guarantee the Contractor's completion of its obligations in the Takeover Phase. The Contractor shall maintain such Performance Bond at all times during the Takeover Phase.

G44 The Contractor shall, prior to requesting approval from the Project Director to begin work on the DDI Phase, obtain a Performance Bond in an amount equal to fifty percent (50%) of the aggregate amounts payable in the DDI Phase to guarantee the Contractor's completion of its obligations in the DDI Phase. The Contractor shall maintain such Performance Bond at all times during the DDI

Phase.

- G45 The Contractor shall, prior to requesting approval from the Project Director for the start of operations of the new Alaska MMIS, obtain a Performance Bond in an amount equal to fifty percent (50%) of the aggregate amounts payable in the second contract year of the Operations Phase (inclusive of all operations line items) to guarantee the Contractor's completion of its obligations in the Operations Phase and Turnover Phase. The Contractor shall maintain such Performance Bond at all times during the Operations Phase and Turnover Phase period and until such time as the final payment due to the Contractor under this Agreement has been made by the State Contracting Agency.
- G46 The Contractor shall ensure that (a) if a Performance Bond expires in accordance with its terms it is immediately replaced with the next Performance Bond specified herein so that there is no gap in the Performance Bonds specified herein, and (b) there is at all times during the term of this Agreement a Performance Bond in place and available for call by the State Contracting Agency. The Contractor's failure to provide a Performance Bond having terms acceptable to the State Contracting Agency within the required times specified in this Section shall be deemed a material breach of this Agreement by the Contractor. The State Contracting Agency may, in addition to its other remedies, withhold any payments otherwise due to the Contractor under this Agreement until the Contractor has complied with the requirements of this Section.
- G47 The provisions of this Section shall in no way affect the rights and remedies expressly reserved hereunder to the State Contracting Agency or bar the State Contracting Agency from claiming all expense, loss and damage incurred or sustained by the State Contracting Agency in the event of any breach by the Contractor of any of the provisions of this Agreement.

G.5 Start Date and Schedule

- G51 The Contractor shall be required to (a) commence work under this Agreement no later than seven (7) days after the Effective Date, (b) prosecute the work diligently, (c) provide all Services and Deliverables in accordance with the deadlines and delivery dates specified in the Work Plan, and (d) complete a Fully Operational Alaska MMIS on or before the date that is specified in the Work Plan as the operations start date for the Alaska MMIS (the "**Operations Start Date**").
- G52 The final Work Plan shall be comprised of the Contractor's Work Plan in the Proposal, as revised by the Contractor to reflect Project changes since Contractor's initial submission. The Work Plan shall provide detailed information on all aspects of the Project, including but not limited to Services, Deliverables, Schedule, deadlines and delivery dates, task dependencies, identification of resource requirements and milestone payments. The Work Plan shall reflect all of the requirements in the RFP and include descriptions of all work to be performed by the State Contracting Agency and the and Contractor in

order to complete the Project successfully. Contractor shall deliver the revised Work Plan to the Project Director for review not later than 30 days after the Effective Date of the Agreement. In the event of failure of the parties to agree upon this Work Plan and/or if State Contracting Agency does not accept the Work Plan within 45 days of the Effective Date, State Contracting Agency may immediately terminate this Agreement without any further obligation to the Contractor, and, in State Contracting Agency's discretion, pursue negotiations with an alternative vendor.

- G53 The Contractor shall provide updates to the official Work Plan (which shall be maintained by the State Contracting Agency) regularly (no less than bi-weekly) and as otherwise necessary throughout the Project to accurately reflect the status of the delivery of the Deliverables and performance of the Services. Any such update changes must be agreed upon by the Project Director prior to their final incorporation into the Work Plan. However, unless otherwise specifically agreed to in writing, the Project Director's agreement on a change to the official Work Plan shall not relieve Contractor of liability for liquidated damages and other damages arising from such failures to perform its obligations as required herein.
- G54 If, for any reason, the Contractor does not deliver the Fully Operational Alaska MMIS on or before the Operations Start Date then the Contractor will forfeit all monthly Fixed Charges for each month (or part thereof) of delay until the date that the Project Director approves the start of operations for the Alaska MMIS. In addition, if Project Director has not approved the start of operations for the Alaska MMIS as of the Operations Start Date, the Contractor shall be liable for all additional costs incurred by the State Contracting Agency to continue current MMIS operations.

G.6 Performance Standards and Service Levels

- G61 In performing the Services, the Contractor's level of performance shall meet or exceed the service levels set forth in the RFP and Exhibit G-4 (the "**Service Levels**"). [*Note -- Exhibit G-4 to be completed following review of Contractor's proposal*].
- G62 Except as otherwise expressly provided herein, all Service Levels shall be measured and reported by the Contractor on a monthly basis.
- G63 The Contractor shall submit to the State Contracting Agency by the tenth (10th) day of each month a Monthly Performance Report which shall document the Contractor's performance with respect to the Service Levels during the previous month and explain deviations from the Service Levels, if any, including a plan for corrective action where appropriate.
- G64 The Contractor shall promptly notify the State Contracting Agency in writing if the State Contracting Agency becomes entitled to a Performance Credit for failure to meet a Service Level. Such notice shall specify each Service Level that the

Contractor failed to meet, and the amount of the Performance Credit the State Contracting Agency is entitled to receive due to such failure under the Agreement. With respect to each Performance Credit that the State Contracting Agency elects to recover:

- (a) Such Performance Credit shall be applied against the Contractor's next monthly invoice after the date that the State Contracting Agency notifies the Contractor that it is electing to recover such Performance Credit and to each monthly invoice thereafter until the Performance Credit is fully utilized.
- (b) If there will be no the Contractor invoices after such notice, the Contractor will pay the amount of any unused Performance Credits to the State Contracting Agency within thirty (30) days after the date of such notice.

G.65 If the Contractor fails to measure and report on any Service Level for any month as required under this Appendix, the Contractor shall be deemed to have missed such Service Level.

G.7 Federal Certification Requirements and Funding Levels

G.7.1 The Contractor shall ensure that (a) the Alaska MMIS, and all of its component parts, meet all requirements established from time to time by the Federal government at all times during the term of this Agreement, including all certification and re-certification requirements, (b) the State Contracting Agency shall receive the maximum allowable enhanced FFP for the DDI Phase of the Alaska MMIS, retroactive to the Operations Start Date, (c) the State Contracting Agency shall receive the maximum allowable enhanced FFP for the Operations Phase and Turnover Phase. The Contractor shall provide on a timely basis, all information, data, forms, system modifications, documentation, correspondence, consultation, and assistance in training as needed to assist the State Contracting Agency in obtaining Federal certification and funding.

G.7.2 If the Alaska MMIS, or any component part of it, is decertified (either retroactively or prospectively) prior to the expiration or termination of this Agreement, the Contractor will be liable for resulting damages if such decertification is attributable, directly or indirectly, to the acts or omissions of the Contractor.

G.7.3 The Contractor shall be liable to the State Contracting Agency for the difference between the maximum allowable enhanced FFP and the FFP actually received by the State Contracting Agency, including any losses due to loss of certification, failure to obtain approval retroactive to the Operations Start Date, or delays in readiness to support certification.

G.7.4 All FFP damages claims assessed by the Federal government against the State Contracting Agency may be withheld from amounts otherwise payable to the

Contractor under this Agreement until all such damages are satisfied in full.

G.8 Continuity of Services

- G.8.1 The Contractor recognizes that the Services provided under this Agreement are critical to the discharge by the State of important public functions and must be continued without interruption and that, upon expiration or termination of this Agreement, a successor, either the State or another contractor, may continue them. The Contractor agrees to:
- (a) Furnish phase-in training and other knowledge transfer and turnover activities specified in the RFP; and
 - (b) Exercise its best efforts and cooperation to effect an orderly and efficient transition to a successor.
- G.8.2 The Contractor shall provide sufficient experienced personnel during the Turnover Phase to ensure that the Services called for by this Agreement are maintained at the required level of proficiency.
- G.8.3 The Contractor shall allow as many personnel as practicable to remain on the job to help the successor maintain the continuity and consistency of the Services required by this Agreement. The Contractor also shall disclose necessary personnel records and allow the successor to conduct on-site interviews with these employees. If selected employees are agreeable to the change, the Contractor shall release them at a mutually agreeable date and negotiate transfer of their earned fringe benefits to the successor.
- G.8.4 The Contractor will ensure that all consents or approvals of third parties required to allow the Contractor and Contractor Agents to provide the transition assistance required following the termination or expiration of this Agreement have been obtained, on a contingent basis, in advance and will be provided by the applicable third parties at no cost or delay to the State Contracting Agency.

G.9 Additional Specific Obligations

In addition to the obligations set forth herein, the Contractor shall perform the specific obligations set forth in Exhibit G-4.

* * *

APPENDIX H DEFINITIONS

“Acceptance” has the meaning set forth in Section E.2.2.

“Agency Head” means the commissioner or head of the State Contracting Agency.

“Agreement” has the meaning set forth in Section A.1.1.

“Alaska MMIS” or **“MMIS”** means the Medicaid Management Information System as described in the RFP that will be installed, integrated, tested, deployed, maintained and operated by the Contractor in accordance with the terms set forth in this Agreement. The Alaska MMIS consists of all CMS and State required components and functionality, including: a pharmacy POS; claims processing and reporting modules; a Data Warehouse/Decision Support System; and the SURS, MARS and TPL and DUR capabilities; prior authorization and drug rebate functions. The Alaska MMIS also includes all ancillary components such as privacy and security functionality, automated tracking and reporting on system and other performance measures, optical scanning equipment and software, automated voice response functionality, translator and messaging products or services, Webportal/internet programs, codes and screens, and all interfaces, documentation, manuals, and publications required for the operation, maintenance and use of the Alaska MMIS.

“Change Control Procedure” has the meaning set forth in Section C.6.1.

“Change Request” has the meaning set forth in Section C.6.3.

“Claims” has the meaning set forth in Section B.1.

“CMS” means the Center for Medicare and Medicaid Services.

“Confidential Information” means any data, files, software, information or materials (whether prepared by the State Contracting Agency or its agents or advisors) in oral, electronic, tangible or intangible form and however stored, compiled or memorialized that is (i) provided by the State to the Contractor or a Contractor Agent or otherwise made available to the Contractor or a Contractor Agent in connection with this Agreement, or (ii) acquired, obtained or learned by the Contractor or a Contractor Agent in the performance of this Agreement. The Confidential Information shall include the State Data, the terms of this Agreement and all discussions and negotiations related thereto.

“Contractor” means the vendor providing Deliverables and/or Services pursuant to this Agreement, as identified on the Cover Sheet.

“Contractor Agent” means a permitted subcontractor and any other agent or representative of the Contractor that provides services or delivers deliverables pursuant to this Agreement.

“Contractor Materials” has the meaning set forth in Section D.2.1.

“Contractor Project Manager” has the meaning set forth in Section C.1.2.

“Contractor Standard of Care” has the meaning set forth in Section C.3.

“Cover Sheet” means the Standard Agreement Form for Professional Services Contracts (Form 02-093).

“DDI Milestone Payment” has the meaning set forth in Section F.2.2.

“DDI Phase” has the meaning set forth in Section G.3.1.

“DDI Withheld Amount” has the meaning set forth in Section F.3.3.

“Delay Credit” has the meaning set forth in Section F.5.1.

“DHHS” means the U.S. Department of Health and Human Services.

“Deliverables” means the reports, documents, templates, studies, strategies, operating models, technical designs, technical architectures, software objects, software programs, source code, object code, specifications, documentation, abstracts and summaries thereof, and all other work product and materials which are to be, or are, originated, prepared, licensed or acquired for the State Contracting Agency and delivered by or for the Contractor (either independently or in concert with the State Contracting Agency or third parties) to the State Contracting Agency pursuant to and during the course of the Contractor’s performance under this Agreement.

“Developed Materials” has the meaning set forth in Section D.4.1.

“Effective Date” means the date that the Cover Sheet was signed by the Project Director.

“Enhancement Hours” has the meaning set forth in Section C.9.2.

“Enhancement Modifications” has the meaning set forth in Section C.9.1.

“Error” has the meaning set forth in Section C.12.6.

“FFP” means Federal Financing Participation, as such term is defined in the applicable Federal regulations.

“Fixed Charges” has the meaning set forth in Section F.2.3.

“FTE” has the meaning set forth in Section C.9.2.

“Fully Operational” means, when used with respect to the Alaska MMIS, that the MMIS (i) is established and operational with five (5) years of claim data on line; (ii) processes correctly all claim types, claims adjustments, and other financial transactions; (iii) maintains all system files; (iv) produces all required reports; (v) meets all system specifications; (vi) supports all required interfaces, (vii) performs all other functional and operational requirements specified in the RFP, and (viii) has been fully tested and finally accepted by the State Contracting Agency in accordance with this Agreement.

“HIPAA” has the meaning set forth in Section A.21.

“Impact Statement” has the meaning set forth in Section C.6.5.

“Key Person” and/or **“Key Personnel”** has the meaning set forth in Section C.1.3.

“Losses” has the meaning set forth in Section B.1.

“Maximum Amount” has the meaning set forth in Section A.19.2.

“Operations Phase” has the meaning set forth in Section G.3.1.

“Operations Start Date” has the meaning set forth in Section G.5.1.

“Operations Transition Date” means the date that both (i) approval from the Project Director has been received for the start of operations for the Alaska MMIS, and (ii) the final payment for the DDI Phase has been made by the State Contracting Agency.

“Performance Bond” has the meaning set forth in Section G.4.2.

“Performance Credit” has the meaning set forth in Section F.5.2.

“Principals” has the meaning set forth in Section E.1.1.

“Project” means the project described in the RFP (including all phases of the project described therein) for which the Contractor will provide Services and Deliverables to the State Contracting Authority.

“Project Director” means the person designated as the project director from time to time by the Agency Head or, in the absence of such designation, the person who signs this Agreement on behalf of the State Contracting Agency and any successor or authorized representative of such person.

“Property” has the meaning set forth in Section A.20.3.

“Proposal” means the Contractor’s successful proposal submitted in reply to the RFP, including any written amendments or clarifications that have been authorized by the State Contracting Agency.

“RFP” means the State Contracting Agency’s request for proposal #[*insert number*], including any written amendments or clarifications thereto that have been authorized by the State Contracting Agency and the State’s written responses to questions posed by the Contactor.

“Service Levels” has the meaning set forth in Section G.6.1.

“Services” means the services to be provided by the Contractor or a Contractor Agent pursuant to this Agreement.

“SOU” has the meaning set forth in Section C.6.7.

“State” means the State of Alaska, including without limitation the State Contracting Agency and all of the State’s other agencies.

“State Contracting Agency” means the department of the government of the State of Alaska for which this Agreement is to be performed, as identified on the Cover Sheet.

“State Data” has the meaning set forth in Section D.6.1.

“State Indemnified Parties” has the meaning set forth in Section B.1.

“System Maintenance” has the meaning set forth in Section C.8.1.

“Takeover Milestone Payment” has the meaning set forth in Section F.2.1.

“Takeover Phase” has the meaning set forth in Section G.3.1.

“Takeover Withheld Amount” has the meaning set forth in Section F.3.2.

“Third Party Materials” has the meaning set forth in Section D.3.1.

“Turnover Phase” has the meaning set forth in Section G.3.1.

“Use” means (i) to make, have made, use, copy, reproduce, maintain, modify, enhance, display, perform, demonstrate and create derivative works, and (ii) to authorize one or more third parties to do any of the foregoing.

“Work in Progress” has the meaning set forth in Section A.6.4.

“Work Plan” means the overall plan of activities for the Project, and the delineation of Services to be performed and Deliverables to be produced with regard to the Project, as submitted with the Proposal and as updated in accordance with Section G.5. The Work Plan and each amendment thereto shall be subject to acceptance by the State Contracting Agency.

* * *

EXHIBIT A-1

BUSINESS ASSOCIATE AGREEMENT

THIS BUSINESS ASSOCIATE AGREEMENT (the “Agreement”) is made and entered into effective the ____ day of _____, 200_, by and between the State of Alaska Department of Health Care Services (hereinafter called “the State”) and **[insert vendor name]** (hereinafter called “Business Associate”).

RECITALS

The State is operating its Medicaid program as a “Covered Entity” as that term is defined under 45 C.F.R. Part 160 and Part 164, Subparts A and E (the “Privacy Rule”) and 45 C.F.R. Part 160 and Part 164, Subparts A and C (the “Security Rule”) which were promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”).

In the course of the performance of services for the State, Business Associate and its partners, employees, agents, advisors, consultants and subcontractors, may be given access to “Protected Health Information” (“PHI”) as that term is defined in the Privacy and Security Rules and “Electronic Protected Health Information” (“EPHI”) as that term is defined in the Security Rule.

To the extent Business Associate is given access to PHI and EPHI by or on behalf of the State, Business Associate is a “business associate” (as that term is defined under the Privacy and Security Rules) of the State.

The State and Business Associate have entered into an agreement effective **[insert effective date of Agreement for vendor services]** (the “Services Agreement”) in which Business Associate has agreed to provide specified services to the State.

The State and Business Associate intend that this Agreement shall be an addendum to the Services Agreement for the purpose of ensuring that all of their business related to the Services Agreement is conducted in compliance with HIPAA, the Privacy Rule and the Security Rule, and that this Agreement shall govern Business Associate’s use and disclosure of all PHI and EPHI obtained or created by Business Associate from or on behalf of the State.

COVENANTS

For good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the State and Business Associate hereby agree as follows:

A. Definitions. For purposes of this Agreement:

1. “Administrative Safeguards” shall have the same meaning as the term “Administrative Safeguards” in 45 C.F.R. § 164.304.
2. “Designated Record Set” shall have the same meaning as the term “Designated Record Set” in 45 C.F.R. § 164.501.
3. “Electronic Protected Health Information” or “EPHI” shall have the same meaning as the term “Electronic Protected Health Information” in 45 C.F.R. § 160.103 except, for purposes of this Agreement, the term shall be limited to

Electronic Protected Health Information received or obtained by Business Associate from the State or created, received, maintained or transmitted by Business Associate on behalf of the State.

4. "Individual" shall have the same meaning as the term "Individual" in 45 C.F.R. § 160.103 and shall include a person who qualifies as a Personal Representative in accordance with 45 C.F.R. § 164.502(g).
5. "Notice of Privacy Practices" shall have the same meaning as the term "Notice of Privacy Practices" in 45 C.F.R. § 164.520.
6. "Physical Safeguards" shall have the same meaning as the term "Physical Safeguards" in 45 C.F.R. § 164.304.
7. "Protected Health Information" or "PHI" shall have the same meaning as the term "Protected Health Information" in 45 C.F.R. § 160.103 except, for purposes of this Agreement, the term shall be limited to Protected Health Information received or obtained by Business Associate from the State or created, received, maintained or transmitted by Business Associate on behalf of the State. As provided in 45 C.F.R. § 160.103, the term PHI includes EPHI.
8. "Required By Law" shall have the same meaning as the term "Required by Law" in 45 C.F.R. § 164.103.
9. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his designee.
10. "Security Incident" shall have the same meaning as the term "Security Incident" in 45 C.F.R. § 164.304.
11. "Technical Safeguards" shall have the same meaning as the term "Technical Safeguards" in 45 C.F.R. § 164.304.
12. Terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms in the Privacy Rule or the Security Rule.

B. Permitted Uses and Disclosures of PHI. Business Associate may use and disclose PHI only for the following purposes:

1. Business Associate may use and disclose PHI as necessary to perform its obligations under the Services Agreement, provided that such use or disclosure would not violate the Privacy Rule if done by the State.
2. Business Associate may use and disclose PHI as Required by Law.

C. Privacy and Security Obligations. Business Associate shall:

1. Not use or further disclose PHI other than as permitted or required by this Agreement, or as Required by Law.
2. Use appropriate safeguards to prevent the use or disclosure of PHI other than as

authorized under this Agreement.

3. Implement Administrative, Physical and Technical Safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of EPHI and that prevent use or disclosure of EPHI other than as provided for by the Agreement.
4. Promptly report to the State: (a) any use or disclosure of PHI or EPHI by Business Associate that is not provided for by this Agreement and of which Business Associate becomes aware; or (b) any Security Incident of which Business Associate becomes aware. This report shall be made as soon as practicable, but in no event later than three (3) business days after becoming aware of the reportable event. The Business Associate shall, in consultation with the State, mitigate, to the extent practicable, any harmful effect that is known to the Business Associate of the reportable event.
5. Ensure that any agent or subcontractor to whom Business Associate provides PHI or EPHI agrees to the same restrictions and conditions that apply to Business Associate with respect to such PHI or EPHI.
6. Within a reasonable time after receiving notice from the State, make available Business Associate's internal practices, books and records relating to the use and disclosure of PHI or EPHI to the State and, upon the State's request, to the Secretary for purposes of determining the State's compliance with the Privacy Rule or the Security Rule.
7. At termination of the Services Agreement, if feasible, return or destroy all PHI that Business Associate still maintains in any form and retain no copies of such PHI or, if such return or destruction is not feasible, extend the protection of this Agreement to the PHI and limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible.

D. Access Obligations

1. Business Associate shall develop and implement all procedures necessary in order for the State to comply with 45 C.F.R. § 164.524. Under such procedures, Business Associate shall be responsible for reviewing such request, informing the Individual of the disposition of the request, and, if appropriate, providing PHI in response to the Individual's request within the time periods specified in 45 C.F.R. § 164.524.
2. Business Associate shall develop and implement all procedures necessary in order for the State to comply with 45 C.F.R. § 164.526. Under such procedures, Business Associate shall be responsible for reviewing such request, informing the Individual of the disposition of the request, and, if appropriate, authorizing any amendment of PHI in response to an Individual's request or filing the Individual's statement of disagreement within the time period specified in 45 C.F.R. § 164.526.
3. Business Associate shall develop and implement all procedures necessary in order for the State to comply with 45 C.F.R. § 164.528. Under those procedures,

Business Associate shall be responsible for keeping records of all disclosures for which the State must account under 45 C.F.R. § 164.528 and authorizing any accounting of disclosures of PHI in response to an Individual's request for such an accounting.

E. Breach of Agreement; Termination; Term

1. *Breach of Agreement.* In the event that the State becomes aware of a pattern or practice of Business Associate that constitutes a material breach or violation of Business Associate's obligations under this Agreement, the State will notify Business Associate of such breach. Business Associate shall promptly cure the breach. If Business Associate fails to expeditiously cure the breach, the State may terminate the Services Agreement. If Business Associate does not cure the breach and the State determines that termination is not feasible, the State may report the breach to the Secretary. If the Services Agreement is terminated, Business Associate shall return or destroy all PHI as specified in Section C(7) of this Agreement.
2. *Term.* This Agreement shall be effective as of the date set forth above. This Agreement shall terminate when all of the PHI is destroyed or returned to the State, or, if it is infeasible to return or destroy PHI, Business Associate has taken adequate steps to ensure that protections are extended to such information in accordance with the termination provisions in Section C(7) of this Agreement.

F. Obligations of the State. To the extent it may affect Business Associate's use or disclosure of PHI, the State shall notify Business Associate of:

1. Any limitations on the use or disclosure of PHI set forth in the State's Notice of Privacy Practices.
2. Any changes or revocation of permission by an Individual to use or disclose that individual's PHI.
3. Any restriction to the use or disclosure of PHI that the State has agreed to in accordance with 45 C.F.R. § 164.522.

G. Re-Negotiation. The parties agree to negotiate in good faith any modification to this Agreement that may be necessary or required to ensure consistency with applicable federal and state laws, including regulations promulgated pursuant to HIPAA, and amendments and changes to such laws and regulations. If the parties are unable to negotiate a modification that the State, in its reasonable discretion, determines is consistent with its obligations under federal or state law, then the State may terminate this Agreement by providing five (5) days' notice to Business Associate.

H. General Provisions

1. *Binding Effect.* This Agreement shall be binding upon and shall inure to the benefit of the parties, and any successor to the operations and business of the parties whether by operation of law or otherwise, including the parties' heirs, legal representatives, successors, and permitted assigns. The preceding sentence shall not affect any restriction on assignment set forth elsewhere in this

Agreement.

2. *Assignment.* This Agreement shall not be assignable by either party without the other's prior written consent.
3. *Notices.* Except as provided in Section H(4) of this Agreement, all notices given pursuant to this Agreement shall be in writing and shall be delivered by hand or sent by registered or certified mail, postage pre-paid, addressed to the party for whom it is intended at its or his address as first set forth below. Any address for the giving of notice may be changed by giving notice to that effect to the other party. Each such notice shall be deemed to have been given on the date of its receipt by the party for whom it was intended.

Notice to the State shall be addressed as follows:

Notice to Business Associate shall be addressed as follows:

4. *E-Mail Notices.* Notices, requests, instructions or other communication between the State and Business Associate under Sections C(4), D(2), or F of this Agreement may be made by electronic mail at the e-mail address below. Any e-mail address for the purpose of the foregoing communications may be changed by giving notice to that effect to the other party. Each such notice shall be deemed to have been given on the date of its receipt by the party for whom it was intended.

Notice to the State shall be addressed as follows:

Notice to Business Associate shall be addressed as follows:

5. *Severability.* If any provision of this Agreement is or becomes unenforceable, the remainder of this Agreement shall nevertheless remain binding to the fullest extent possible, taking into consideration the purposes and spirit of this Agreement.

6. *Entire Agreement.* This Agreement contains the entire understanding of the parties hereto with regard to the subject matter hereof, and supersedes all other agreements and understandings, written and oral, relating to the subject matter hereof. This Agreement may not be amended or modified, nor may any of its provisions be waived, except by a writing executed by both of the parties hereto or, in the case of a waiver, by the party waiving compliance.
7. *Waiver.* The waiver of any one breach of the Agreement shall not be construed as a waiver of any rights or remedies with respect to any other breach or subsequent breach.
8. *Survival.* Any provision of this Agreement, which by its terms is intended to survive the termination or expiration of this Agreement shall so survive.
9. *Governing Law.* This Agreement and the rights of the parties shall be governed by and construed in accordance with the laws of the State of Alaska, excluding any conflicts or choice of law rule or principle that might otherwise refer construction or interpretation of the Agreement to the substantive law of another jurisdiction.
10. *No Third Party Rights.* This Agreement is intended only to regulate the relations among the parties and does not create or grant any other person any rights or benefits.
11. *Counterparts.* This Agreement may be executed in one or more counterpart copies, each of which shall be deemed an original and together shall constitute one and the same Agreement.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the date first set forth above.

THE STATE

BUSINESS ASSOCIATE

By: _____

By: _____

Date: _____

Date: _____

ATTACHMENT B

MITA BASELINE

Overview

This baseline matrix is to be used by the offeror to demonstrate how the system proposed for Alaska aligns with MITA. The baseline should include capabilities of the proposed system (transfer, COTS, As-built) as modified to meet functional requirements presented in the RFP. The matrix employs standard MITA concepts as expressed in MITA Framework, version 2.0, published in April, 2006 by CMS. It is available for download at:

<http://www.cms.hhs.gov/MedicaidInfoTechArch/>.

The baseline is intended to facilitate proposal evaluation. It is necessarily high-level, but must be delivered in sufficient detail to establish the current capability of the proposed solution for DHSS.

Part 1: MITA Vision

In order for the State to assess the proposal within the context of MITA, the proposal must provide a description of the offeror's vision for MITA. The vision statement must describe the process by which the offeror identifies, selects, and develops opportunities for system enhancement within a dynamic business and technology landscape. The discussion will provide a general plan for moving the state forward to higher Maturity and Capability Levels for Medicaid processes and technology as a whole. This should include a discussion of how the vendor currently supports, and future plans to support, the development of interoperable data standards and architectures such as RHINs needed to support the Medicaid program..

Part 2: Technical Capability Assessment

The State is utilizing the MITA technical capability categories as a framework for offerors to describe the technology solution contained within the proposal. This is consistent with State goals for utilizing the MITA framework to develop and implement business process and service delivery efficiencies. The State requires a robust platform that meets current needs and requirements, and provides a flexible and extensible platform for future enhancement.

MITA Technical Capabilities, as described in MITA Volume 2, Part III, Chapter 5, depict a capability development continuum that produces increasingly automated and sophisticated technical systems which facilitate the development of more flexible and efficient business processes. These Technical Capabilities are defined by the following top-level categories:

- Business enabling services: Functionality ranging from workflow and forms management to decision support services such as a data warehouse, reporting tools, and statistical analysis.
- Access channels: Technical capabilities that support beneficiary, provider, and stakeholder access.
- Interoperability: Service oriented architecture components, standard data exchanges, and integration of legacy systems.
- Data management and data sharing: Automated, standard data exchange across organizations and adoption of data standards.
- Performance Measurement: Collection, reporting, and display of performance information.
- Security and Privacy: Access, authentication, and detection capabilities.

- Adaptability and extensibility: Capabilities that support rapid deployment of technical and policy changes by minimizing impact.

Technical Capability Assessment Matrix

The following matrix will be used to provide a technical cross reference for enabling technologies presented in this proposal:

Column 1: Shows the seven top-level MITA Technical Capabilities and related Technical Functions.

Column 2: Shows applicable sources of mission, goals, and objectives as described in Chapter 5.

Column 3: Offeror will document the current proposal cross reference(s) to the Technical Capabilities. For each Technical Category/Technical Function in the first column, the offeror will identify the section references in the proposal where the component is described and discussed.

Column 4: Offeror will address future progression. Provide descriptions of enhancements in the next major release, in development, and planned evolution of the listed components. Descriptions (bulleted lists are preferred) should be no more than 100 words for each of the categories describing the improvements to be added with the release. (Please use Part III - Technical Architecture Chapter 5 of the Medicaid IT Architecture (MITA) Framework 2.0 as a reference and guide.)

Column 5: Tentative release date.

Proposed System MITA Technical Capabilities Matrix

Technical Area / Technical Function	Applicable Sources	Current Proposal Cross Reference(s) to Description	Component Milestone / Transition	
			Description of Implementation / Improved Capability	Est. Release Date
B.0 Business Enabling Services				
B.1 Forms Management	MM Level 2, O4, G6			
B.2 Workflow Management	O4, G4, G6			
B.3 Business Process Management (BPM)	G4			
B.4 Business Relationship Management (BRM)	O4			
B.5 Foreign Language Support	1. Manage Applicant and Member Communication, Level 3 2. O4			
B.6 Decision Support				
B.6.1 Data Warehouse	G5, O7			
B.6.2 Data Marts	G5, O7			
B.6.3 Ad hoc Reporting	MG2 Level 2			
B.6.4 Data Mining	MG2 Level 2			
B.6.5 Statistical Analysis	MG2 Level 2			
B.6.6 Neural Network Tools	MG2 Level 2			

A.0 Access Channels				
A.1 Portal Access	1. O4 2.MM Level 2 3.Enroll Provider, Level 2 4.Manage Applicant and Member Communications, Level 2			
A.2 Support for Access Devices	1. O4 2. MM Level 2 3. Enroll Provider, Level 2 4. Manage Applicant and Member Communications, Level 2			
I.0 Interoperability				
I.1 Service-Oriented Architecture				
I.1.1 Service Structuring and Invocation	G4, O2, O5			
I.1.2 Enterprise Service Bus	G4, O2, O5			
I.1.3 Orchestration and Composition	G4, O2, O5			
I.2 Standards-Based Data Exchange	G3			
I.3 Integration of Legacy Systems				
D.0 Data Management and Sharing				
D.1 Data Exchange Across Multiple Organizations	G5, G6			
D.2 Adoption of Data Standards	G3, O3			
P.0 Performance Measurement				
P.1 Performance Data Collection and Reporting	G2			
P.2 Dashboard Generation	G2			
S.0 Security and Privacy				
S.1 Authentication	MM			
S.2 Authentication Devices				
S.3 Authorization and Access Control				
S.4 Intrusion Detection				

S.5 Logging and Auditing				
S.6 Privacy				
F.0 Flexibility – Adaptability and Extensibility				
F.1 Rules-Driven Processing	1. Determine Eligibility, Level 3 2. G4			
F.2 Extensibility	G4			
F.3 Automate Configuration and Reconfiguration Services	G4			
F.4 Introduction of New Technology	O2, O5			

Part 3: MITA Business Process and Maturity Levels Assessment

MITA provides a hierarchy structure that groups together business processes that have a common purpose. The baseline assessment matrix below utilizes the 32 high level business processes described in Tiers 1 and 2 of the Medicaid enterprise business process model presented in MITA Volume 2, Part I, Chapter 4. Refer to this section for definitions and descriptions of the business processes included within each Tier.

MITA also identifies five levels of progressively mature capabilities that can be associated with each business process. These levels are described in MITA Volume 2, Part I, Chapter 5. A business process can have from one to five Maturity Levels of business capabilities associated with it. With Maturity Level 1 as the base, the other levels show advances in timeliness, effectiveness, and efficiency of the business process as innovations are added.

Level 1	Level 2	Level 3	Level 4	Level 5
At Level 1, the agency focuses on meeting compliance thresholds dictated by state and federal regulations. It primarily targets accurate enrollment of program eligibles and timely and accurate payment of claims for appropriate services.	At Level 2, the agency focuses on cost management and improving quality of and access to care within structures designed to manage costs, e.g., managed care, catastrophic care management, disease management.	At Level 3, the agency focuses on coordination with other agencies and collaboration in adopting national standards and developing shared business services as a means to improving cost effectiveness of health care service delivery. The agency promotes usage of intra-state data exchange.	At Level 4, widespread and secure access to clinical data enables the Medicaid enterprise to improve healthcare outcomes, empower beneficiary and provider stakeholders, measure quantitative objectives, and focus on program improvement.	At Level 5, national (and international) interoperability allows the Medicaid enterprise to focus on fine tuning and optimizing program management, planning, and evaluation.

MITA further defines six specific characteristics that differentiate the general Maturity Level descriptions above. Reference MITA Part 1, Appendix B. These characteristics combine with the capability maturity levels to establish boundaries between the each of the five levels.

Characteristic	Level 1	Level 2	Level 3	Level 4	Level 5
1. Timeliness of process	Business processes meet threshold, mandated requirements for timeliness, i.e., the Results are achieved within the time specified by law or regulation.	Business process timeliness is enhanced through use of Web portal, EDI. Business processes that result in cost savings are prioritized. Timeliness exceeds legal requirements.	Timeliness improves via collaboration, data sharing, and use of state/regional information exchange hubs.	Clinical data is available in real time. Processes using clinical data provide immediate action, response, and result. State or regional stakeholders are interoperable, optimizing timeliness.	Processes are further enhanced through connectivity with other states and federal agencies. Most business processes are executed at the point of service. Results are as close to immediate as we can envision at this time.
2. Access to and accuracy of data	Data and format are indeterminate. Inputs are not standardized and may still be hard copy. Some operational records are stored electronically but storage is not centralized. Critical data needed to associate records is not comparable across programs reducing ability to monitor program outcomes or detect fraud and abuse.	Data and format are standardized and electronic within the agency and as mandated, with external stakeholders; these are received from many sources and triaged to appropriate programs for processing. Critical operational records for different programs continue to be stored separately but can be accessed and aggregated as needed with manual negotiation. Although critical data comparability is improved and supports the use of performance	Data and format are standardized and electronic to support non-mandated exchange among Medicaids and other key stakeholders, improving access and accuracy. Critical operational records may be stored locally but are accessible globally via local federated registries that enforce access rules when pointing to record locations. Critical data needed to associate records	Entity registries used to locate indexed records are federated with regional data exchange networks Agency may auto/ad hoc query registries for standardized, timely, and complete data for operational, reporting, and analysis purposes. Authorized, authenticated parties have virtual, instant access to data stored locally.	Entity registries are federated with regional data exchange networks across the country and if desired, internationally. Agency automatically receives standardized, timely, and complete data notifications about members for operational, reporting, and analysis purposes. Authorized, authenticated parties have

Characteristic	Level 1	Level 2	Level 3	Level 4	Level 5
	Communications with stakeholders are state-specific and differ by stakeholder type.	measures to evaluate contractors and programs, performance data is only periodically measured and requires sampling and statistical calculation.	are comparable across programs and entity IDs are linked algorithmically based on other standardized data so that records are automatically linked across programs.		virtual, instant access to critical data, nationally.
3. Effort to perform; efficiency	Most business processes are labor-intensive and stove-piped.	Business processes that result in cost management are enhanced within business areas with the use of automated data interchange, business rules and workflow.	Effort to perform is reduced and efficiency is increased through enterprise integration of business rules and workflow; state and regional data exchange, collaboration; and adoption of data standards.	Business processes are transformed and efficiency is optimized through integration of clinical data. Transformation creates a paradigm shift from labor-intensive operations to strategic planning.	With national interoperability, the gains of Level 4 extend these capabilities to the maximum we can envision at this time.
4. Cost Effectiveness	Requires a large staff to meet business process targets, e.g., enrollment of members. Siloed processes result in redundant infrastructure, effort and costs.	Process requires fewer staff than Level 1 and produces better results. Fewer business processes are done redundantly, unnecessarily, or erroneously, reducing program costs.	Process requires fewer staff than Level 2 and improves on results. Shared services and inter-agency collaboration contribute to streamline the process.	Full automation of the process plus ability to auto/ad hoc query local entity registries reduces staff needed for verification, coordination and fraud detection and improves cost savings. Alerts improve workflow and reduce staff needed for outreach to stakeholders or verification of entity status.	More effective operational data exchange because information about all events of interest are pushed vs. querying potential sources of data.
5. Quality of Results	Much of the application data is manually validated and	Standardized data permits blending of cross enterprise information,	Automation of data interchange improves timeliness and	Ability to auto/ad hoc query federated registries to	Automated notification (data push vs. data pull) of

Characteristic	Level 1	Level 2	Level 3	Level 4	Level 5
	verification may be difficult resulting in increase error rates and potential for fraud. Decisions may be inconsistent. Due to limited monitoring and re-verification of input data about entity's status, ineligible entities may continue to be enrolled, e.g., providers, contractors, and members. Minimal ability to monitor whether business rules support results meeting program goals (i.e., performance measures). Data in intra- and inter-enterprise entity registries are frequently not synchronized. Compliance with state / federal law may be suboptimal.	enabling automation of business rules and workflow capabilities, resulting in (1) more encompassing view of program benefits and stakeholders; (2) improved accuracy of validation and verification; (3) increased consistency of decisions; and (4) improved ability to monitor whether business rules support results meeting program goals. Use of standardized, electronic interchange somewhat improves accuracy of data exchange between intra- and inter-enterprise entity registries, but these may not be synchronized because of periodic batch updates. Compliance with state / federal law is somewhat improved.	quality of data. Synchronization of intra- and inter-enterprise entity registries ensures data and decision consistency, thereby improving results. Performance measures are derived from operational data for improved monitoring of business rules to ensure that results are meeting program goals. Automated coordination of cross enterprise information improves stakeholders' access to appropriate services and compliance with state/federal law.	access intra-and inter-enterprise data increases data reliability and completeness, and real time access ensuring better business process results. Real-time iterative performance and outcome measures are derived from operational data for use by feedback mechanisms to adjust business rules if these measures do not meet program rules. Compliance with changes in state/federal laws ensured by ability to immediately adjust business rules.	business events of interest, e.g., the enrollment of a stakeholder in a program or the registration of an entity in another enterprise further increases data reliability and completeness, ensuring better process results.
6. Value to Stakeholders	Focus is on accurately processing operational information as efficiently as possible. Staff does not have	Automation and coordination of processes and customer relationship management within business areas enable staff to focus	Cross enterprise coordination and customer relationship management result in stakeholders experiencing a	Applicants and stakeholders can "pull" information about and applications for potential opportunities to	Applicants are "pushed" pr notified automatically at initial point of contact (e.g., point of care for

Characteristic	Level 1	Level 2	Level 3	Level 4	Level 5
	time to focus on appropriateness of services for health, functional, cultural and linguistic compatibility or satisfaction of stakeholders.	more on providing the most appropriate services to optimize health, functional, cultural and linguistic compatibility and satisfaction of stakeholders.	seamless and efficient provision of services no matter how or where they contact the enterprise. E.g., no redundant request for stakeholder data; no need to schedule appointments, greater ability to verify data online. Stakeholders receive services specifically designed to meet individual needs	provide or receive services from the enterprise at anticipated points of contact (e.g., enterprise portal) automating stakeholder outreach.	members, point of state licensure for providers) about potential opportunities to provide or receive services from the enterprise ensuring immediate access to appropriate enterprise business processes, e.g., enrollment for members, contracting for providers.

Business Process Maturity Assessment Matrix

An example matrix is presented on the following page for reference. The offeror will use the MITA defined general Maturity levels and six specific characteristics identified above to baseline their proposed system and services. In addition, a brief explanation of no more than 100 words per business process is required for each Tier 1 business process, and permitted for Tier 2. This explanation should identify the specific capabilities that support the basis for the score and can be presented in a bulleted fashion.

For each Tier 2 Business Process, identify the level of maturity of the system and services as proposed to meet Alaska's RFP requirements. In each of the eight Tier 1 Business Process headers, place the average level of Maturity for all the Tier 2 Business Processes pertaining to that area. (E.g. Member Management has four Tier 2 Business Processes. Average the maturity levels for those four business processes to obtain the Tier 1 Member Management Maturity level).

It is acknowledged that Tier 2 business processes may contain a cluster of sub-processes. For purposes of identifying the Maturity Level of the business process, assess the maturity level supported by each sub process and assign the lowest level. For example, if a business process has three sub-processes, and the proposed system and services are at a level 1 for one process and a level 2 for two processes, a level 1 must be indicated for the business process. Sub-processes that exceed the base maturity level can be identified in the "Capabilities Supporting Scoring" section.

Business Process Maturity: Matrix Example

	MITA Business Process Maturity Rating						
MITA Business Process	Level 1	Level 2	Level 3	Level 4	Level 5	Average Level	Capabilities Supporting Scoring / Reference to Proposal Description
Member Management						2	
Eligibility Determination		2					
Enrollment	1						
Member Inform. Management			3				
Prospective/Current Member Support		2					
Provider Management						1.7	
Provider Enrollment	1						
Provider Info. Mgt.	1						
Provider Support			3				
Contractor Management							
Health Services Contracting							
Administration Contracting							
Contractor Information Management							
Contractor Support							
Operations Management							
Payment Management							
Payment Management Info. Mgmt							
Member Payment Management							
Cost Recoveries							
Service Authorization							
Program Management							
Benefit Administration							
MITA Business Process	Level 1	Level 2	Level 3	Level 4	Level 5	Average Level	Capabilities Supporting Scoring / Reference to Proposal Description
Program Administration							
Budget							
Accounting							
Program Quality Management							
Program Information							

Care Management							
Manage Medicaid Population Health							
Establish Case							
Manage Case							
Manage Registry							
Program Integrity Management							
Identify Candidate Case							
Manage Case							
Business Relationship Management							
Establish Business Relationship							
Manage Business Relationship							
Manage Business Relationship Communication							
Terminate Business Relationship							

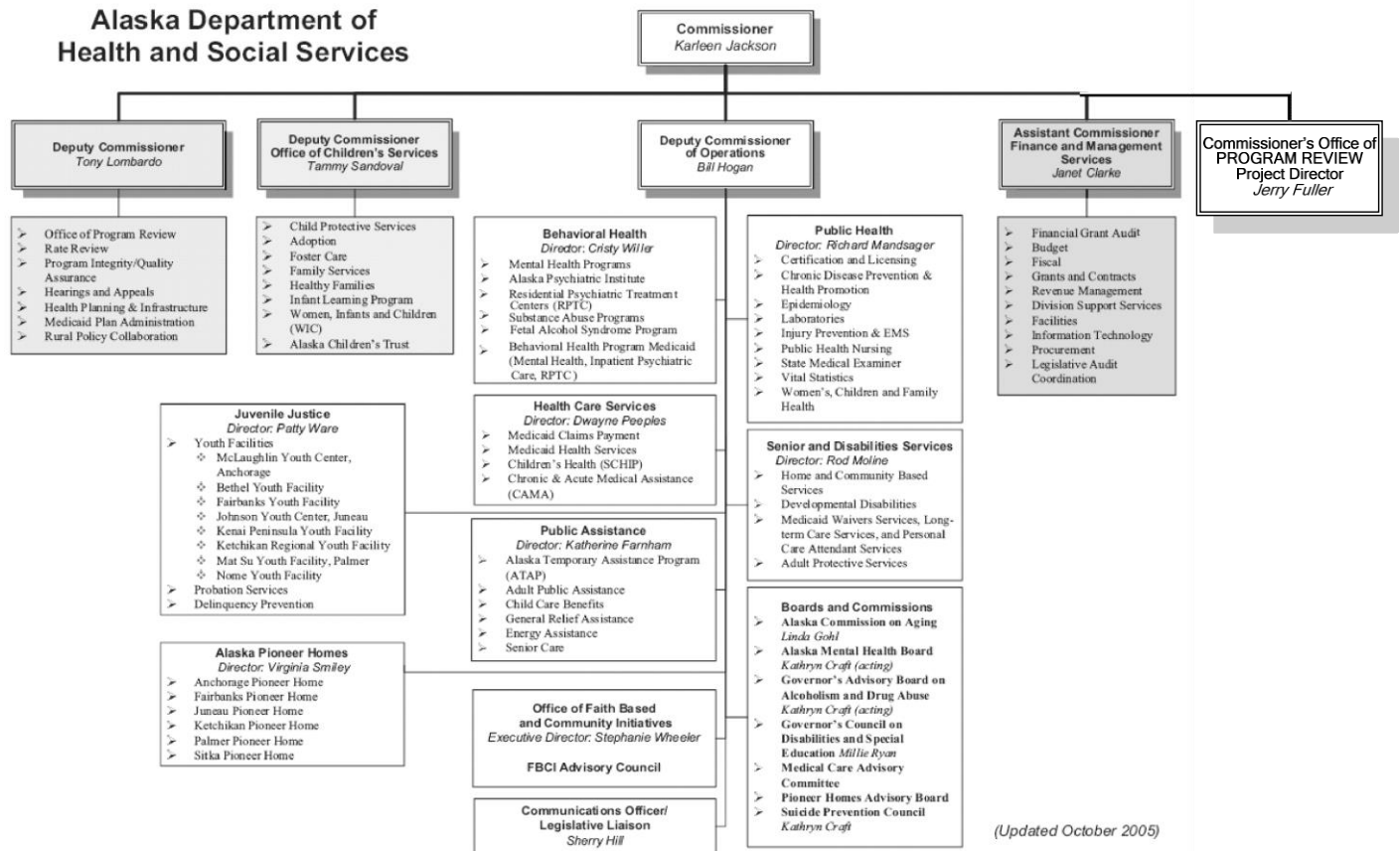
ATTACHMENT C
MEDICAID PROGRAM STATISTICS

Medicaid Program Statistics can be found in the Procurement Library including statistical information on the following:

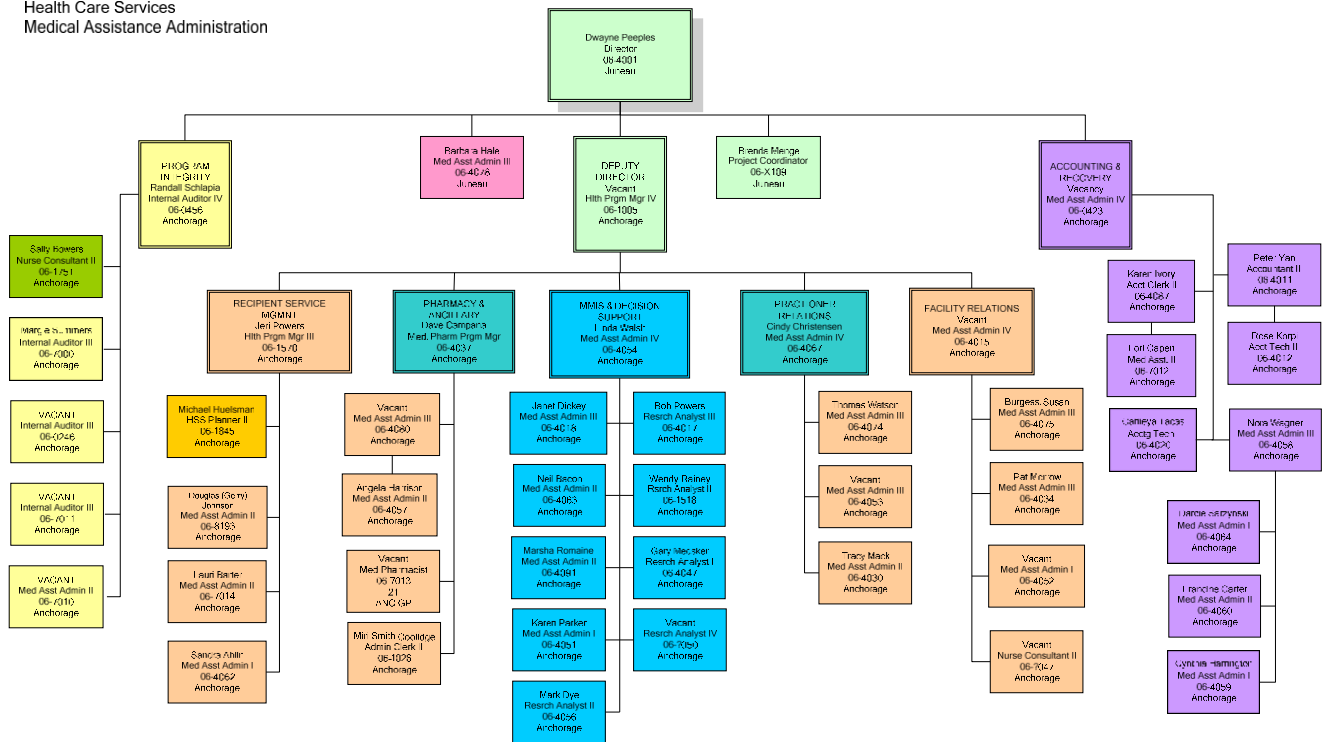
- **Providers**
- **Claims**
- **Recipient Services**
- **Eligibility**
- **MARS Reports**
- **Operations**
- **Programmer Hours**

ATTACHMENT D

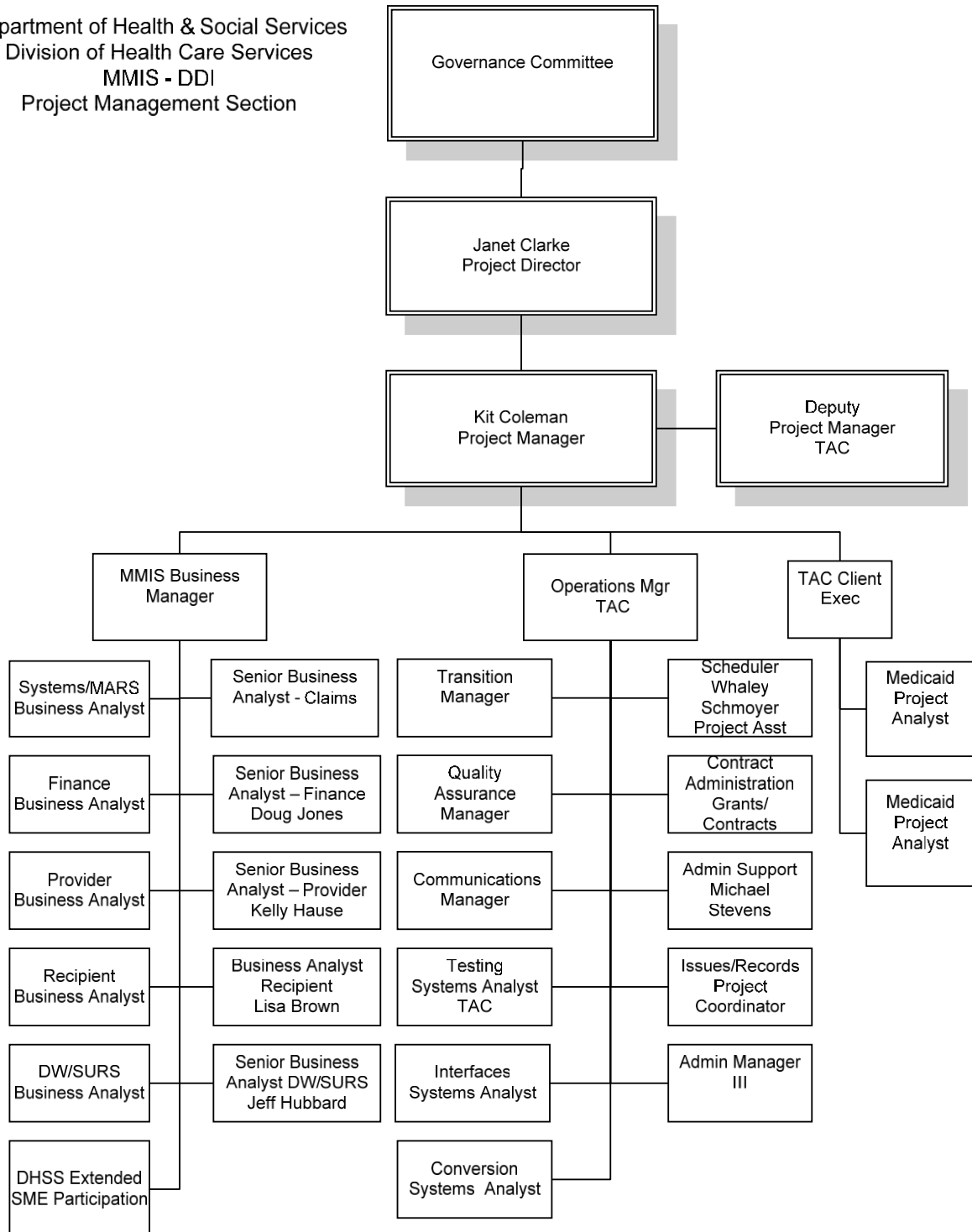
STATE ORGANIZATION CHARTS



Department of Health & Social Services
Health Care Services
Medical Assistance Administration



Department of Health & Social Services
Division of Health Care Services
MMIS - DDI
Project Management Section



ATTACHMENT E
REFERENCE MATERIALS IN THE PROCUREMENT LIBRARY

(i) System Documentation Index

(ii) ADMINISTRATION

1. Project Management (State)

- Alaska MMIS Replacement Project Summary
- Alaska Project Roles
- DHSS DDI Organizational Chart
- Alaska PMO Manual
- Issue Management System Flow Chart
- Issue -Change Form
- Project Progress Communications Table
- Deliverable Flow Concept
- Project Status Report

2. Administration (Current Fiscal Agent)

- Pends - Inventory
- Provider Enrollment Applications-Inventory
- Provider Manuals and Forms-Inventory
- Fiscal Agent Role
- **3. Employees and Contractors (Current Fiscal Agent)**
- Total number of employees
- Staffing Organization: Positions by department/area
- Description of each functional area by department
- Current application systems support breakout
- List of all subcontractors, function, and begin/end dates

(iii) MEDICAID PROGRAM INFORMATION

1. Claims

- Types and owners of electronic devices and software to support electronic claims(Claims, Local Software Inventory verSRP)
- Support for Electronic Claims
- Types and owners of electronic devices and software to support paper claims (paper claims support)

2. Provider Billing Manuals

- Advanced Nurse Practitioner and Nurse Midwife Services

- Ambulatory Surgical Services
- Behavioral Health Services-Community Mental Health Center/Substance Abuse
- Consumer Directed Personal Care Services
- Chiropractic Services
- Day Treatment Services
- Dental Services
- Direct Entry Midwife Services
- Durable Medical Equipment, Medical Supplies, and Respiratory Therapy Services
- DME Update 05/23/2006
- DME Update 04/20/2006
- Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Services
- End Stage Renal Disease (ESRD) Services
- Family Planning Services
- Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) Services
- Home and Community Based (HCB) Waiver - Agency Services
- Home and Community Based (HCB) Waiver - Care Coordination Services
- Home and Community Based (HCB) Waiver - Environmental Modification Services
- Home and Community Based (HCB) Waiver - Residential Supported Living/Assisted Living Services
- Hearing Services
- Home Health Services
- Hospice Services
- Independent Laboratory Services
- Independent Personal Care Services
- Indian Health Service/Tribal Health Facility Services
- Inpatient/Outpatient Hospital Services
- Inpatient Mental Health Services (Inpt Psych & Residential Psych)
- Long Term Care Facility Services
- Mental Health Physicians Clinic Services
- Nutrition Services
- Outpatient Therapy Center, Independent Physical Therapist, Certified Speech Pathologist, & Independent Occupational Therapist Services
- Personal Care Agency (Based) Services
- Pharmacy Services
- Prescriber ID's Update 05/09/2005
- Physician Services
- Podiatry Services
- Private Duty Nursing Services
- School Based Services
- Transportation and Accommodations (including Prematernal Homes) Services
- Transportation Authorization Form Guide and Extended Instructions
- Vision Services

- X-Ray Services
- Care Management-Appendix
- Telemedicine Services-Appendix
- Eligibility Verification System (EVS) Packet

3. Operational Reports

- Operational Reports for the last two years i.e. Recipient Inquiry Services, Provider Inquiry Services, PA, SURS and REOMBs, Pends, BIC.
- Anticipated call volume by call type by call center
- Call volume peaks during the course of a normal business day by call type by call center
- Other peak call volume periods
- Number of (local and long distance) lines used for handling provider, recipient, and other caller initiated calls
- Number of calls to the POS and EMC/HIPAA/EDI help desks in the past 12 months and average duration of each call by call type
- POS/MAP Call Statistics 08/2005-06/2006 (view 1)
- POS/MAP Call Statistics 08/2005-06/2006 (view 2)
- Number of calls to AVR and EVS system on an average day and average length of call (include number of abandoned calls)
- Number of written inquiries received daily and monthly with a breakout by provider type and type of inquiry and media
- Number of provider enrollment requests received monthly and annually by provider type
- Number of provider enrollment applications received monthly and annually by provider type
- Number of enrollment packets distributed yearly and by media of distribution
- Number of provider enrollment files currently maintained and retained by the MMIS vendor (hardcopy)
- Number of denied enrollment applications annually by provider type
- Number of provider enrollment calls monthly for the last 12 months
- Number of provider enrollment documents that are imaged monthly
- Provider Enrollment Summary Report 2005
- Provider Training Volume 2005
- Provider Training Volume 2006
- Prior Authorization Summary Yearly Reports (2 years of reports)
- Number of PA requests received and processed for the last year for each service type (2 years of reports)
- Number of PA requests received by method received i.e. mail, fax, web, telephone, interface, etc. (2 years of reports)
- Number of provider PA calls in the past 12 months
- Daily, monthly, annual volume of PA's, PA requests and associated documents to be imaged (2 years of reports)
- Number of PA forms mailed to providers during the past 12 months by PA type
- Prior Auth Statistics

- Programmer Hours (2005)
- Programmer Hours (2006)
- Appeals Volume (2 years)
- Data Entry Claims Inventory Chart
- Pends by Month
- Number of checks replaced due to spoilage, stop payment, non-receipt, replacement, etc. in past 12 months for and for an average month (2 years of reports)
- Finance Unit Manual Warrants
- Recipient Services 2005 Annual Report
- Recipient Services Stat's 2005-2006
- A listing of types of mailings per month and per year and average page counts for each type (2 years of reports)
- Provider SURS and Appeals Mailouts
- Number of claim forms, by claim form type, mailed to providers in the past 12 months (and data for average month) (2 years of reports)
- Number of hardcopy mailing labels produced in the last 12 months and average per month (2 years of reports)
- Number of paper remittance advice pages printed and mailed for a weekly payment cycle (printed simplex or duplex) (2 years of reports)
- Number of electronic RA's produced monthly/yearly (2 years of reports)
- Average number of provider bulletins, newsletters, and alerts printed and mailed monthly/yearly
- Number of provider manuals printed and distributed yearly (by provider type) and the average number of pages each

4. Statistical Reports

- CA-0-03-CPAS Report 7/1/2004 – 06/3/2006
- Claim Check Savings Report 2004-2006
- CNTL-W240 Aged Pend Report (2 years of reports)
- CP-0-14 Claims Processing Reports (multiple periods summary)
- CP-0-90T Error Analysis (2 years of reports)
- CP-0-90P Error Analysis (2 years of reports)
- CP-0-90PT Error Analysis (2 years of reports)
- CP-0-90R Error Analysis (2 years of reports)
- CP-0-90RT Error Analysis (2 years of reports)
- CP-0-90D Error Analysis (2 years of reports)
- CP-0-131 Paperless Claims Process Summary (2 years of reports)
- CP-0-97 Paper and EMC Monthly Billing Reports (1,2,3) (2 years of reports)
- CP-0-97-3 June 2006 and July 2006
- MR-0-02-T FY 2005 - 052006
- MR-0-02-T2 FY 2005 - 052006
- MR-0-04-T FY 2005 - 052006
- MR-0-05-T FY 2005 - 052006
- MR-0-08-T FY 2005 - 052006

- MR-0-08-T FY 2005 - 052006
- MR-0-09-T FY 2005 - 052006
- MR-0-09-T2 FY 2005 - 052006
- MR-0-11-T FY 2005 - 052006
- MR-0-11-T2 FY 2005 - 052006
- MR-0-12-T FY 2005 - 052006
- MR-0-12-T FY 2005 - 052006
- MR-0-02 Combined 1999 - 2005
- MR-0-02 -T June 2006
- MR-0-02 -T July 2006
- MR-0-04 -T June 2006
- MR-0-04 -T July 2006
- MR-0-05 -T June 2006
- MR-0-05 -T July 2006
- MR-0-08 -T June 2006
- MR-0-08 -T July 2006
- MR-0-09 -T June 2006
- MR-0-09 -T July 2006
- MR-0-11 -T June 2006
- MR-0-11 -T July 2006
- MR-0-12 -T June 2006
- MR-0-12 -T July 2006
- POS Management Reports for FirstSX and First Rebate (including prospective and retrospective DURS) i.e.: Denied Claims Analysis, Paid Claims Analysis, Summarization of Paid Claims, Summary report for First Rebate for last two years, and summary report for DURS for last 2 years. Please do NOT include any protected health information/data.
- ProDUR Denials by HIC3
- Drug Rebate Summary
- Supplemental Drug Rebate Summary
- POS Reports for pharmacy claims received by hour for a typical week
- Recipient Eligibility Statistics

(iv) MANUALS AND OTHER RELATED INFORMATION

1. Procedure Manuals

- AVR/EVS Procedures
- Edit/Audit, Claims Resolution, and Cost Avoidance Procedures
- Imaging Procedures
- Mail Room Procedures
- Data Entry Procedures
- DURS Procedures (Prospective and Retrospective Procedures)
- EDI Help Desk Procedures (Richmond)

- EDI Help Desk Procedures (Alaska)
- EDI Submitter File Procedures
- EDI Translator and Database Procedures
- Enhanced Provider Support Procedures
- File Maintenance Procedures (Anchorage Operations)
- Financial Transaction Procedures (including processing of all financial transactions i.e. adjustments, payouts, receivables, voids, voided checks, reversals, cash dispositions, system negative adjustments, reproprocesses, levies, etc. including financial reason codes)
- Daily Claims Balancing Procedures (MMIS)
- SX to MMIS Claims Balancing Instructions
- Weekly Claims Balancing Procedures 2 (MMIS)
- HIPAA Privacy Procedures
- HIPAA Security Procedures
- Medical Review Procedures
- Operations Manuals
- PayerPath Procedures (internal relating to batch submission and balancing procedures)
- Pend Instructions
- POS Help Desk and Call Center Procedures (including First Trax)
- Production Schedule and Procedures
- Provider Enrollment Procedures, Instructions, and Policy
- Provider (Canadian) Enrollment, Claims Processing, and Purge Procedures, Instructions, and Policy
- Provider Relations Procedures (including call center, appeals, pends, correspondence, education/training internal & external, publications, etc.)
- Purge and Archive Procedures
- Recipient Relations Procedures (including call center, fair hearing support, eligibility pend resolution, etc.)
- Remedy Procedures
- Remote Job Entry (RJE) Procedures
- Surveillance and Utilization (SURS) Review Procedures (provider and recipient) (includes: Provider Enrollment, REOMB, Complaints, & Recip Care Mgmt)
- SURS Case Tracking Procedures
- SURS Complaint Procedures
- Testing Procedures
- TPL Procedures (including Medicare Buy-In, Crossover processing, TPL avoidance, etc.)
- Web Site Maintenance Procedures

2. Eligibility Manuals

- Eligibility Manual (CAMA, Medicaid, Waiver, etc.)

3. MMIS System Documentation

- General System Documents
- Current HIPAA Trans Cross walks and Change Requests 082006

- Alaska Pricing Manual 082006 v
- Collocode Table

4. Data Element Dictionaries (DED)

- DED Accounting Interface (AI) Subsystem
- DED Bank Account Reconciliation (BAR) Subsystem
- DED Claims Processing Subsystem 082006 v
- DED EPSDT Subsystem
- DED Management and Administrative Reporting (MAR) Subsystem
- DED Provider Subsystem 082006v
- DED Provider Subsystem 2004
- DED Recipient Subsystem
- DED Reference Subsystem
- DED Surveillance Utilization and Review (SUR) Subsystem
- DED Third Party Liability (TPL) Subsystem
- Attachment Code List

5. Interfaces and File Transfers

- Current EIS Update Interface Layout and Processing Specifications
- EIS Update Specifications
- EIS Editing rules with Error Numbers (modified 01/19/2006)
- Current POS/First SX Interface between MMIS and POS
- Child Support Enforcement Division (CSED) Interface
- Qualis Interface Layout
- Other Loads or Interface(s) specifications and processes i.e. Occupational Licensing, OIG Sanction/Reinstatement, DEERS, CPT/HCPC/ICD/ABC codes, CLIA, Rates, Other Division PA's, etc.
- CLIA Load
- CLIA Processing
- EPSDT File Transfer
- Occupational Licensing Update and File
- Other State Fee Schedule Loads
- REHF File Transfer
- Journal Entry Record Layout
- Warrant Transaction Record Layout

6. Related MMIS Information

- Staff Training materials, presentations, handouts, curriculum, schedule, flyers, etc.
- Recipient Services Materials
- Web site layout, format, contents list by section
- Form letters (samples) i.e. enhanced provider support, PA, finance/accounting, etc.

7. Electronic File Formats

- Dental AK Custom
- HCFA 1450 UB92 V5
- HCFA 1500 V3 01 AK

- NSF Professional Pre3 AK
- PA PROW AK Custom
- PA Result AK Custom
- PA Trans AK Custom
- Pharmacy AK Custom 1
- Pharmacy AK Custom 2
- Professional AK Custom
- RA Specs AK Custom
- RSS MHPA
- UB82 AK Custom
- UB92 4

8. FHSC Web Site

- Behavior Health
- Enrollment (Provider)
- Error Codes
- Fee Schedules
- HIPAA
- Internet Claims-PayerPath
- Newletters
- Pharmacy
- Provider Billing Manuals
- Provider Training
- Provider Updates
- Psychiatric Services-Coordination of Care
- SURS
- TPL Carrier Codes

9. Qualis Website

- Qualis Inpatient Acute Care and Case Management forms and manuals

(v) MMIS COMPONENTS

1. MMIS Application Components

- Source code in electronic format either on CDROM or on cartridge tape
- Copies of program listings
- Copies of run books and operator logs
- Job balancing procedures
- ABEND procedures
- Current platform specifications
- Operating system specifications
- Application languages
- Cycles & Processing i.e. adjudication, payment, check write, account reconciliation, audit trail, and 1099 processing
- Back-up procedures

- Disaster Recovery plan (Anchorage & Data Center)
- Contingency Plan (Anchorage & Data Center)
- Security Plan
- Business Continuity Plan (Anchorage & Data Center)
- Open System Alerts for the last two years ending 6/30/2006 (Change Orders/Work Orders)
- Closed System Alerts for the last two years ending 6/30/2006 (Change Orders/Work Orders)
- Number and type of ad-hoc reports for previous 12 months (by month and total)

2. MMIS Facility (Anchorage)

- Monthly depreciation or monthly lease amount
- Book value and market value (if owned)
- Lease start and end date (if leased)
- Monthly taxes on facility
- Square footage
- Data center square footage total and for the raised floor
- Computer Room/RJE Site Server Room Square Footage
- Computer Room/RJE Site data operations (see list below for data center-any performed/stored in Anchorage list here)
- Additional Storage/Warehouse Square Footage
- Other area square footage (programmers, analysts, offices, etc.)
- Power-KVA for the data center
- Cooling-BTU for data center

3. MMIS Hardware (Anchorage First Health Facility & Data Center)

- Owned Hardware and Configuration
- Owned Hardware-Maintenance agreements with outside vendors
- Leased Hardware-Lease and maintenance agreements with outside vendors

4. MMIS and Supporting Software

- Purchased MMIS/Software-Product name, vendor, number, version or release and vendor
- Primary user(s)
- Install Method
- Install Location
- Leased/Rented MMIS/Software-Primary user(s)
- Leased/Rented MMIS/Software-Install Method
- Leased/Rented MMIS/Software-Install Location
- Internally developed not supported by vendor (including all system and application software)
- Internally developed supported by vendor (including all system and application software)
- Internally developed databases or spreadsheets used for operations tracking or management

5. Data Center Operations (including EDI translator and database)

- Prime time hours of operation.

- Percent batch versus percent on-line processing.
- Batch
- Batch CPU time per month by category (MVS, TSO, etc.) in increment (hours, minutes, etc.)
- Batch prime percent versus off-shift percent
- Percent production versus percent test and development
- On-line
- On-line CPU time per month (CICS, IMS, IDMS/hours, minutes)
- On-line transactions per month and TSO transactions per month
- On-line database calls per month (I/O) per month
- Percent production versus percent test and development
- Performance
- CPU utilization prime time average percent
- CPU utilization peak time percent and time of occurrence
- On-line average response time (both local and remote)
- Storage DASD
- Gigabytes installed
- Gigabytes utilized
- Percent production versus test and development
- Storage Tapes and Cartridges or Other
- Round reel tape mounts per month
- Cartridge tape mounts per month
- Number of onsite round reel tapes
- Number of offsite round reel tapes
- Number of offsite cartridges
- Frequency and types of foreign tapes (such as BENDIX or buy-in)
- Number and type of other onsite storage
- Output processing (Anchorage & Data center)
- Laser print: Local (lines per month, pages per month)
- Impact print: Local (lines per month, pages per month)
- Fische/Film
- Originals per month
- Duplicates per month
- Optical disk storage (description of any Computer Output to Laser Disk or other types of CDROM technology used)
- Supplies
- Stock paper-pages per month
- Custom forms-pages per month
- Postage/freight average monthly expenditure
- Outside services
- Microfiche/film vendor

6. Telecommunications

- Data communications (Anchorage & Alaska Applications)
- Comprehensive Telecommunications Service Agreement

- Information Services Technology Plan
- Telecommunications network diagram and/or written description (including architecture and connectivity)
- Location to location (circuits)
- Line speeds
- Area codes and exchanges for circuits
- Dial-up locations
- Equipment (FEPs, modems, channel extensions equipment, etc)
- Logical units (i.e. terminals, PCs, printers)
- Equipment
- Front-end processors (FEPs) (quantity, manufacturer, item, model, number of channel adapters and location of each)
- Channel extension equipment (quantity, manufacturer, item model hardware attached, and location of each)
- Control units (quantity, manufacturer, item model hardware attached, and location of each)
- Terminals (quantity, manufacturer, item model)
- Network Control Program generation (NCP gen.) of FEP, if available
- Protocol
- Description of any contracts with outside communication vendors
- Voice communication (Anchorage, EVS, AVR, POS)
- Number of minutes per month (total, local, intrastate, interstate)
- Description of any contracts with outside vendors

(vi) STATE OF ALASKA

1. Budget

- FY 2007 DHSS Budget Overview
- FY 2006 DHSS Budget Overview
- FY 2006 DHSS Summer Update
- DHSS 2006 Missions and Measures
- DHSS 2006 M & M Detail Report
- Strategic Report 2003-2005
- FY 2002 DMA Annual Report
- FY 2001 DMA Annual Report
- FY 2000 DMA Annual Report
- FY 1999 DMA Annual Report
- FY 1998 DMA Annual Report

2. Contracts and Amendments

- 1987 MMIS RFP 87 02
- 1986 Fiscal Agent Proposal
- 1987-2006 Amendments 1 - 24
- 1987 FA MMIS Contract

- 2002 MMIS RFP
- 2003 FA Proposal
- 2003 FA Contract
- State Medicaid Manual 07/98 (Alaska)
- Medicaid State Plan (Alaska)
- FA Contract and Amendments Spreadsheet

3. Organizational Charts

- Org Chart: Division of Public Health (DPH)
- Org Chart: Alaska Psychiatric Institute (API)
- Org Chart: Division of Behavioral Health Services (DBHS)
- Org Chart: Office of Children Services-Juneau (OCS-J)
- Org Chart: Office of Children Services-Anchorage Region (OCS-A)
- Org Chart: Office of Children Services-Northern Region (OCS-N)
- Org Chart: Office of Children Services-Southcntrl Region (OCS-SC)
- Org Chart: Office of Children Services-Southeast Region (OCS-SE)
- Org Chart: Department of Health and Social Services (DHSS)
- Org Chart: Division of Health Care Services (DHCS)
- Org Chart: Division of Public Assistance (DPA)
- Org Chart: Division of Juvenile Justice (DJJ)
- Org Chart: Office of Finance and Management (OFM)
- Org Chart: Alaska Pioneer Homes
- Org Chart: MMIS DDI Project (PMO)
- Project Roles 08222005

4. Laws

- Alaska Regulations (AK Administrative Code)
- Alaska Statutes
- Alaska Medicaid Regulation 7 AAC 43 Rewrite Project Public Notice
- Medicare Prescription Law
- PERM Citation
- CMS Guidelines to FFP
- Federal Citations
- Deficit Reduction Act of 2005

5. Websites-Related

- Alaska Medicaid Related Websites

6. HIPAA Standards

- HIPAA Standards

7. Information Service Technology

- State-DHCS Information Service Technology (statement)

(vii) PAYMENT ERROR RATE MEASUREMENT (PERM)

- PERM Pilot Resource Guide

(viii) DDI 2004-2005

1. Provider

- DDI Provider Enrollment Forms (Application and Addendums)
- Form Letters
- Languages
- License Cert Permit Info
- Multiple Locations
- Reason Codes
- Reports
- Provider Type Spreadsheet 10292005 v
- Provider Grid

2. Recipient

- EIS Interface documents
- EIS Interface File Layout
- Revised Lock-in Procedures
- Race Coding

3. Benefit Packages

- Proposed Benefit Packages

4. Edits

- Error Codes in the MMIS 032005

5. TPL

- Coverage Codes x-reference

6. Claims

- CMS Place of Service Codes
- Crosswalk of all HIPAA Transactions
- PT and Spec by CT v3 JH

7. Prior Authorization

- DDI PA Matrix 04182005
- Field Edits by PA Type for State
- PA Data by PT-Spec (Margie)

8. Pricing

- Pricing Spreadsheet

9. EPSDT

- EPSDT Database (PHN clinics/locations)

**ATTACHMENT F
OFFEROR CHECKLIST**

RFP Reference	Requirement	Check
1.1	Correct address for mailing or delivery	
1.1	Original Technical Proposal, clearly marked	
1.1	Fifteen (15) hard copy Technical Proposals	
1.1	One electronic copy of the Technical Proposal and the cost proposal in correct format on CD	
1.13	Sub-Contractor Information (Alaska Business License, etc.)	
1.15	Offeror Certification Information (Alaska Business License, etc.)	
1.16	Conflict of Interest Statement	
2.1	Transmittal Letter on official business letterhead, signed by individual authorized to legally bind the Offeror	
2.7	Experience requirements in Appendix	
2.7.3	Letter of Commitment for Performance Bond	
2.10	Evidence of the Offeror's Alaska Business License?	
2.11	Alaska Preference Certificate/s	
Section 6	Proposal Format Requirements: - Organization Chart - Resumes - Appendices	
6.2.6	Proposal Appendices Requirements	
6.3	Complete Cost Proposal in sealed envelope	

Note: The Offeror is responsible for reviewing the RFP, in detail, and submitting all minimum requirements with their proposal. The list above is provided to assist the Offeror, and is not intended to be an all-inclusive list of minimum requirements. This form does not need to be returned with the proposal.

ATTACHMENT G

GLOSSARY

AAC.....	Alaska Administrative Code
AAM.....	Alaska Administrative Manual
ABADA	Advisory Board on Alcoholism and Drug Abuse
ABDR	Alaska Birth Defects Registry
ABS.....	Alaska Budget System
ACOA.....	Alaska Commission On Aging
ACT.....	Alaska Children's Trust
ADAP.....	DPH AIDS Drug Assistance Program
ADRD.....	Alzheimer's Disease and Related Dementias
ADTPF.....	Alcohol and other Drug Treatment and Prevention Fund
AFHCAN.....	Alaska Federal Health Care
AJJAC.....	Alaska Juvenile Justice Advisory Committee
AKAIMS.....	Alaska Automated Information Management System
AKPH.....	Alaska Pioneer Homes
AKSAP	Alaska Senior Assistance Program
AKSAS	Alaska State Accounting System
AMHB.....	Alaska Mental Health Board
AMHTA.....	Alaska Mental Health Trust Authority
APA.....	Adult Public Assistance
APD.....	Adults with Disabilities (Waivers)
API	Alaska Psychiatric Institute
APHIP.....	Alaska Public Health Improvement Process
ARND.....	Alcohol and Related Neurodevelopmental Disorder
ARBD	Alcohol Related Birth Defects
ART.....	Aggression Replacement Training
ASAP	Alcohol Safety Action Program
ASC.....	Ambulatory Surgery Center
ASTHO	Association of State & Territorial Health Officials
ATAP.....	Alaska Temporary Assistance Program
ATCA.....	Alaska Tobacco Control Alliance
ATSDR	Agency for Toxic Substances and Disease Registry
AVCP.....	Association of Village Council Presidents
BB	Better Beginnings
BBNA	Bristol Ban Native Association
BCC.....	Breast and Cervical Cancer
BH.....	Behavioral Health
BMI.....	Body Mass Index
BRFSS.....	Behavioral Risk Factor Surveillance System
BRS.....	Behavioral Rehabilitation Services
BTKH.....	Bring the Kids Home
BVS.....	Bureau of Vital Statistics

CAHPS.....	Consumer Assessment of Health Plans Survey
CAMA.....	Chronic and Acute Medical Assistance
CAPI	Community Action, Prevention and Intervention
CCDF.....	Child Care Development Fund
CCISC.....	Comprehensive, Continuous, Integrated System of Care
CCMC.....	Children with Complex Medical Conditions (Waiver)
CCTHITA	Central Council of Tlingit and Haida Indian Tribes of Alaska
CD.....	Chronic Disease Prevention and Health Promotion component
CDC	Center for Disease Control
CDDG.....	Community Developmental Disabilities Grants
CDFA.....	Catalogue of Federal Domestic Assistance
CDVSA.....	Council on Domestic Violence and Sexual Assault
CFR.....	Code of Federal Regulations
CFSR.....	Federal Child and Family Services Review
CHATS	Community Health Aide Training and Supervision
CHEMS.....	Community Health & Emergency Medical Services
CHIP	Children's Health Insurance Program
CIMHP.....	Comprehensive Integrated Mental Health Plan
C&L	Certification & Licensing
CITC	Cook Inlet Tribal Corporation
CLIA	Clinical Laboratory Improvement Amendments
CMHC.....	Community Mental Health Center
CMHS.....	Community Mental Health Services Block Grant
CMI.....	Chronically Mentally Ill
CMS.....	Centers for Medicare and Medicaid Services
COFIT.....	Outcome Fidelity and Implementation Tool
COMPASS.....	Community Partnership for Access Solutions and Success
COPD.....	Chronic Obstructive Pulmonary Disease
COSIG.....	Co-Occurring State Inventive Grants
CPS	Child Protective Services (Office of Children's Services)
CPS	Child Passenger Safety (Public Health)
CQL.....	Continuous Quality Improvement
CSAT	Center for Substance Abuse Treatment
CSM.....	Children's Services Management
CSN.....	Children with Special Needs
CSR.....	Client Status Review
CSU.....	Crisis Stabilization Unit
CTC.....	Crisis Treatment Center
DAI	Detention Assessment Instrument
DBH.....	Division of Behavioral Health
DCCED.....	Dept. Commerce, Community and Economic Development
DCBPL.....	Div. Corporation, Business, and Professional License
DD.....	Developmentally Disabled
DE&ED.....	Department of Education & Early Development
DET.....	Designated Evaluation & Treatment
DHSS	Department of Health and Social Services

DJJ.....	Division of Juvenile Justice
DKC.....	Denali KidCare (State Children’s Health Insurance Program)
DME.....	Durable Medical Equipment
DOL.....	Department of Law
DOL/WD.....	Department of Labor and Workforce Development
DOT	Direct Observed Therapy
DPA.....	Division of Public Assistance
DPH.....	Division of Public Health
DSDS	Division of Senior and Disabilities Services
DSH.....	Disproportionate Share Hospital
DSS	Department Support Services (aka Finance and Management Services)
DWI.....	Driving While Intoxicated
EAP.....	Energy Assistance Program
EBT.....	Electronic Benefit Transfer
ECCS.....	Early Childhood Comprehensive Systems Project
EI.....	Early Intervention
EIEIO	Early Intervention, Enhancement and Improvement Opportunity
EI/ILP.....	Early Intervention/Infant Learning Program
EIS.....	Eligibility Information System
EMS	Emergency Medical Services
EPI.....	Epidemiology
EPSDT	Early & Periodic Screening, Diagnosis and Treatment
FAE.....	Fetal Alcohol Effects
FARS.....	Fatal Accident Reporting System
FAS	Fetal Alcohol Syndrome
FASD	Fetal Alcohol Spectrum Disorder
FBCI.....	Faith Based and Community Initiatives
FLSW.....	Front Line Social Worker
FMAP.....	Federal Medical Assistance Program
FMS.....	Finance and Management Services
FS.....	Food Stamps
FTE	Full Time Equivalent
GCDSE	Governor’s Council on Disabilities and Special Education
GRA.....	General Relief Assistance
HAIL.....	Healthy Alaskans Information Line
HAN.....	Health Alert Network
HAP.....	Heating Assistance Program
HCBC.....	Home and Community Based Care
HCBW.....	Home and Community Based Waivers
HCP.....	Health Care Program
HCS.....	Health Care Services
HF	Healthy Families
HIFA	Health Insurance Flexibility and Accountability
HIPP.....	Health Insurance Premium Payment (Medicaid)
HIPPA.....	Health Insurance Portability and Accountability Act

HIV	Human Immunodeficiency Virus
HPG.....	Health Purchasing Group
HRSA.....	Health Resource Services Administration
HSCMG	Human Services Community Matching Grants
IA	Interim Assistance
I/A	Interagency Receipts
IDEA.....	Individuals with Disabilities Education Act
IDP	Institutional Discharge Planning
IEP.....	Individualized Education Plan
IFSP.....	Individual Family Service Plan
IHS	Indian Health Services
ILLECP.....	Local Law Enforcement & Community
ILP.....	Infant Learning Program
IMD.....	Institution for Mental Disease
IOP	Intensive Outpatient Program
ISA	Individualized Service Agreements
IT.....	Information Technology
ITG.....	Information Technology Group
JABG.....	Juvenile Accountability Block Grant
JCAHO.....	Joint Commission on Accreditation of Healthcare Organizations
JJDP	Office of Juvenile Justice and Delinquency Prevention
JOMIS.....	Juvenile Offender Management Information System
JPO.....	Juvenile Probation Officer
JTPA	Job Training Partnership Act
LCSW	Licensed Certified Social Worker
LIHEAP	Low Income Home Energy Assistance Program
LTC.....	Long Term Care
MBU	Medicaid Budget Unit
MCAC.....	Medicaid Care and Advisory Committee
MCFH.....	Maternal, Child, & Family Health
MCH	Maternal, Child Health (Block Grant)
MHDD	Mental Health and Developmental Disabilities
MHSIP	Mental Health Statistics Improvement Project
MHTAAR	Mental Health Trust Authority Authorized Receipts
MIS	Management Information System
MMIS.....	Medicaid Management Information System
MMIS-JUCE.....	MMIS – Juneau Claims and Eligibility System
MOA.....	Municipality of Anchorage or Memorandum of Agreement
MOE.....	Maintenance of Effort
MRAC.....	Medicaid Rate Advisory Committee
MRDD.....	Mental Retardation/Developmental Disability (Waiver)
MYC	McLaughlin Youth Center
NPS	National Pharmaceutical Stockpile
NRO.....	Northern Region Office
NSH.....	North Star Hospital
NSIF.....	Nutrition Services Incentive Program

NTSS.....	Nutrition, Transportation and Support Services
OA.....	Older Alaskans
OAA.....	Older Alaskan's Act
OCS.....	Office of Children's Services
OEP.....	Office of Emergency Preparedness
OOS.....	Out of State
OPR.....	Office of Program Review
ORCA	Online Resource for the Children of Alaska
ORR	Office of Rate Review
OSEP.....	Office of Special Education Programs
PA	Public Assistance
PASS.....	Parents Achieving Self-Sufficiency
PASS Grant.....	Personal Assistance, Supports and Services (Sr. & Disabilities Services)
PC.....	Personal Computer
PCA.....	Personal Care Attendant
PCBs	Polychlorinated Biphenyls
PCCM	Primary Care Case Management
PCN.....	Position Control Number
PCSA.....	Protection, Community Services and Administration
PDL.....	Preferred Drug List
PDPs.....	Prescription Drug Plans
PEC	Proposal Evaluation Committee
PERM.....	Payment Error Rate Measure
PES.....	Psychiatric Emergency Services
PFDHH	Permanent Fund Dividend Hold Harmless
PFT.....	Permanent Full Time
PHAB.....	Pioneers' Homes Advisory Board
PHN.....	Public Health Nursing
PIC	Private Industry Council
PIP.....	Performance (or Program) Improvement Plan
POP	Persistent Organic Pollutants
PPC	Prevention Policy Committee
PPT.....	Permanent Part-Time
PRAMS.....	Pregnancy Risk Assessment Monitoring System
PRWORA	Personal Responsibility and Work Opportunity Reconciliation Act
PSR	Protective Service Reports
RBRVS.....	Resource Based Relative Value System
RCC.....	Residential Child Care
RDT.....	Residential Diagnostic Treatment
RDU.....	Results Delivery Unit
RFP	Request for Proposal
RFR.....	Request for Recommendations
RHSS.....	Rural Health Services System
RPMS.....	Resources and Patient Management System
RPTC.....	Residential Psychiatric Treatment Center

RSA.....	Reimbursable Services Agreement
RSS	Receipt Supported Services
RSSP	Rural Services and Suicide Prevention
SAG.....	Subsidized Adoption and Guardianship
SAMHSA.....	Substance Abuse and Mental Health Services Administration
SAPT.....	Substance Abuse Prevention and Treatment Block Grant
SCHIP	State Children's Health Insurance Program
SCRO.....	Southcentral Region Office
SDPR.....	Statutory Designated Program Receipts
SDS	Senior and Disabilities Services
SECC.....	State Emergency Coordination Center
SED.....	Seriously Emotionally Disturbed
SERO	Southeast Region Office
SIG/ACT.....	State Incentive Grant/Alaskans Collaborating for Teens
SME	State Medical Examiner
SMI	Supplementary Medical Insurance
SSBG.....	Social Services Block Grant
SSI.....	Supplemental Security Income
STAR Grants.....	Short Term Assistance and Referral
STD.....	Sexually Transmitted Disease
SVCS/SMI	Services to the Seriously Mentally Ill
TANF.....	Temporary Assistance to Needy Families
TB	Tuberculosis
TCC.....	Tanana Chiefs Conference
TCM.....	Targeted Case Management
TDM.....	Team Decision Making
TEFRA.....	Tax Equity and Fiscal Responsibility Act of 1982
TFAP.....	Tribal Family Assistance Programs
Title V	Maternal, Child Health Block Grant
Title X	Family Planning (Federal)
Title XIX.....	Medicaid
Title XXI.....	SCHIP/Denali KidCare
T&H.....	Central Council of Tlingit and Haida Indian Tribes
TPL	Third Party Liability
TWWIA	Ticket to Work and Work Incentives Improvement Act of 1999
USDA.....	U. S. Department of Agriculture
WAS.....	Women and Adolescent Services
WIA.....	Workforce Investment Act
WIC.....	Women, Infants and Children
WSEA.....	Western States EBT Alliance
WtW.....	Welfare to Work
YF	Youth Facility
YKHC.....	Yukon-Kuskokwim Regional Health Corporation
YRBS.....	Youth Risk Behavior Survey

ATTACHMENT H
COST PROPOSAL PRICING SCHEDULES

Summary Pricing Sheet

Proposal Cost Totals

TO	TAKEOVER	Total from TO Pricing Sheet
DDI	SYSTEM DESIGN DEVELOPMENT & IMPLEMENTATION	Total from DDI Sheet
SO	SYSTEM OPERATIONS	Total from SO Sheet

Pricing Schedule A will include all costs for Takeover, Takeover Operations, DDI, and New System Operations.

In the event that the State of Alaska - DHSS determines that TAKEOVER, SYSTEM DESIGN DEVELOPMENT & IMPLEMENTATION, and SYSTEM OPERATIONS are to be included in the bid award The Cost evaluation will consist of all three Line items TO + DDI + SO.

In the event that the State of Alaska - DHSS determines that the TAKEOVER will not be included in the bid award the Cost evaluation will consist of two Line items DDI + SO.

In the event that the State of Alaska - DHSS determines that the SYSTEM DESIGN DEVELOPMENT & IMPLEMENTATION, and SYSTEM OPERATIONS will not be included in the bid award the Cost evaluation will consist of Line item TO only.

PRICING SCHEDULE A

TAKEOVER PHASE I (TO Sheet)

The Takeover component is optional, and will be included at the State's discretion.

TO	Total Current System Cost Component Takeover and Operations	Sum of Line 1 and 2 (Enter in summary Pricing sheet)

Line

1	Current System Takeover :		
2	Total Pricing Current System Operation (year 1 + Year 2) :	Sum Year 1 + Year 2	
	Annual Pricing Current System Operation	Year 1	Year 2
2a	Claims Processing		
2b	POS/Pro DUR		
2c	Prior Authorization		
2d	Web portal / Web Services		
2e	SURS		
2f	Interfacing / Messaging (translator)		
2g	Hardware Hosting / Hardware Maintenance		
2h	MMIS Application Maintenance		
	Total Annual Pricing Current System Operation :	sum 2a-2h	sum 2a-2h

Enter a value for **Line 1** the Takeover of the Current System.

Enter values for **2a** through **2h** for each year of current system operations.

Total the values for 2a through 2h for **Year 1** and **Year 2**.

Add the totals for each year into **Line 2** Total Pricing Current System Operation

Add **Line 1** and **Line 2** to arrive at the **TO** Total Current System Cost Component.

This number is entered in the summary pricing sheet above.

**SYSTEM DESIGN DEVELOPMENT & IMPLEMENTATION
PHASE II
(DDI Sheet)**

Line

3		Total DDI Pricing :	sum 3a-3h
3a	Claims Processing		
3b	POS/Pro DUR		
3c	Prior Authorization		
3d	Web portal / Web Services		
3e	SURS		
3f	Interfacing / Messaging (translator)		
3g	Hardware Hosting / Maintenance		
3h	MMIS Application Maintenance		

Enter values for **3a** through **3h** for the Design Development and Implementation of the new system.

Total those values to arrive at **Line 3** Total DDI pricing.

The Total DDI Pricing value is entered in the Summary pricing sheet on the **DDI Line** above.

**NEW SYSTEM OPERATIONS SHEET
PHASE III and PHASE IV
(SO SHEET)**

Line		Five Yr Operations (2009-2014)	One Yr Extension (2014-15)	One Yr Extension (2015-16)	One Yr Extension (2016-17)
	Total Annual Price for New System Operations	Sum 4a-4h	Sum 4a-4h	Sum 4a-4h	Sum 4a-4h
4a	Claims Processing				
4b	POS/Pro DUR				
4c	Prior Authorization				
4d	Web portal / Web Services				
4e	SURS				
4f	Interfacing / Messaging (translator)				
4g	Hardware Hosting / Maintenance				
4h	MMIS Program Maintenance				

4	Total New System Operations Pricing	Sum of All Years Operations

Enter values for 4a through 4h for each column on the SO sheet.

Total the Values at the top of each column to arrive at total pricing for each of the operational components.

Sum the totals for each column and enter the total in contract **Line 4** Total Annual Price for New System Operations.

Enter this total in the Summary pricing sheet on the **SO Line**.

PRICING SCHEDULE B

DEVELOPMENT AND OPERATIONS LABOR RATES

For all labor categories engaged in the development and operations of the proposed system enter a description and an hourly labor rate to be used in the development of enhancement and contract amendment pricing.

DESCRIPTION	HOURLY RATE*
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

PRICING SCHEDULE D

SOFTWARE PRICING

To ensure the State of Alaska - DHSS has an understanding of the distribution of application software, and Licensing costs for the proposed system, enter the name and anticipated cost of software used in the development and delivery of the system. Identify the software and type (Proprietary, COTS, Open Source) of software and the associated cost.

	TYPE of SOFTWARE	Purchase Cost	License Fees	Maintenance Fees	Total
Phase I Takeover					
Software a					
Software b					
As many as required					
Phase II DDI					
Software a					
Software b					
As many as required					
MMIS OPERATIONS					
Software a					
Software b					
As many as required					
GRAND TOTAL					

ATTACHMENT I

PROPOSAL CROSS REFERENCE

RFP #	Description	Proposal #	Description
1	Introduction and Instructions		
1.1	RFP Contact Information - Return Mailing Address, Contact Person, Telephone & Fax Numbers, Deadline for Receipt of Proposals		
1.2	Contract Term & Work Schedule		
1.3	Purpose of the Request for Proposal (RFP)		
1.4	Location of Work		
1.5	Assistance to Offerors with a Disability		
1.6	Required Review		
1.7	Questions Received Prior to Opening of Proposals		
1.8	Amendments		
1.9	Alternate Proposals		
1.10	Right of Rejection		
1.11	State Not Responsible for Preparation Costs		
1.12	Disclosure of Proposal Contents		
1.13	Subcontractors		
1.14	Joint Ventures		
1.15	Offeror's Certification		
1.16	Conflict of Interest		
1.17	Right to Inspect Place of Business		
1.18	Solicitation Advertising		
1.19	News Releases		
1.20	Budget		
1.21	Disputes		
1.22	Severability		
1.23	Federal Requirements		
1.24	Budget		
2	STANDARD PROPOSAL INFORMATION		
2.1	Authorized Signature		
2.2	Pre-Proposal Conference		
2.3	Site Inspection		
2.4	Amendments to Proposals		
2.5	Supplemental Terms and Conditions		
2.6	Clarification of Offers		
2.7	Minimum Requirements		
2.8	Evaluation of Proposals		
2.9	Vendor Tax ID		
2.10	Alaska Business License & Other Required Licenses		

2.11	Application of Preferences		
2.11.1	5% Alaskan Bidder Preference		
2.11.2	Formula Used to Convert Cost to Points		
2.11.3	Alaskan Offeror's Preference		
2.12	Contract Negotiation		
2.13	Failure to Negotiate		
2.14	Notice of Intent to Award (NIA)- Offeror Notification of Selection		
2.15	Protest		
2.12	Contract Negotiations		
2.13	Failure to Negotiate		
2.14	Notice of Intent to Award (NIA) Offeror Notification of Selection		
2.15	Protest		
2.16	Discussion with Offerors		
3	STANDARD CONTRACT INFORMATION		
3.1	Contract Type		
3.2	Contract Approval		
3.3	Standard Contract Provisions		
3.4	Proposal as a Part of the Contract		
3.5	Additional Terms and Conditions		
3.6	Insurance Requirements		
3.7	Performance Bond		
3.8	Contract Funding		
3.9	Contract Payment		
3.9.1	Operational Takeover Phase I		
3.9.1.1	Operational Takeover Milestones		
3.9.1.2	Operational Maintenance Payments		
3.9.2	DDI Phase II		
3.9.3	Operations Phase III		
3.9.3.1	Escalation Factor		
3.9.4	Turnover Phase IV		
3.9.4.1	No Additional Payments		
3.10	Data Compliance Warranty		
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5.7.1	Performance Monitoring and Reporting		
5.7.2	Fiscal Agent Internal Quality Assurance		
5.7.2.1	Business Needs		
5.7.2.2	State Responsibilities		
5.7.2.3	Contractor Responsibilities		
5.7.2.4	Interfacing Systems		
5.7.2.5	Inputs		
5.7.2.6	Outputs		
5.7.2.7	Performance Standards		
5.7.3	Contract Management		
5.7.3.1	Business Needs		
5.7.3.2	State Responsibilities		
5.7.3.3	Contractor Responsibilities		
5.7.3.3.1	General Contract Management		
5.7.3.3.2	Training		
5.7.3.3.3	User Support		
5.7.3.3.4	Production Operations Support		
5.7.3.4	Interfacing Systems		
5.7.3.5	Inputs		
5.7.3.6	Outputs		
5.7.3.7	Performance Standards		
5.7.4	Management of Change		
5.7.4.1	System Maintenance – Including DDI		
5.7.4.2	System Enhancement – Including Additions		
5.7.4.3	Issue Management Systems		
5.7.4.4	State Responsibilities		
5.7.4.5	Contractor Responsibilities		
5.7.4.5.1	System Maintenance		
5.7.4.5.2	System Modification/Enhancement		
5.7.4.6	Performance Standards		
5.7.5	Other Requirements		
5.7.5.1	Web Portal		
5.7.5.2	Data Processing		
5.7.5.2.1	System Reliability		
5.7.5.2.2	System Access and Navigation		
5.7.5.2.3	System Auditability		
5.7.5.2.3.1	Data Maintenance Audit Trail		
5.7.5.2.3.2	Audit Trail Requirements		
5.7.5.2.3.3	Data Capture for On-line Audits		
5.7.5.2.3.4	Before-Images of Data		
5.7.5.2.3.5	Control and Balancing		

5.7.5.2.3.6	Edit Dispositions		
5.7.5.2.3.7	Overridden Edit/Audit Trail		
5.7.5.2.3.8	Payment Request Edit Failure Audit Trail		
5.7.5.2.4	Telecommunication Links with Other Entities		
5.7.5.2.5	Compatibility with State Environment		
5.7.5.3	Security and Confidentiality		
5.7.5.3.1	Privacy Requirements		
5.7.5.3.2	Administrative Security Requirements		
5.7.5.3.3	Physical Security Requirements		
5.7.5.3.4	Technical Security Requirements: System Access		
5.7.5.3.5	Technical Security Requirements: Data Security		
5.7.5.3.5.1	Software Program Change Controls		
5.7.5.3.5.2	Data Integrity Safeguards		
5.7.5.3.5.3	Archive and Purge Controls		
5.7.5.3.6	System/Application Security		
5.7.5.3.6.1	Threat Assessment		
5.7.5.4	Configuration Management/Version Control		
5.7.5.4.1	Software Version Control		
5.7.5.4.2	Hardware and "Off the Shelf" Software Version Control		
5.7.5.4.3	Documentation and User Manual Version Control		
5.7.5.5	Documentation Requirements		
5.7.5.5.1	User Documentation		
5.7.5.5.2	Operating Procedures		
5.7.5.5.3	System Documentation		
5.7.5.5.3.1	Detailed System Design (DSD)		
5.7.5.5.3.1.1	System Overview		
5.7.5.5.3.1.2	Functional Documentation		
5.7.5.5.3.1.3	Program Documentation		
5.7.5.5.3.2	Production Control Documentation		
5.7.5.5.3.3	Data Element Dictionary		
5.7.5.5.3.4	Table Description		
5.7.5.6	Disaster Recovery and Backup		
5.7.5.6.1	Business Continuity Plan		
5.7.5.6.2	Disaster Recovery Plan		
5.7.5.6.3	Back-Up Requirements		
5.7.5.7	Records Retention		
5.7.5.8	Location of Activities		
5.7.5.9	Facility Requirements		
5.7.5.10	Equipment Requirements		
5.7.5.11	Equipment Ownership		

5.7.5.12	Audit Requirements		
5.8	Operations		
5.9	Turnover		
5.9.1	DHSS Objectives		
5.9.2	Turnover Tasks		
5.9.3	DHSS Responsibilities		
5.9.4	Contractor Responsibilities		
5.9.5	Milestones		
5.9.6	Deliverables		
6	PROPOSAL FORMAT AND CONTENT		
6.1	Proposal Format and Content		
6.2	Technical Proposals		
6.2.1	Introduction		
6.2.1.1	Transmittal Letter		
6.2.1.2	Executive Summary		
6.2.1.3	Proposal Cross Reference		
6.2.2	Understanding of the Alaska MMIS Project		
6.2.2.1	Outline of the Approach for Takeover of the Legacy System		
6.2.2.2	Outline of Proposal Solution and Approach		
6.2.2.3	System Proposed for Transfer to Alaska		
6.2.2.4	Changes to Proposed System		
6.2.2.5	MITA Architecture		
6.2.3	Management Plan for the Project		
6.2.4	Methodology for the Alaska Project- Scope of Work		
6.2.4.1	Phase I- Operational Takeover		
6.2.4.2	Phase II – DDI		
6.2.4.3	Functional Requirements		
6.2.4.4	Management and Operational Requirements		
6.2.4.5	Phase III Operations		
6.2.4.6	Phase IV Turnover		
6.2.5	Experience and Qualifications		
6.2.5.1	Corporate Capabilities		
6.2.5.2	Resumes		
6.2.6	Appendices		
6.3	Cost Proposal		
6.3.1	Pricing Schedule A- Takeover and Legacy Operations, DDI, MMIS Operations and Turnover Pricing		
6.3.2	Pricing Schedule B- Operations Labor Rates		
6.3.3	Pricing Schedule C- Change Order Billing Price		
6.3.4	Pricing Schedule D- Software and Training Price		

6.4	Evaluation Criteria		
7	EVALUATION CRITERIA AND CONTRACTOR SELECTION		
7.1	Evaluation of Proposals		
7.1.1	Reasonably Susceptible for Award		
7.1.2	Scripted Demonstrations		
7.1.3	Recommendation		
7.2	Federal/State Approvals		
7.3	Evaluation Factors and Weighting Factors		
7.4	Evaluation Requirements for Technical Proposals		
7.4.1	Introduction and Understanding of the Alaska MMIS Project (5 Percent)		
7.4.2	Management Plan for the Project (4.5%)		
7.4.3	Methodology Used for the Alaska MMIS Project (5 Percent)		
7.4.3.1	System Overview		
7.4.3.2	Phase II- DDI (9.5%)		
7.4.3.3	Functional Requirements (13%)		
7.4.3.4	Operations Management Requirements (5.5%)		
7.4.3.5	Operations Phase III (3%)		
7.4.3.6	Phase IV- Turnover (1%)		
7.4.4	Experience and Qualifications (9%)		
7.4.4.1	Claims Processing Activity		
7.5	Contract Costs (30%)		
7.6	Alaskan Offeror's Preference (10%)		
7.7	Demonstration Scoring and Evaluation Factor (10%)		

ATTACHMENT J

PROPOSAL EVALUATION FORM

Proposal Evaluation and Scoring

Technical Evaluation Criteria

	Section Points		
Introduction and Understanding of the Alaska Project	205	2.1%	Score
6.2.1 Introduction - Executive Summary (6.2.1.2)	60	0.6%	
6.2.2 Understanding AK Medical Assistance Project	75	0.8%	
6.2.2 MITA Architecture (6.2.2.5)	70	0.7%	

Management Plan for the Project

Comprehensive Requirements 6.2.3	540	5.4%	Score
(1), (10) Project management approach for completing all project phases; including management and reporting requirements in 5.5.1	50	0.5%	
(2) Approach for requirements definition	40	0.4%	
(3), (14), (15), (16) Approach to resource planning, authority/responsibilities of key staff, work hour estimating/reporting, and approach for coordinating staff	75	0.8%	
(4) Approach for change management control and reporting	75	0.8%	
(5) Approach for test planning and management	50	0.5%	
(6) Approach for issue and risk identification, tracking, resolving, and reporting	45	0.5%	
(7) Approach for internal quality control	65	0.7%	
(8) Approach for scope management	20	0.2%	
(9) Approach for developing deliverables as described in section 5.5.2	30	0.3%	
(11), (12) Approach for interfacing with the State and incumbent contractor	30	0.3%	
(13) Process for identifying and maintaining privacy and security requirements	20	0.2%	
(17) Approach for meeting contract performance standards	40	0.4%	

Scope of Work

Operational Takeover Phase 1 6.2.4.1 - Using presentation criteria in this section, documentation of how the following requirements will be met

	310	3.1%	Score
5.4.1 Takeover Implementation component	20	0.2%	
5.4.2 Requirements Analysis	10	0.1%	
5.4.3 Takeover Documentation	10	0.1%	

5.4.4 Takeover DW/DSS extract	30	0.3%	
5.4.5 System Takeover Testing	50	0.5%	
5.4.6 Provider and Recipient Support			
ServicesTakeover	50	0.5%	
5.4.7 HIPAA Takeover	20	0.2%	
5.4.8 Takeover Operational Readiness and Operability			
Testing	30	0.3%	
5.4.9 Takeover Implementation	50	0.5%	
5.4.10 Post Takeover Implementation	10	0.1%	
5.4.11 Takeover Maintenance Component	30	0.3%	

DD&I Phase II 6.2.4.2 - Using presentation criteria in this section, documentation of how the following requirements will be met

	895	9.0%	Score
5.5.3 Project Initiation	25	0.3%	
5.5.4 Requirements Analysis	110	1.1%	
5.5.5 Systems Design	125	1.3%	
5.5.6 DW/DSS Development and Implementation	130	1.3%	
5.5.7 MMIS Development and Testing	125	1.3%	
5.5.8 Conversion	125	1.3%	
5.5.9 Acceptance Testing	130	1.3%	
5.5.10 Implementation	100	1.0%	
5.5.11 Post-implementation Evaluation	25	0.3%	

Functional Requirements 6.2.4.3 - Using presentation criteria in this section, documentation of how the following requirements will be met

	1500	15.0%	Score
5.6.2 Recipient Eligibility and Relations	70	0.7%	
5.6.3 Benefit Packages	90	0.9%	
5.6.4 Provider Enrollment and Relations	80	0.8%	
5.6.5 Reference Databases	50	0.5%	
5.6.6 Prior Authorization	90	0.9%	
5.6.7 Reimbursement	90	0.9%	
5.6.8 Claims Processing	125	1.3%	
5.6.9 Claims Payment	125	1.3%	
5.6.10 Financial Services	80	0.8%	
5.6.11 Third Party Liability	70	0.7%	
5.6.12 Early and Periodic Screening, Diagnosis and			
Treatment	40	0.4%	
5.6.13 Managed Care function	40	0.4%	
5.6.14 Home and Community-based Waivers	40	0.4%	
5.6.15 Pharmacy Point of Sale	110	1.1%	
5.6.16 Drug Utilization Review	60	0.6%	
5.6.17 Drug Rebates	50	0.5%	
5.6.18 Data Warehouse/Decision Support System	110	1.1%	
5.6.19 Management and Administrative Reporting	40	0.4%	
5.6.20 Utilization Review and Quality Assurance	60	0.6%	
5.6.21 Case Tracking	80	0.8%	

Operations Management Requirements 6.2.4.4 - Using presentation criteria in this section, documentation of how the following requirements will be met

	650	6.5%	Score
5.7.1 Performance Monitoring and Reporting	160	1.6%	
5.7.2 Fiscal Agent Internal Quality Assurance	130	1.3%	
5.7.3 Contract Monitoring	80	0.8%	
5.7.4 Management of Change	130	1.3%	
5.7.5 Other Requirements	150	1.5%	

Operations Phase III 6.2.4.5 - Using presentation criteria in this section, documentation of the following requirements will be met

	300	3.0%	Score
5.6.1 General requirements	150	1.5%	
5.8 Operations	150	1.5%	

Turnover Phase IV 6.2.4.6

	100	1.0%	Score
5.9.2 Turnover Tasks	50	0.5%	
5.9.4 Contractor Responsibilities	50	0.5%	

Vendor Experience and Qualifications

	500	5.0%	Score
<u>Corporate Capabilities 6.2.5.1</u>	200	2.0%	
<u>Resumes 6.2.5.2</u>	300	3.0%	

Score

Technical Evaluation Total :	5000	50.0%	

Score

Vendor System Demonstration :	1000	10.0%	

Score

Cost Proposal Evaluation :	3000	30.0%	

Score

Alaska Offerers Preference :	1000	10.0%	

Score

Total Evaluation :	10000	100.0%	

**ATTACHMENT K
NOTICE OF INTENT TO AWARD**

**STATE OF ALASKA
NOTICE OF INTENT TO AWARD**

1. Name of Program, Project, or Service (Use RFP Title)	2. Date Issued
3. Authority Number (s)	4. Name of Procurement Officer

This is notice of the State's intent to award a contract. The offeror, identified here as the apparent successful offeror, is instructed not to proceed until a signed contract or other written notice of award is received from the State. A firm or person who proceeds prior to receiving a signed contract or other written notice does so at their own risk. AS 36.30. 365

An offeror who wishes to protest this Notice of Intent to Award must file a protest within ten (10) calendar days following the date this notice is issued. If the tenth day falls on a weekend or holiday, the last day of the protest period is the first working day following the tenth day. AS 36.30.565

Per AS 36.30.560, the protest shall be filed with the procurement officer in writing and include the following information:

- (1) The name, address and telephone number of the protester
- (2) The signature of the protester or the protester's representative
- (3) Identification of the contracting agency and the solicitation or contract at issue
- (4) A detailed statement of the legal and factual grounds of the protest, including copies of relevant documents
- (5) The form of relief requested

5. Name and Address of Successful Offeror

6. Names and Addresses of All Other Respondents (in alphabetical order)

ATTACHMENT L
OFFEROR DEMONSTRATION SCRIPTS



MMIS PROJECT
Offeror Demonstration Scripts
Manual

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

Offeror Demonstration Scripts

Overview

Scripted demonstrations will be available to offerors who submit proposals that are determined to be reasonably susceptible for award. The purpose of the scripted demonstrations is to assess how well the offeror proposal and/or system meets the functional requirements.

The following instructions provide additional detail regarding the demonstration schedule, scripts, and logistics, as well as the detailed scripts that must be demonstrated. The offerors will provide demonstrations of the functionality of their MMIS components, based upon scripts provided by DHSS as contained in this document. Demonstrations are scripted to cover major subsystems of the MMIS or areas of particular interest to the State.

The major requirements to be demonstrated are:

- Recipient Eligibility and Relations and Benefit Packages
- Provider Enrollment and Relations
- Prior Authorization
- Reference Database
- Pricing, Claims Processing and Payment
- Financial Services
- Third Party Liability
- Pharmacy Point-of-Sale (POS)
- Drug Rebate
- Data Warehouse/Decision Support System (DW/DSS)
- Healthcare Utilization Review and Quality Assurance
- Managed Care
- Tracking
- Web Portal
- Management and Operational Requirements

Finalists

Offerors deemed reasonably susceptible for award will be invited to demonstrate their proposed system MMIS features to a panel of evaluators. Demonstrations will be scheduled by a blind draw. Selected offeror firm names will be drawn to determine the order of the demonstrations. The first offeror name that is drawn will have the first option for scheduling their demonstrations; the second offeror drawn will have the second option, etc.

Schedule

Demonstrations will take two (2) full days for each offeror. The State will not be responsible for any vendor related demonstration costs. The Procurement Officer will notify finalists of their demonstration dates and times based on the results of the blind draw described above. Finalists will select from available time slots, yet to be determined.

Each day demonstrations will begin promptly at 8:00 AM and proceed until 10:00 AM. There will be a 15 minute break from 10:00 AM to 10:15 AM. Demonstrations will resume promptly at 10:15 AM and will continue until 12:15. There will be a 1 hour and 30 minute lunch break from 12:15 to 1:45. Demonstrations will resume promptly at 1:45 and will continue until 3:15. There will be a 15 minute break between 3:15 and 3:30 with the final demonstrations for the day beginning promptly at 3:30 and continuing until 5:00. (See chart below.)

Demo set 1	8:00-10:00	2 hr
Break	10:00-10:15	15 min
Demo set 2	10:15-12:15	2 hr
Lunch	12:15-1:45	1 hr 30 min
Demo set 3	1:45-3:15	1 hr 30 min
Break	3:15-3:30	15 min
Demo set 4	3:30-5:00	1 hr 30 min

Time Allotment

Time allotted for each demonstration will be strictly adhered to by the evaluators. Any script not presented within the time allotment will receive a score of zero. If a script is partially completed when the allotted time expires, the evaluators will score the script based upon the portion presented. If demonstrations finish before the allotted time expires, the demonstrators may choose to take an extra break or proceed to the next demonstration. The time for each demonstration is fixed and can not be adjusted. Any remaining time from the previous demonstration will not be transferred to remaining demonstrations.

The time allotments are listed in the table below:

Demonstration Title	Time Allotment
Day 1	
Recipient Eligibility and Relations and Benefit Packages	60 minutes
Provider Enrollment and Relations	60 minutes
Prior Authorization	60 minutes
Reference Databases	60 minutes
Pricing, Claims Processing and Payment	90 minutes
Financial Services	45 minutes
Third party Liability	45 minutes
Day 2	
Pharmacy Point-of-Sale	80 minutes
Drug Rebate	40 minutes
Data Warehouse/Decision Support System (DW/DSS)	60 minutes
Healthcare Utilization Review and	60 minutes

Quality Assurance	
Managed Care	40 minutes
Tracking	50 minutes
Web Portal	50 minutes
Management and Operational Requirements	40 minutes

Set Up

Offerors will be admitted to the demonstration room the day preceding their scheduled demonstration to set up and test equipment, phone and internet connections as needed.

The demonstration room will be equipped with two projection screens or surfaces, one internet connection, one phone line connection, and tables and chairs for the offeror's use.

Demonstration Protocol

Demonstrators will face the evaluators and will project the scripted demonstration materials on to screen(s) behind the demonstrators.

When demonstration scripts call for the demonstration of a report, offerors should show the report on-line as far as possible. No requirement for paper reports are intended during the demonstrations.

Demonstrators **must** explicitly inform the evaluators of any functionality being demonstrated that has not been used in a production mode by an organization of similar claims processing requirements.

Functionality **incidentally** demonstrated by the offeror in the course of responding to a requirement will not be scored and will not have an effect on the response score. Offerors may not demonstrate **additional** functionality that is not in direct response to a script.

Demonstrators will present their MMIS system according to the defined scripts. Demonstrators may present the scripted items within a script in the order they prefer, but must keep the evaluators oriented as to which scripted item they are presenting a response.

Evaluators will only ask questions of the demonstrators as they relate to orientation within the demonstrations. Otherwise, to maintain schedule adherence, evaluators will not ask questions of the demonstrators.

Demonstration Scoring, Evaluation, and Ranking Procedures

Scoring and Evaluation

Demonstrations will be evaluated by members of the demonstration PEC. Evaluators will perform an independent review and award points based on the offerors system being demonstrated and whether the scripted demonstration satisfies the functional requirements in

the RFP. Evaluators will strive to score each demonstration on its own merits, against the functional requirements.

In addition, each demonstration will receive a score related to the system ease of use, navigation, and efficiency as observed by the evaluators.

A maximum of 600 points are available for the demonstrations.

After PEC evaluators separately evaluate and score each demonstration, they will meet as a group to discuss their individual scores. PEC members will have the opportunity to adjust their own individual scores based upon group discussions.

Each demonstration script carries a pre-assigned weight that defines its relative importance to other scripts within the demonstration. Table 1-Scripted Demonstration Score Sheet lists the evaluation factor and weight factor assigned to each demonstration script. The weight is multiplied by the raw score assigned by the evaluators to arrive at a weighted score for each script within the demonstration. Raw and weighted scores for each script will be recorded by PEC members in the Scripted Demonstration Score Sheet, to follow. The score sheet contains a section for evaluators' comments. Evaluators will use the comments area to indicate any discrepancies, omissions and supporting information that led to the raw score assignment. These comments are valuable sources of information on both the good aspects of a demonstration and the areas needing improvement in order to meet the functional requirements in the RFP.

Ranking

Weighted scores for all scripts within a demonstration will be summed and recorded within the Scripted Demonstration Score Sheet.

Offeror demonstrations will be ranked, from highest ranked score to lowest, by the total demonstration score (weighted). Final demonstration scores will be calculated, based upon raw scores and weighting factors and tabulated by the Procurement Officer. The remaining offerors will receive a proportional score, using the following formula:

$$y = (n/x) * 600 \text{ (maximum points available) where:}$$

y	=	Final demonstration score for offeror n
n	=	Total demonstration score for offeror n
x	=	Highest demonstration score for all qualified offerors

After the above calculation, the Procurement Officer will tabulate individual demonstration scores and prepare a report on ranking of proposals, based upon the PEC demonstration materials. The offerors will be ranked in descending order of final demonstration scores.

Table 1- Scripted Demonstration Score Sheet

The following form will be used to record point scores for each functional requirement for each offeror demonstration. A separate form will be completed for each offeror.

Date:					
Offeror Name:					
Reviewer Name:					
Script Number	Demonstration	Score	Weight	Weighted Score	Comments
1	<u>Recipient Eligibility and Relations and Benefit Packages</u>				
<u>Script #1.1</u>	<u>Enter and Update Recipients and benefit packages</u>		5		
<u>Script #1.2</u>	<u>Recipient/Benefit Packages Database Maintenance, Update, Inquiry, and Edit Function</u>		4		
<u>Script #1.3</u>	<u>Ease of Use</u>		3		
<u>SCORE</u>					
2	<u>Provider Enrollment and Relations</u>				
<u>Script #2.1</u>	<u>Provider Enrollment</u>		5		
<u>Script #2.2</u>	<u>Searching, viewing and editing</u>		4		
<u>Script #2.3</u>	<u>Ease of Use</u>		3		
<u>SCORE</u>					
3	<u>Prior Authorization</u>				
<u>Script #3.1</u>	<u>Capture, Edit, Store & Control</u>		5		
<u>Script #3.2</u>	<u>View and User Access</u>		4		
<u>Script #3.3</u>	<u>Ease of Use</u>		3		
<u>SCORE</u>					
4	<u>Reference Databases</u>				
<u>Script #4.1</u>	<u>Data Management & User Access</u>		4		
<u>Script #4.2</u>	<u>Error Text and Edit/Audit Criteria</u>		5		
<u>Script #4.3</u>	<u>Ease of Use</u>		3		
<u>SCORE</u>					
5	<u>Pricing, Claims Processing and Payment</u>				
<u>Script #5.1</u>	<u>Electronic Transactions Management and Control</u>		5		
<u>Script #5.2</u>	<u>Edits, Audits and Business Rules</u>		5		
<u>Script #5.3</u>	<u>Adjudication Functionality</u>		5		
<u>Script #5.4</u>	<u>Pricing Functionality</u>		5		
<u>Script #5.5</u>	<u>Adjustments</u>		5		

<u>Script #5.6</u>	<u>Remittance Advice/Budget Monitoring Functionality</u>		5		
<u>Script #5.7</u>	<u>Ease of Use</u>		3		
<u>SCORE</u>					
6	<u>Financial Services</u>				
<u>Script #6.1</u>	<u>Account Coding and General</u>		5		
<u>Script #6.2</u>	<u>Accounts Receivable</u>		5		
<u>Script #6.3</u>	<u>Federal Taxes</u>		4		
<u>Script #6.4</u>	<u>Accounts Payable</u>		5		
<u>Script #6.5</u>	<u>Ease of Use</u>		3		
<u>SCORE</u>					
7	<u>Third Party Liability</u>				
<u>Script #7.1</u>	<u>Processing and Adjudication</u>		5		
<u>Script #7.2</u>	<u>Administration of Recipient TPL Resource Data</u>		5		
<u>Script #7.3</u>	<u>Viewing and Editing a TPL Record</u>		4		
<u>Script #7.4</u>	<u>Administration of Insurance Carrier File</u>		4		
<u>Script #7.5</u>	<u>Ease of Use</u>		3		
<u>SCORE</u>					
8	<u>Pharmacy Point-of Sale (POS)</u>				
<u>Script #8.1</u>	<u>Recipient Eligibility and Benefit Verification</u>		5		
<u>Script #8.2</u>	<u>Provider Eligibility Verification</u>		5		
<u>Script #8.3</u>	<u>Prior Authorization</u>		5		
<u>Script #8.4</u>	<u>Pharmacy Claims Capture and Adjudication (including ProDUR)</u>		5		
<u>Script #8.5</u>	<u>Retro-DURS</u>		4		
<u>Script #8.6</u>	<u>Drug File Functionality</u>		5		
<u>Script #8.7</u>	<u>Exchanging Data between the POS and MMIS</u>		5		
<u>Script #8.8</u>	<u>Ease of Use</u>		3		
<u>SCORE</u>					
9	<u>Drug Rebate</u>				
<u>Script #9.1</u>	<u>Drug Rebate Database</u>		4		
<u>Script #9.2</u>	<u>Invoicing</u>		4		
<u>Script #9.3</u>	<u>Accounting</u>		4		
<u>Script #9.4</u>	<u>Dispute Resolution</u>		4		
<u>Script #9.5</u>	<u>Ease of Use</u>		3		
<u>SCORE</u>					
10	<u>Data Warehouse/Decision Support System</u>				
<u>Script #10.1</u>	<u>General Demo</u>		4		
<u>Script #10.2</u>	<u>Scenario A</u>		4		
<u>Script #10.3</u>	<u>Scenario B</u>		4		
<u>Script #10.4</u>	<u>Scenario C</u>		4		
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SCORE					
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SCORE					

Final Demonstration Score

The table below shows the total and final demonstration scores for all offeror demonstrations.

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1. Recipient Eligibility and Relations and Benefit Packages (60 Min/8:00am-9:00am/Day 1)

Requirement #1.1 Enter and Update Recipients and Benefit Packages

- ☐ Create a new Medicaid benefit package and show how a non-Medicaid benefit package is created.
- ☐ Assign individual and ranges of procedure, diagnosis, and National Drug Codes (NDC) included in the new benefit package.
- ☐ View all details associated with an existing benefit package.
- ☐ Make a change to a recipient data element where the source of the information is typically an external eligibility system that interfaces with the MMIS. Show both how the change could be permanent (not altered by future eligibility interface file updates) and how it could be temporary (continues to accept changes when the eligibility interface file is updated)
- ☐ View LTC certification data, assign a recipient's spend-down patient liability amount for LTC and the capability to assign liability amounts for other programs, i.e. hospice, waiver, other.

Requirement #1.2 Recipient/Benefit Packages Database Maintenance, Update, Inquiry, and Edit Function

- ☐ View, edit, and update a recipient's benefit package(s) including assignment to multiple benefit packages concurrently. Show the hierarchy for applying the benefit packages.
- ☐ View and edit the recipient's eligibility history, dates, and benefit packages, buy-in status, etc., including the number of eligibility segments that can be captured either directly in the MMIS and/or through an interface with an external eligibility system.
- ☐ View overlapping eligibility segments between Medicaid and other State Programs
- ☐ View and edit a recipient's file with multiple IDs and ID sources, including historical recipient ID's and other foreign system generated IDs. Show that current and past identification numbers are linked and duplicate names are eliminated.
- ☐ View the history of changes to the recipient's data such as changes in demographic data, SSN, recipient ID's, etc.
- ☐ Demonstrate on-line query to recipient data, including finding a recipient's record/data by searching on recipient ID, partial name, case manager, SSN, previous recipient ID, and other searchable fields
- ☐ Demonstrate capability to identify recipients of special programs
- ☐ Demonstrate the tracking and recording of the State's Medicare buy-in payment for a recipient showing premium payments and coverage dates (include showing online "alias" database and match review process)

Requirement #1.3 Ease of Use

Evaluator: Score this demonstration for the ease of use (i.e. menu systems, window taps, availability of help screens) access, display, navigation and efficiency observed during the demonstration. (The offeror is not requested to present a separate response for this requirement.)

2. Provider Enrollment and Relations (60 Min/9:00am-10:00am/Day 1)

Requirement #2.1 Provider Enrollment

Demonstrate the enrollment of a provider into the MMIS

- ☐ Demonstrate the ability to enter and edit current, historical, date-sensitive, provider demographic information (such as NPI, name, address, phone number, fax number, certification/license/permit, etc)
- ☐ Demonstrate the process for rate entry, changes/updates to include: various types of rates, on-line update capability, mass update capability, and mass adjustment capability. Show one audit trail via on-line inquiry.
- ☐ Demonstrate that multiple provider types, specialties, taxonomy designations, program participation, locations, addresses, rates, contact information, etc. are maintained in a single provider record
- ☐ Demonstrate the “template” that defines the required information necessary to enroll a provider once high level provider data (i.e. provider type, provider specialty, etc) is entered. Required information includes mandatory licensing, certification, and/or credentialing requirements, ownership information, employer ID number (EIN) etc.
- ☐ Demonstrate the verification process that shows each submitter is authorized to submit:
 - On behalf of a specific provider
 - Each specific transaction
 - Test and then production status transactions
 - Within specific date spans
- ☐ Demonstrate the ability to enter and edit trading partner data, including demographic data, each transaction approved for submission, test/production status, and the relationship to a specific provider record
- ☐ Show two-way cross-referencing using various enumeration values
- ☐ Reactivate an inactive provider
- ☐ Demonstrate the flexibility to add a new data item to the provider file

Requirement #2.2 Searching, viewing and editing

- ☐ Demonstrate the capability to limit an individual provider reimbursement/coverage based on specific services, program participation eligibility categories, locations, regions, lock-in/lock-out status, etc
- ☐ Demonstrate the validity of accumulated financial data for an individual provider (from at least two payment cycles) and the associated warrant (or EFT) information
- ☐ Demonstrate the ability to accumulate provider history based on a single National Provider Identifier (NPI)
- ☐ Search and access the provider subsystem by means such as provider ID, NPI, name, EID, Medicare number, and other searchable fields.
- ☐ Demonstrate the EVS and AVR systems

Requirement #2.3 Ease of Use

Evaluator: Score this demonstration for the ease of use (i.e. menu systems, window taps, availability of help screens) access, display, navigation and efficiency observed during the demonstration. (The offeror is not requested to present a separate response for this requirement.)

3. Prior Authorization (60 Min/10:15am-11:15am/Day 1)

Requirement #3.1 Capture, Edit, Store and Control

- ☐ Demonstrate how system captures, controls, assigns, tracks, and stores hard-copy and electronically submitted authorization requests and how users view imaged/transmitted authorization requests and the associated attachments/documents
- ☐ Demonstrate interfacing with recipient eligibility and benefit package information; include the ability to apply different prior authorization start, re-check, and denial criteria based on program eligibility and capability to suspend request for specified period to re-check eligibility and/or eventually deny requests as applicable
- ☐ Enter three or more procedures or services, each of which are being requested/authorized for various, multiple health care providers
- ☐ Demonstrate the ability to capture and maintain both requested service amounts (units and/or dollars) and authorized service amounts (units and/or dollars)
- ☐ Show screen entry edits that demonstrate validation capability such as invalid recipient, provider, etc
- ☐ Demonstrate the ability to:
 - Search, view, and edit the services, units, provider(s), dates and fund details
 - Add additional line items with codes and dates
 - Reflect partial denial and/or partial approval
 - Assign a termination date prior to the original end date for some services while leaving other service(s) open
 - Show the history of the changes via an on-line audit trail of modified information and demonstrate change to PA status on line-item level
- ☐ Show claims processed appropriately (i.e. denial and/or approval to pay at rate/unit of service) based on above modification
- ☐ Demonstrate the ability to draw down or add back units/dollars and associate claim CCN/ICN data of all claim activities affecting prior authorization record data
- ☐ Populate a 278 response and/or vendor web portal response with prior authorization record information after final determination
- ☐ Demonstrated mass update capability for the following scenario: A procedure code changed. Some claims were processed using former code. Future claims need to be processed using new code

Requirement #3.2 View and User Access

Provide a pre-populated 278 electronic prior authorization transaction and a non-electronic i.e. paper, fax, telephonic) prior authorization for the demonstrations below. Based on the prior authorization record provided, continue the demonstration with the following scenarios:

- Demonstrate hyperlink from prior authorization file/record to auto-generated approval and denial notices to requesting and assigned providers, case managers, and recipients and/or other associated letter(s)/notice(s)
- Demonstrate the capability to query the prior authorization data files based on the following: type of authorization, requestor, recipient name or ID, prior authorization number, specific requesting or rendering provider or provider type, staff involved, service codes with or without modifiers, dates prior authorization request was received, returned for additional information, routed, processed, or other data elements, etc.
- Demonstrate viewing of prior authorization record status and other information via vendor's web portal by using requesting or rendering provider and/or recipient

Requirement #3.3 Ease of Use

Evaluator: Score this demonstration for the ease of use (i.e. menu systems, window taps, availability of help screens) access, display, navigation and efficiency observed during the scenario. (The offeror is not requested to present a separate response for this requirement.)

4. Reference Databases (60 Min/11:15am-12:15am/Day 1)

Requirement #4.1 Data Management & User Access

- ☐ Demonstrate the ability to enter codes for diagnosis, procedure, NDC, etc., and demonstrate the ability to view, add and update.
- ☐ Show how the system maintains procedure code, diagnosis code, NDC code and revenue code data sets and display the data elements (i.e. procedure/item/drug codes, diagnosis code, descriptions, errors, edits, service sites, payment methodology types, edit criteria, dispositions, status, taxonomy codes, staff identifiers, code set source, date specificity, rates, etc.)
- ☐ Demonstrate the storage of multiple date-specific reference segments per procedure/diagnosis/NDC/revenue code
- ☐ Demonstrate the ability to enter date sensitive rate/pricing information, i.e., minimums/maximums
- ☐ Demonstrate the on-line inquiry (i.e. by code, code type, partial description of diagnosis, procedure/item/drug name, error or remark content, etc). and report request functionality.
- ☐ View historical records of change and related change dates
- ☐ Show the capability to perform mass update, i.e. annual rate changes such as RBRVS

Requirement #4.2 Error Text and Edit/Audit Criteria

Demonstrate how the Reference Subsystem supports the following claims adjudication editing and auditing functionality

- ☐ Demonstrate system parameters, showing the user's ability to create new edit and audit rules, on-line, real-time
- ☐ View audit and edit disposition elements, demonstrating the on-line capabilities of disposition changes, history of changes, and real time service limit history
- ☐ Demonstrate date effective audit parameters including the ability to view business rule change history and modify the on line audit criteria "on review" or other special indicators (i.e. surgery indicator, ASC grouper, drug class, co-payment by-pass indicator) for procedure/drug/item, diagnosis, taxonomy, other HIPAA code set values:

Requirement #4.3 Ease of Use

Evaluator: Score this demonstration for the ease of use (i.e. menu systems, window taps, availability of help screens) access, display, navigation and efficiency observed during the demonstration. (The offeror is not requested to present a separate response for this requirement.)

5. Pricing, Claims Processing, and Payment (90 Min/1:45-3:15/Day 1)

Note: Please include core functionality as required below and discuss/demo variations to that core functionality that is based on differences in claim invoice type (i.e. UB, HCFA, POS//line vs. document/header levels//)

Requirement #5.1 Electronic Transactions Management and Control

- ☐ Demonstrate how the system prescreens electronic transactions (including claims) to determine HIPAA compliance before acceptance into the main system. Show examples of positive acknowledgement and negative response (such as TA1/997). Include timeframes between receipt of transaction and notification/response to submitter for all modes of transmission
- ☐ Demonstrate how the system electronically assigns a unique control number to each claim and/or other transactions and how it links the electronic transactions to its attachment documentation
- ☐ Demonstrate the electronic transaction control functions including balancing procedures.
- ☐ Demonstrate how the system will prevent duplicate files from being entered
- ☐ Demonstrate how the files are accounted for to prevent lost files
- ☐ Demonstrate how and where the data transmitted on inbound transactions is captured and reformatted for viewing in a usable format on a user's desktop
- ☐ Demonstrate and discuss the testing environment and process for electronic transactions (including claims) submissions from new submitters through technical assistance to final authorization for live/production submissions

Requirement #5.2 Edits, audits and business rules

- ☐ Demonstrate different types of audits such as history related, timely filing limitations, contraindications, code set relationships, once in a lifetime, other service limitations, and claim characteristics (including program eligibility, lock-in, and TPL coverage).
- ☐ Show the capability to audit claims across claim lines regardless of claim type as appropriate as follows:
 - Service limits
 - Coverage restrictions/variations across provider type/taxonomy,
 - Recipient eligibility/benefit program, age, gender,
 - History related,
 - Contraindications
 - Code set relationships
 - Claim characteristics (i.e. lock-in, TPL coverage, etc)
 - Payment limits
 - Concurrent care
 - Prior authorization restrictions
- ☐ Show that all applicable Claim Control Numbers (CCN) are viewable when multiple claims are edited/evaluated during the editing/adjudication process (i.e. duplicates,

- lifetime/other service limits, early refill, concurrent care, visit frequency, incidental, mutually exclusive, re-bundling, etc.) and show the ability to reference the CCNs on claim history and a remittance advice (RA) statement
- View payment limit audits that apply across claim lines, regardless of claim type; include potential concurrent care auditing capability (i.e. inpatient to LTC to home health to residential care)
 - Demonstrate service limit flexibility such as
 - Application by units and dollars,
 - Various periodicity schedules,
 - Capability to track and view amounts used vs. available,
 - Capability to cutback to remaining available units/dollars resulting in partial payment/partial denial, and
 - Capability to exceed service limits based on presence of valid authorization
 - Demonstrate the ability of the system to define pricing edits based on:
 - Combinations of a hierarchy of multiple modifiers on a claim,
 - Other such hierarchical pricing/comparative rate pricing or other editing among other characteristics such as
 - Specific services,
 - Provider,
 - Provider groupings,
 - Benefit packages, and
 - Multiple fee schedules.
 - Demonstrate the ability to retain and display the claim record with all the business rules that were applied to the adjudication and pricing of the claim. Show the resulting update to claim history, other appropriate files (PA units/dollars limits, lifetime services, etc), and on-line financial files (inclusion of check/warrant number, date of payment, amount paid, etc) after claims processing and payment cycle activities
 - Demonstrate the business impact analysis testing functionality of any new or changed business rules including changes to reimbursement methodology

Requirement #5.3 Adjudication Functionality

- View the claim status (e.g. paid, suspended, denied, adjusted, etc.)
- Show on-line claims resolution and correction process and how various pend locations are assigned. Include the following:
 - The capability to route and reassign claims within/among the same and/or multiple locations,
 - The ability to review claim data/imaged claims/attachments,
 - How pending claims are resolved toward final resolution/adjudication
 - How the system identifies and tracks the identity of the person who resolves suspended claims at all locations including those who authorize exception to rule or policy payments, and
 - The ability of the system to reprocess claims previously processed in error and/or claims previously denied that have been granted reconsideration for approval
- Show how the system processes co-payments/cost-sharing at the claim line level and at the claim header level

- Show how the system assigns an account code for designating a funding source among various parameters for which the funding sources criteria is determined; show that the claim will pend if the funding source can't be determined
- Show a processed claim that is not for a Title XIX or XXI recipient, particularly for services, recipients or providers who have not been traditionally processed by the MMIS

Requirement #5.4 Pricing Functionality

- Demonstrate the ability of the system to document in claim history the pricing methodology applied by line item
- Demonstrate the ability of the system to price appropriately based on:
 - Hierarchy of multiple modifiers, i.e. assistant surgeon, multiple procedures, bilateral procedures, etc.,
 - Hierarchical pricing/comparative rate pricing, i.e., "lesser of" calculations between various methodologies (i.e. AK rate vs. Medicare rate, Avg. Wholesale price vs. Avg. Mfgr. Price,)
 - Cut-back, i.e. length of stay, remaining available units/dollars
 - Other characteristics such as
 - Specific services, i.e., unlisted procedures,
 - Provider, i.e., midlevel versus preceptor, case management fee,
 - Regional differentials,
 - Place of service,
 - Benefit packages, and
 - Multiple fee schedules and multiple methodologies (RBRVS, Medicare rates, percentages, length of stay, etc)
 - Variations in rate for service dates; suspends if rate is not on file
 - Retroactive rate changes and policy changes/limitations
- Price a claim at a base amount and account for payment differential (up or down) based on recipient benefit program, provider type specialty/taxonomy, and region/location showing the base amount separate from the differential amount
- Demonstrate how the system selects the correct value (price) based on the appropriate reimbursement methodology, other differentials, effective date of the price and the date of service on the claim
- Demonstrate how a claim system price may be overridden with a manual price
- Demonstrate how an alternate pricing method may be selected
- Demonstrate the use of the Length of Stay file and Prior Authorization File information to determine claim approval and payment
- Price a drug using the NDC and units submitted on a non-pharmacy claim in an 837 transaction and capture for use in drug rebate and drug utilization review processes
- Edit and price institutional claim using line level HCPCs and units similar to those used for professional services (i.e. lab services validity, coverage, fee schedule reimbursement, and subject to code relationship evaluation re: bundling)
- Demonstrate how the system deducts recipient co-payments for specified services.
- Demonstrate how the system accommodates all-inclusive encounter rate payment on multiple line item claims within a single claim document

- Demonstrate how the system accommodates payment at individual negotiated provider-specific and recipient-specific rates for services that may or may not have rate information otherwise

Requirement #5.5 Adjustments

- Show the system's ability to maintain original claim data/transactions and subsequent adjustments to that claim data via adjustment and void transactions; highlight the system's tracking and processing capability and identify any differences between handling paper vs. electronically submitted adjustments/voids; include use of and linkages among the various claims control and financial control numbers
- Show a re-priced and adjusted paid claim based on a subsequently submitted/received adjustment request (include both debit and credit in the examples) and tie to provider remittance advice, 1099, and accounting code
- Demonstrate the system's ability and range of selection or parameters for mass adjustment criteria, including the ability of the user to review and modify that criteria prior to the mass adjustment being released

Requirement #5.6 Remittance Advice/Budget Monitoring Functionality

- Show how both the hardcopy paper and electronic RA includes all required financial transactions such as:
 - The RA reporting garnishments, cost settlements, recoupments, etc.
 - Provider's past balance and current balance
 - Financial summary in addition to claims transaction details
- Show the capability to include informational messages and flexibility in use of format, type style, symbols, etc. in messages. Show how RA messages files are maintained.
- Show the capability to enter, track, maintain, and expend budgeted funds by appropriation, account, and collocation code.
- Show security/safeguards in use regarding electronic fund transfer (EFT) account number information including the capability to restrict access to EFT account information to specific users

Requirement #5.7 Ease of Use

Evaluator: Score this demonstration for the ease of use (i.e. menu systems, window taps, availability of help screens) access, display, navigation and efficiency observed during the demonstration. (The offeror is not requested to present a separate response for this requirement.)

6. Financial Services (45 Min/3:30-4:15/Day 1)

Requirement #6.1 Account Coding and General

- ☐ Create a new line of account coding (i.e. adding collocation codes and criteria to the collocation code table) and assign an effective date to the line of account coding
- ☐ View and edit the data, including collocation code that is used to generate a line of account coding. Demonstrate the business process logic, data elements and events that determine account coding
- ☐ Demonstrate that all financial transactions are edited for validity and/or reversed; include edits to prevent duplicate transactions from being entered
- ☐ Demonstrate how claims processed, adjudicated, adjusted, and voided in the MMIS are given account codes and how the account code(s) are retained for each claim detail line item at the line level
- ☐ Demonstrate how to retroactively re-assign account codes to a payment to reflect a change in recipient eligibility

Requirement #6.2 Accounts Receivable

- ☐ Demonstrate the establishment and maintenance of an A/R account and line item detail. Create a new A/R account with an associated reason code for the following event: audit recovery. Show the capability to create an A/R account for the following: drug rebate, COB recovery, TPL settlement, write-off, and overpayment.
- ☐ Demonstrate the provider refund process including the capability to draw down refunds through claim-specific transactions, payouts and through gross level transactions.
- ☐ Demonstrate how, within the system, a specific refund or adjustment/void may be associated with specific claims
- ☐ Demonstrate how a third party refund can be drawn down through claim-specific transactions and through gross level transactions without affecting the provider's 1099 amount or the provider's remittance advice

Requirement #6.3 Federal Taxes

- ☐ Demonstrate the provider 1099 process by showing the calculation of 1099's based on Federal Employee ID Number (FEIN), social security number, or other tax ID number and show how all payments to the same tax ID are accumulated on a single 1099, i.e. all payments, cost settlements, annual checks, adjustments, and recoupments

Requirement #6.4 Accounts Payable

- ☐ Demonstrate the creation and maintenance of an A/P account e.g. a lump sum cost settlement payment to a provider
- ☐ Demonstrate the capability to set a start date for recoupment and a rate of recoupment for a State requested manual warrant

- ☐ Demonstrate split payments between a provider and third party (e.g. a lien holder) and production of separate checks for each
- ☐ Create an outstanding account receivable for a provider. Demonstrate how excess funds associated with claims adjustments are released to a provider and how the outstanding receivable balance is processed against the released funds
- ☐ Demonstrate how a lien and assignment information is used to direct and split payment to the provider and lien holder
- ☐ Demonstrate the follow-up on an outstanding warrant and the capability to delete, adjust, and correct transactions entered in error

Requirement #6.5 Ease of Use

Evaluator: Score this demonstration for the ease of use (i.e. menu systems, window taps, availability of help screens) access, display, navigation and efficiency observed during the demonstration. (The offeror is not requested to present a separate response for this requirement.)

7. Third Party Liability (45 Min/4:15-5:00/Day 1)

Requirement #7.1 Processing and Adjudication

- ☐ Demonstrate the process for identifying claims with retroactive TPL coverage
- ☐ Demonstrate the process for identifying all conditions where the claim information contains TPL information not present on the TPL resource database

Demonstrate the processing logic and outcome of adjudicating Medicaid claims using TPL carrier information

- ☐ Apply the following to the adjudication of a Medicaid claim
 - A third party payment amount,
 - A third party deductible amount,
 - A third party patient liability amount,
 - A third party contractual allowance

Requirement #7.2 Administration of Recipient TPL Resource Data

- ☐ Display a recipient Medicare data record (i.e. policy #1) and data elements. Add additional TPL data records (i.e. policy #2-4) to the recipient record
- ☐ Display the hierarchy of policy #1 (above) and apply a different hierarchy to policies #2-4 (above)
- ☐ View an update or addition to recipient TPL information that resulted from
 - An electronic eligibility response (i.e. HIPAA 270/271 transaction) from an insurance company, and
 - A claim with TPL coverage information present that is not found on the recipient file

Requirement #7.3 Viewing and Editing a TPL Record

- ☐ View and update the recipient TPL benefit package
- ☐ View and update the subscriber information to include demographics and relationship to recipient
- ☐ View and update the history of recipient's type of policy and coverage, including identification of services covered, effective and termination dates and coinsurance and deductible amounts
- ☐ View and update the recipient's history of coverage dates
- ☐ View and update the recipient's history of services covered
- ☐ View and update the recipient's history of coinsurance and deductible amounts
- ☐ View and update the subscriber's information
- ☐ View and update the type of insurance coverage for each policy
- ☐ View and update pharmacy benefit manager's BIN, and Processor Control Numbers. Display other data elements for billing pharmacy TPL
- ☐ View and update insurance cancellation data

Requirement #7.4 Administration of Insurance Carrier File

- ☐ Create on-line, a new record for an insurance carrier with a unique identifier. Display the data elements
- ☐ View and update benefit package information for insurance carrier record
- ☐ View and update insurance carrier claims address, carrier name, contact person, and customer service telephone number
- ☐ View and update insurance carrier claims filing limits
- ☐ Display the National Common Carrier ID data element for each carrier file
- ☐ Demonstrate the mass update capability to update the TPL carrier data and corresponding TPL resource data when a TPL carrier changes its name, policy data, or other carrier data

Requirement #7.5 Ease of Use

Evaluator: Score this demonstration for the ease of use (i.e. menu systems, window taps, availability of help screens) access, display, navigation and efficiency observed during the demonstration. (The offeror is not requested to present a separate response for this requirement.)

8. Pharmacy Point-of Sale (80 Min/8:00am-9:20am/Day 2)

Requirement #8.1 Recipient Eligibility and Benefit Verification

- ☐ Demonstrate the verification of recipient eligibility for a specific service on a specific date
- ☐ Demonstrate verification of a recipient's benefit package. Include a recipient with a single plan and a recipient with multiple plans. Explain the benefit package hierarchy process
- ☐ Demonstrate the identification of pharmacy service restrictions appropriate to a recipient

Requirement #8.2 Provider Eligibility Verification

- ☐ Demonstrate verification the provider is eligible (enrolled in State program) and approved for participating in POS. Show the provider's authentication and certification for access. Perform the verification for both the prescribing and dispensing provider. Demonstration should include processing NCPDP, NPI, taxonomy, and crosswalks, as applicable

Requirement #8.3 Prior Authorization

- ☐ Access the online POS system indicating whether it is stand alone and interfaced to the MMIS or an integrated part of the MMIS
- ☐ View a prior authorization file, including historical information on the authorization and user comments
- ☐ View a list of all drug related authorizations for a recipient and then view an authorization from the list
- ☐ Create an authorization which is not related to a specific claim, which will allow the recipient to receive a medication in any pharmacy. Show various ways it can be linked to the drug (e.g. NDC, GSN, HICL SEQ#). Edit the authorization to restrict it to a specific pharmacy
- ☐ Create an authorization from a denied claim (denied for lack of authorization) for the particular NDC billed
- ☐ Edit an existing authorization, limiting it to 1 unit per day, a 7 day supply, and a maximum reimbursement of \$20.00
- ☐ Create a business rule requiring a PA that allows payment without the PA if the claim shows a predefined specific diagnosis, the diagnosis is indicated in the recipients disease states, or the recipient's historical claims include the diagnosis, drug, or diagnosis related procedure
- ☐ Identify a drug that requires a PA for all claims for that drug. Allow the drug to pay without need for authorization when the recipient has paid claims in history for another appropriately related drug
- ☐ Choose a name brand drug requiring PA. Enter data in the system that allows this drug to pay without the need for authorization when the recipient claims history includes paid claims for a generic drug in the same GSN

Requirement #8.4 Pharmacy Claims Capture and Adjudication (including ProDUR)

- ☐ View a history claim with the "standard" view

- Enter a “clean” NCPDP 5.1 pharmacy claim for on-line, real time processing that results in payment. Show resulting paid amount and pricing method used
- Enter a claim that denies. The denied claim must show what the paid amount would have been if the claim had paid and the pricing method used
- While creating a new claim, view the following screens. Repeat the same views from a finalized history claim: Recipient file, provider file, Drug file, Authorization file, Related claims history
- Define business rules to deny claims based on data elements from the drug file, recipient file, filling pharmacy provider file, prescribing physician provider file, history claims for the same recipient and associate the denials with NCPDP rejection reasons. Include an override in one which will allow claim payment when “1C’ or “1D” is present in the DUR Outcome field
- Create a business rule when DUR Outcome code “1C” or “1D” is submitted. Rule should check history for the most recent matching claim (same recipient, drug in same GCN), and return an NCPDP reject if the value of quantity divided by the days supply on the claim in history is equal to the same value from the current claim
- Demonstrate the methodology used to validate that step therapy has been provided when appropriate, including a series of questions to determine if previous steps using less costly therapeutic substitutes have been tried before dispensing more costly medicines
- Demonstrate override of a PRODUR message by a provider and/or by able to comment on the message according to NCPDP standards
- Create a business rule that defines conditions under which a paid claim is returned with a user defined message not associated with a rejection
- Create a secondary message to be returned to the submitting pharmacy when receiving a specific NCPDP rejection
- Edit business rules to return an NCPDP reject code without denying the claim
- Demonstrate a claim reversal, void, and adjustment
- Demonstrate processing of a partial fill
- Demonstrate processing of a multi-ingredient compound prescription with dispensing fee ingredients and compounding fee paid

Requirement #8.5 Retro-DURS

- View the RetroDUR therapeutic criteria file and show the capacity for at least thirty therapeutic classes and at least three thousand exception criteria standards of the highest significance used to identify specific pharmaceutical use problems
- Create and display a RetroDUR ranking report showing the top 10 prescribers for a particular drug and show where a prescriber ranks compared to his peers. Create and display the related prescriber profile. Display how this provider’s prescribing pattern falls outside normal provider patterns
- Create, display, and view on-line a RetroDUR recipient profile. Profile should include: quantitatively significant value or severity rating (on chosen criteria), total number of prescriptions, total dollars of prescriptions, outpatient dollars and services, inpatient dollars and services, exceptions, and the specific providers causing exceptions
- Demonstrate how the on-line case tracking and letter generation system will allow DUR staff to indicate profiles requiring intervention, track the intervention, and customize a standard letter for use

Requirement #8.6 Drug File Functionality

- ☐ View a drug “master file” that contains First Data Bank (FDB) data (or similar) and drug data elements including present and historical pricing information associated values
- ☐ Define which elements of this file will appear in a standard view of a drug file. Display the standard view
- ☐ Make a change to a data element normally based on FDB information. Show both how the change could be permanent (not altered by future drug file updates) and how it could be temporary (continues to accept changes when drug file is updated)
- ☐ Create a new data element in a Drug file which is not part of the FDB record
- ☐ Demonstrate ability to set drug limits based on: quantity (per claim, per time span and per lifetime); days supply (per claim, per time span and per lifetime); daily does (min/max); gender; maximum reimbursement (per claim, per time span, and per lifetime); age (min/max and/or multiple specified ranges); number of fills; acceptable diagnosis codes; etc.
- ☐ Change one of more pricing variables (AWP, State Max Acquisition Cost, Fed Max Acquisition Cost, number of manufacturers) on the drug file and demonstrate the resulting change, the current applicable pricing source and the reimbursement per unit.
- ☐ Show a drug with a changed NDC demonstrating how the system tracks the change. Show an NDC that was, at one time, one drug and later re-used with a different drug name

Requirement #8.7 Exchanging Data between the POS and MMIS

- ☐ Demonstrate how information maintained in the POS is reconciled with information maintained in the MMIS
- ☐ View and compare data in the POS to the data in the MMIS as follows: a recipient record, a pharmacy record, a prescriber record, a recipient’s benefit package record, COB record, reference/formulary record, PA record, and claims pricing record

Requirement #8.8 Ease of Use

Evaluator: Score this demonstration for the ease of use (i.e. menu systems, window taps, availability of help screens) access, display, navigation and efficiency observed during the demonstration. (The offeror is not requested to present a separate response for this requirement.)

9. Drug Rebate (40 Min/9:20am-10:00am/Day 2)

Requirement #9.1 Drug Rebate Database

- Display the following data elements on the drug manufacturer database: elements for processing drug rebate invoices including NDC level data, manufacturer agreement elements, drug rebate exemption elements, supplemental agreement elements, unit rebate amounts and other elements necessary for Veterans Act 1993, NDC termination and DESI flag elements, public health drug rebate agreement elements; and federal T-Bill interest rate data for calculating overdue interest charges
- Demonstrate the query and reporting of Drug Rebate information by users on an isolated basis or integrated with data from other MMIS tables and databases

Requirement #9.2 Invoicing

- Create an invoice identifying rebate eligible claims and withhold invalid claims from invoicing (i.e., the 340(b) program) for:
 - Medicaid recipients only;
 - Rebate eligible providers;
 - Rebate eligible manufacturers;
 - Rebate eligible products
- Generate and display a rebate invoice for a drug manufacturer indicating the following: Manufacturer's Name and Address, State Name, National drug Code, Drug Name, Rebate Amount per Unit, Total Units Reimbursed, Total Rebate Amount Claimed, Number of Prescriptions, Total Reimbursed Amount, Correction Flag (0 unless a correction to a previously invoice NDC) Quarter Covered (based on the original paid date of the claim).
- Show the capability to generate a rebate invoice
 - that references the records corrected in the requirement above and show how they are reported on the invoice,
 - that combines claim information for drugs dispensed in a physician's office and from a pharmacy, and
 - with a supplemental rebate and show how the rebate is calculated
- Demonstrate the following:
 - how drug rebate information is updated when a claim is updated in MMIS,
 - the ability to manually enter corrections to an invoice based on resolution of disputes or other factors, and
 - the ability to flag and change a manufacturer's invoice and times on the quarterly CMS tape before each item is sent

Requirement #9.3 Accounting

- Set up the Account Receivables at the NDC level for one previously generated invoice, one of which is for
 - late penalty interest receivable, and
 - supplemental rebate invoice
- Display and view the flag or other data element on unpaid invoices

- ☐ Demonstrate the tracking and accounting process for: manufacturer changing their unit rebate amount; posting payments (include a single payment applied to multiple manufacturer accounts); moving credit balances to current invoices; calculating and adjusting interest; recording and tracking disputed NDC's and manufacturer correspondence

Requirement #9.4 Dispute Resolution

- ☐ Demonstrate the online accessibility of claims with NDC level detail for manufacturer disputed items

Requirement #9.5 Ease of Use

Evaluator: Score this demonstration for the ease of use (i.e. menu systems, window taps, availability of help screens) access, display, navigation and efficiency observed during the demonstration. (The offeror is not requested to present a separate response for this requirement.)

10. Data Warehouse/Decision System Support (60 Min/10:15am-11:15am/Day 2)

Demonstrate data warehouse query environment and the tools that meet ad hoc query requirements. Demonstrate different tools for different user access/capability/security levels.

Requirement #10.1 General Demo

- ☐ Show the user manual, help functionality including context sensitive application assistance, and look up features
- ☐ Demonstrate the ability to invoke standard data validity checks. Write a query using incorrect data format/types in different fields and show the message that users receive
- ☐ Show the library/catalog of standard reports, frequently used queries and other query optimization tools; demonstrate capability for users to modify reports, and add to the list and establish limits for other users such as 'read only' access and include informational notes/messages
- ☐ Demonstrate how the query optimization tool will ensure the most efficient and highest performance of data warehouse functions
- ☐ Run any query from the catalogue of previously generated queries and specify two different and "as of date" parameters
- ☐ Demonstrate how query results can be accessed and reviewed by multiple users
- ☐ Demonstrate how a user can run two or more queries at the same time
- ☐ Select and show a MARS report that reflects claims processing analysis. Demonstrate a query that produces the same results as three separate values shown on the MARS report
- ☐ Demonstrate the generation of reporting based on statistical evaluation
- ☐ Demonstrate the generation of complex multi-series graphs with at least three axis, independently controlled axis numbering, and unique labeling.

Requirement #10.2 Scenario A

- ☐ Create a query and display the resulting output by recipient for all claims paid for one year and include all claim statuses (e.g. denied, adjusted, and final paid claims) in tabular and graphic presentations
- ☐ Demonstrate linkage to original recipient identifier when multiple identifiers exist
- ☐ Demonstrate inclusion of claims for all benefit packages the recipient was eligible
- ☐ Sort data by both separate and multiple data fields
- ☐ Perform unduplicated count of primary diagnoses for the recipient; sort descending by dollars paid for each unique diagnosis
- ☐ Drill down and generate a subset of data to identify universe of claims with dates of service within 30 days (+/-) of an inpatient service
- ☐ Show ability to save results to various outputs (e.g. Excel, CSV, XML) and mediums (e.g. print, file, magnetic)
- ☐ Produce both a tabular report representation of the results;
- ☐ Generate documentation from this query showing query parameters and data elements used, and the sorting and grouping applied.

Requirement #10.3 Scenario B

Show the following results based on a statistically valid random sample of emergency room claims:

- ☐ Analyze by adult (age 21+) vs. children (age up to 21) and group by diagnosis within each
- ☐ Include basic calculations (unduplicated counts of recipients, sum encounters, dollars billed/paid, compute averages, minimums/maximums, subtotals/grand totals, percentages) and simple to complex cross-tabulation
- ☐ Demonstrate a cross-table (data cube or OLAP table) with the following (or similar) dimensions and measures from source data:
 - Dimensions: Service Date (FFY, SFY, CY, Qtr, Mo, Day), Recipient Name, Recipient Program Code, Recipient Match Code, Recipient Age, Provider Name
 - Provider Type Measures: Amount Billed, Amount Allowed, Amount Paid by Third Party, Amount Paid by Recipient, Amount Paid by DHSS
 - Demonstrate how a user would put one or more dimensions on either axis and one or more measures in the summaries
- ☐ Export graphic representations of results/import to MS PowerPoint and show/view slides(s)

Requirement #10.4 Scenario C

- ☐ Import an Excel list of six instate physician identification numbers and use it to generate a data subset which includes provider ID number, provider name, city/region/location information, the total amount paid and total number of claims adjudicated during the prior State fiscal year
- ☐ Produce reports including a map and other graphic representations of the data; include header/footer/page numbers on reports

Requirement #10.5 Scenario D

- ☐ Create a query and the result that shows a claim that has been denied, resubmitted and adjusted showing the chain of the claim from beginning to final paid claim

Requirement #10.6 Ease of Use

Evaluator: Score this demonstration for the ease of use (i.e. menu systems, window taps, availability of help screens) access, display, navigation and efficiency observed during the demonstration. (The offeror is not requested to present a separate response for this requirement.)

11. Healthcare Utilization Review and Quality Assurance (60 Min/11:15am-12:15am/Day 2)

Requirement #11.1 SURS Control File/Parameters

- ☐ Show that SURS contains or has the capability to contain data from the recipient, provider, prior authorization, TPL, reference, and claims files
- ☐ Demonstrate the creation of SURS peer groups as follows: (1) Rendering pediatricians with a prior year billed amount less than \$20,000, (2) Recipients in lock-in under age 21.
- ☐ Display a peer group summary report and one provider profile report that collects data as follows: Provide an analysis of physicians performing gastric bypass surgery including volume, number of denied prior authorizations, number of denied claims, and average dollars paid. Please rank most frequent top 20 edits hitting these claims. Please explain report values. These reports must include exception processing with the identification of exceptional activity
- ☐ Demonstrate the ability to show, print, and record parameters used in the production of the "gastric bypass" items above
- ☐ View a list of ranked providers that are found to be exceptional, and place in ranked order.
- ☐ Demonstrate a "forced" recipient to profile. Demonstrate a "suppressed" provider from exception processing
- ☐ Demonstrate geographical groupings used to create peer groups and report items
- ☐ Demonstrate the ability to vary time periods for SURS reporting purposes and how reports may be stored on a daily, monthly, quarterly, or other basis
- ☐ Demonstrate how data, parameters, and reports developed by SURS staff can be secured from other State users of the SURS system

Requirement #11.2 Recipient Care Management Program (Lock-In)

- ☐ Demonstrate setting the Care Management Program indicator on the MMIS recipient database for a recipient
- ☐ Record Care Management data, add additional provider types to a Care Management record, and allow overlapping Care Management segments for the same service
- ☐ Demonstrate that a recipient is reassigned a different Care Management provider from the original provider

Requirement #11.3 Recipient Explanation of Medical Benefits (REOMB)

- ☐ Demonstrate that different return addresses may be used for different types of REOMB's, i.e. one return address for monthly REOMB's and a different return address for targeted REOMB's.
- ☐ Demonstrate that confidential services are excluded from REOMB's
- ☐ Demonstrate the capability to produce targeted REOMB's. Explain the parameters available for selecting the sample. Demonstrate how user defined test is entered to the REOMB letter

Requirement #11.4 Payment Error Rate Measurement (PERM)

- ☐ Generate and display a claims sample list and control report after the last processing cycle of a month
- ☐ Generate and display a recipient history profile for three claims selected from the sample above

Requirement #11.5 Ease of Use

Evaluator: Score this demonstration for the ease of use (i.e. menu systems, window taps, availability of help screens) access, display, navigation and efficiency observed during the demonstration. (The offeror is not requested to present a separate response for this requirement.)

12. Managed Care (40 Min/1:45-2:25/Day 2)

Requirement #12.1 Recipient Enrollment

- ☐ Demonstrate the processing logic, edits, and outcome of enrollment of a recipient to a PCP. Processing logic should use the following criteria: Recipient must be eligible for the PCP program; the PCP must provide service in the area approved for the recipient; the PCP must have availability in the service zip code area and service area; the PCP must be within its capacity for that service area
- ☐ Demonstrate the automatic assignment of a recipient to a PCP.
- ☐ Display an example of the electronically transmitted enrollment notification roster to the PCP of recipient enrollment activity including all data elements contained in the notice

Requirement #12.2 Provider Recruitment and Enrollment

- ☐ View and edit a PCP provider enrollment file, status, geographical locations served, associated dates, maximum recipient enrollment, and alternate PCP's (when PCP is on vacation or is otherwise unavailable). View cross reference of recipients enrolled with the PCP and demonstrate that maximum enrollment is not exceeded
- ☐ View history case management fee payment information, month of coverage, payment reference number, date paid, and disposition of payment (paid or denied)

View and edit a PCP:

- ☐ With different benefit packages
- ☐ Serving recipients with different eligibility criteria
- ☐ Funded from different and/or multiple sources
- ☐ Capacity to accept new Medicaid recipients
- ☐ Service areas

Requirement #12.3 Claims Processing

- ☐ Demonstrate the processing logic and outcome of calculating the recipient per member per month case management fee
- ☐ Demonstrate the processing logic and editing of a claim paid from a PCP provider
- ☐ Demonstrate the processing/edit logic that prevents duplication of monthly case management fee payment for the same recipient. Edit logic should include consideration of type of service, provider type, and benefit package
- ☐ Demonstrate the processing/edit logic that prevents services rendered by a provider other than the PCP or the PCP referred provider
- ☐ Inquire and view payment history of the case management monthly fee(s) for a recipient and a provider. Demonstrate the link of claims for referred service to the PCP

Requirement #12.4 Quality of Care Monitoring

- Demonstrate the capacity for SURS to report on PCP as a class group, and types of PCP's within the overall PCP group by geographic region
- Demonstrate the capacity for SURS to report on enrolled PCP recipients as a class group, by geographic region, aid category, and disease category
- Display and view a PCP provider profile in which PCP activity and non-PCP activity is displayed for the same provider in a single profile

Requirement #12.5 Reporting

- Display and view an example report that produces a comparative analysis report of the number of recipients eligible to choose PCP vs. the number of recipients who are assigned through the auto-assignment process
- Query the system to select and report: all recipients with a PCP provider; all participating PCP providers in region/area

Requirement #12.6 Ease of Use

Evaluator: Score this demonstration for the ease of use, access, display, navigation and efficiency observed during the demonstration. (The offeror is not requested to present a separate response for this requirement.)

13. Tracking (50 Min/3:30-4:20/Day 2)

Requirement #13.1 Case Tracking

- ☐
- ☐ Create a record to track a provider call center contact in an on-line case tracking system. Display fields which are pre-populated by entering a provider identification number or other provider identifier. Record a contact/call reason and action taken. Record multiple contacts/calls reasons and actions on the same record
- ☐ Create a record to track a recipient call center contact in an on-line case tracking system. Display fields which are pre-populated by entering a recipient identification number or name or other identifier. Record a contract/call reason and action taken. Record multiple contacts/calls reasons and actions on the same record
- ☐ Enter a submitted provider enrollment application in an on-line case tracking system. Display fields which track the status of the enrollment application from receipt to resolution, and if applicable, entry into the MMIS
- ☐ Enter a Recipient Care Management Program case in an on-line case tracking system and display fields which track the status from initiation to resolution
- ☐ Display the tracking of a SURS case and its attached documents, i.e. Access, Excel, Word documents.
- ☐ Demonstrate the add/delete/change function for tracked items
- ☐ Demonstrate setting the security level for four different levels of security
- ☐ Demonstrate the capability to download data from reports into the case tracking record or link reports to the case tracking record. Demonstrate the capability to export case tracking data to spreadsheets, databases, and word processing packages
- ☐ Select and display a provider contact. Assign a priority to the contact. Repeat assigning a priority to a different provider contact. Display the contact priority levels list
- ☐ Create a follow-up date on a PCCM case and display the notification sent to staff when follow-up is required
- ☐ Demonstrate, create and display and query for the following; the number of open calls for a specific contact reason. Display a list of lines extracted for this query, the totals data and sort the report by action taken

Requirement #13.2 Issue Tracking

- ☐ Demonstrate the tracking of an issue (i.e. DDI change, maintenance change, enhancement modification, or addition) in an on-line tracking system as follows:
 - Create an issue, enter it into the Issue Management System, set a priority, and show the capability to track from initiation to resolution
 - View and display an issue record, including status, report and coding changes, attached test results, and record of notes from State and Contractor staff
 - Create an issue record in which a notification is sent to another party based on selectable issue criteria. Demonstrate the receipt by other party
 - Assign an issue to one area then reassign it to an individual in another area
 - Display and view on-line an issues list for each issue type. View and explain data elements.

- View and display examples of at least two reports and explain data elements
 - Create an issue and enter it via the web portal, independent of the network
 - Display a report of issues grouped by severity, age, type impacted area, owner
 - Display a report and graph demonstrating issue count totals over time based on issue severity and average age of issues for major areas of the project
- Demonstrate the tracking of an issue from initiation through closure, the required documentation, and approvals
 - Demonstrate the tracking of a quality control issue such as a performance measure from the automated performance monitoring system that fell below a tolerance threshold for three months. Display fields which track this quality control issue from receipt to resolution in an on-line tracking system

Requirement #13.3 Ease of Use

Evaluator: Score this demonstration for the ease of use (i.e. menu systems, window taps, availability of help screens) access, display, navigation and efficiency observed during the demonstration. (The offeror is not requested to present a separate response for this requirement.)

14. Web Portal (50 Min/2:25-3:15/Day 2)

Requirement #14.1 Web Portal

- ☐ Demonstrate a provider's registration and entry into the Contractors Web Portal and explain navigation
- ☐ Demonstrate a provider's view of claims status, payment history, recipient eligibility (including TPL, lock-in status, LTC status, etc), and benefit information and prior authorization information
- ☐ Demonstrate the Electronic Provider Enrollment Process including EDI Trading Partner agreement process via web
- ☐ View an example of a provider manual, fee schedule and rates
- ☐ Demonstrate the on-line submission, correction, and resubmission of a claim (837)
- ☐ Demonstrate retrieval of Remittance Advice (RA) (835)
- ☐ Show the capability to:
 - Submit a prior authorization request (278) and a response
 - Submit a recipient eligibility inquiry (270) and a response (271)
 - Submit and retrieve a batch eligibility inquiry and a response
 - Submit a claims status inquiry (276) and a response (277)
- ☐ Demonstrate a recipient's secured access to view their activity history over time periods and show the capability to view detail and summary data for:
 - Prior authorizations
 - Claims
 - Eligibility information
- ☐ Demonstrate a recipient's access to recipient relations information including; publications and provider participation information
- ☐ Demonstrate the on-line submission, correction, and resubmission of a claim (837)

Requirement #14.2 Ease of Use

Evaluator: Score this demonstration for the ease of use (i.e. menu systems, window taps, availability of help screens) access, display, navigation and efficiency observed during the demonstration. (The offeror is not requested to present a separate response for this requirement.)

15. Management and Operational Requirements (40 Min/4:20-5:00/Day 2)

Requirement #15.1 Security

- ☐ Show security hierarchy and how it is invoked by demonstrating log-in(s) to the following applications:
 - MMIS
 - DW/DSS (if not integrated with MMIS system)
 - SURS (if not integrated with MMIS system)
 - Point of Sale (if not integrated with MMIS system)
 - Tracking systems (if not integrated with MMIS system)
 - Web portal
 - EVS/AVR
 - Document retrieval system (i.e. claims, publications, system/operational documentation, etc.)
- ☐ For each application demonstrated above, show user access that:
 - Provides access restriction capability to data relevant to the particular user or role for, but not limited to:
 - Application module (e.g., recipient, provider, finance, PA, etc.)
 - Screens and tables
 - Data elements
 - Functions (add, change, delete inquiry, etc.)
 - Electronic documents (electronic approvals)
 - Business event
 - Organizational unit
 - Accounting period (prior, current, etc.)
 - Does not require multiple log-in after initial log-in,
 - Permits a user to have a single log-in and password for all applications, and
- ☐ The same password begin/end dates and other updates apply to all applications
- ☐ Demonstrate for a single user the change history of security access for all systems from account creation to present

Requirement #15.2 Documentation

- ☐ View on-line documentation, including data element dictionary, detail system design, user help information and other system, user, procedure and operational documentation.
- ☐ Demonstrate the capability, at a user's desktop, to hyperlink from user documentation to associated sections in systems and operations documentation
- ☐ View an online historical library of retired provider publications
- ☐ Display the version history of a selected document, and display the specific changes from a single version to another

Requirement #15.3 Performance Monitoring

- ☐ Display a list of sample performance standards. Select one standard and demonstrate how to adjust and update the criteria
- ☐ Display on-line a sample monthly report card which compares a sample of performance standard requirements to sample performance
- ☐ Display the overall score of performance and provide a sample plan of correction for an item falling below the standard
- ☐ Display the history of an example criteria as it has changed over time
- ☐ Display and explain elements for sample reports as follows:
 - Operational activities,
 - System maintenance and modification activities,
 - Internal quality control and assurance activities, and
 - Fiscal agent staffing levels

Requirement #15.4 Audit Trail

- ☐ Show an example of an audit trail for an automated process and demonstrate the balancing and control activities

Requirement #15.5 Ease of Use

Evaluator: Score this demonstration for the ease of use (i.e. menu systems, window taps, availability of help screens) access, display, navigation and efficiency observed during the demonstration. (The offeror is not requested to present a separate response for this requirement.)

ATTACHMENT M

PROPOSAL EVALUATION CRITERIA

	Section Points	
Introduction and Understanding of the Alaska Project	205	2.1%
6.2.1 Introduction - Executive Summary (6.2.1.2)	60	0.6%
6.2.2 Understanding AK Medical Assistance Project	75	0.8%
6.2.2 MITA Architecture (6.2.2.5)	70	0.7%

Management Plan for the Project

Comprehensive Requirements 6.2.3	540	5.4%
(1), (10) Project management approach for completing all project phases; including management and reporting requirements in 5.5.1	50	0.5%
(2) Approach for requirements definition	40	0.4%
(3), (14), (15), (16) Approach to resource planning, authority/responsibilities of key staff, work hour estimating/reporting, and approach for coordinating staff	75	0.8%
(4) Approach for change management control and reporting	75	0.8%
(5) Approach for test planning and management	50	0.5%
(6) Approach for issue and risk identification, tracking, resolving, and reporting	45	0.5%
(7) Approach for internal quality control	65	0.7%
(8) Approach for scope management	20	0.2%
(9) Approach for developing deliverables as described in section 5.5.2	30	0.3%
(11), (12) Approach for interfacing with the State and incumbent contractor	30	0.3%
(13) Process for identifying and maintaining privacy and security requirements	20	0.2%
(17) Approach for meeting contract performance standards	40	0.4%

Scope of Work

Operational Takeover Phase 1 6.2.4.1 - Using presentation criteria in this section, documentation of how the following requirements will be met

	310	3.1%
5.4.1 Takeover Implementation component	20	0.2%
5.4.2 Requirements Analysis	10	0.1%
5.4.3 Takeover Documentation	10	0.1%
5.4.4 Takeover DW/DSS extract	30	0.3%

5.4.5 System Takeover Testing	50	0.5%
5.4.6 Provider and Recipient Support ServicesTakeover	50	0.5%
5.4.7 HIPAA Takeover	20	0.2%
5.4.8 Takeover Operational Readiness and Operability Testing	30	0.3%
5.4.9 Takeover Implementation	50	0.5%
5.4.10 Post Takeover Implementation	10	0.1%
5.4.11 Takeover Maintenance Component	30	0.3%

DD&I Phase II 6.2.4.2 - Using presentation criteria in this section, documentation of how the following requirements will be met

895 9.0%

5.5.3 Project Initiation	25	0.3%
5.5.4 Requirements Analysis	110	1.1%
5.5.5 Systems Design	125	1.3%
5.5.6 DW/DSS Development and Implementation	130	1.3%
5.5.7 MMIS Development and Testing	125	1.3%
5.5.8 Conversion	125	1.3%
5.5.9 Acceptance Testing	130	1.3%
5.5.10 Implementation	100	1.0%
5.5.11 Post-implementation Evaluation	25	0.3%

Functional Requirements 6.2.4.3 - Using presentation criteria in this section, documentation of how the following requirements will be met

1500 15.0%

5.6.2 Recipient Eligibility and Relations	70	0.7%
5.6.3 Benefit Packages	90	0.9%
5.6.4 Provider Enrollment and Relations	80	0.8%
5.6.5 Reference Databases	50	0.5%
5.6.6 Prior Authorization	90	0.9%
5.6.7 Reimbursement	90	0.9%
5.6.8 Claims Processing	125	1.3%
5.6.9 Claims Payment	125	1.3%
5.6.10 Financial Services	80	0.8%
5.6.11 Third Party Liability	70	0.7%
5.6.12 Early and Periodic Screening, Diagnosis and Treatment	40	0.4%
5.6.13 Managed Care function	40	0.4%
5.6.14 Home and Community-based Waivers	40	0.4%
5.6.15 Pharmacy Point of Sale	110	1.1%
5.6.16 Drug Utilization Review	60	0.6%
5.6.17 Drug Rebates	50	0.5%
5.6.18 Data Warehouse/Decision Support System	110	1.1%
5.6.19 Management and Administrative Reporting	40	0.4%
5.6.20 Utilization Review and Quality Assurance	60	0.6%
5.6.21 Case Tracking	80	0.8%

Operations Management Requirements 6.2.4.4 - Using presentation criteria in this section, documentation of how the following requirements will be met

	650	6.5%
5.7.1 Performance Monitoring and Reporting	160	1.6%
5.7.2 Fiscal Agent Internal Quality Assurance	130	1.3%
5.7.3 Contract Monitoring	80	0.8%
5.7.4 Management of Change	130	1.3%
5.7.5 Other Requirements	150	1.5%

Operations Phase III 6.2.4.5 - Using presentation criteria in this section, documentation of the following requirements will be met

	300	3.0%
5.6.1 General requirements	150	1.5%
5.8 Operations	150	1.5%

Turnover Phase IV 6.2.4.6

	100	1.0%
5.9.2 Turnover Tasks	50	0.5%
5.9.4 Contractor Responsibilities	50	0.5%

Vendor Experience and Qualifications

	500	5.0%
<u>Corporate Capabilities</u> 6.2.5.1	200	2.0%
<u>Resumes</u> 6.2.5.2	300	3.0%

Technical Evaluation Total :	5000	50.0%

Vendor System Demonstration :	1000	10.0%

Cost Proposal Evaluation :	3000	30.0%

Alaska Offerers Preference :	1000	10.0%

Total Evaluation :	10000	100.0%