RFP 2023-1600-0138

Attachment C – Scope of Work

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1.0 Member Eligibility and Relations

1.1 Maintain System Capabilities for Member Database Maintenance, Update, Inquiry, and Edit Functions

(1) Maintain current and historical date-sensitive information on members' program eligibility.

(2) Maintain member identification and demographic data.

(3) For each address maintained in the member database, provide an address type, effective dates, and the capability to select the mailing address when mailings are prepared for members.

(4) Maintain current and historical Medicare and insurance coverage data in the member eligibility database.

(5) Maintain long-term care (LTC), hospice, and waiver program patient liability data.

(6) Maintain the capability to identify members of other State programs with data necessary to process claims for these members.

(7) Support the truncation logic used to load overlapping eligibility segments. Additionally, support claims processing in alignment with the DOH hierarchy for using multiple open benefit plan enrollment segments.

(8) Maintain member lock-in data including lock-in dates and lock-in provider ID numbers.

(9) Maintain service limit data, including updating the information using paid original, adjustment, and voided claims data.

(10) Allow service limits to apply to various unit types (units or dollars).

(11) Maintain for data elements to support primary care case management (PCCM) including:

   (a) Primary care provider identification

   (b) Beginning and ending dates of PCCM

(12) Maintain daily transaction update interfaces with the State's eligibility information systems to obtain all necessary data for the Alaska MMIS member database.

(13) Apply updates received to the MMIS eligibility database, on a schedule as defined by the department.

(14) Notify DOH within one business day of the anticipated update if the update is not received or if the update was not applied as scheduled.

(15) Maintain a monthly full-file reconciliation process with the State's eligibility information systems and provide a manual monthly reconciliation with all the other external sources of data.

(16) Maintain for on-line and automated input of eligibility data for members enrolled in State programs. Allow on-line input, change, or void of member data by authorized users for State-specified fields.

(17) Edit eligibility transactions to allow only valid data to update member information as defined by the Department.

(18) Maintain capability to update State-specified data through an on-line update process, including beginning and ending dates as appropriate.

(19) Maintain the capability to place a member on review, including the capability to include or exclude claims. Include a review reason code and beginning and ending dates of the review.

(20) 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.

(21) Help the State in researching member database discrepancies.

(22) Link current and past identification numbers and eliminate any duplicate names. Maintain the capability to access member data and process claims using any valid member number once the information is made available by the Division of Public Assistance.

(23) Maintain historical data of eligibility changes on the member record.

(24) Maintain on-line inquiry by member name, member number, SSN, fiscal agent, and other Offeror staff.

(25) Maintain capability to request member reports using data elements on the eligibility database as selectable data elements.

(26) Produce member operational reports accessible on-line.

(27) Maintain audit trails and history log of changes made on-line.

(28) Maintain 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.

(29) Maintain accurate and current information to other MMIS components that utilize member information to support member and provider customer service inquiries, service authorization functions, production of management and utilization reports, and adjudication of claims.

1.2 Maintain Medicare Buy-In System Processing

(1) The Offeror must maintain 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 include interfaces and procedures to receive, logically integrate, process, and store federal data. The Offeror must make this data available to DOH via online access and queries.

(3) Thoroughly and continuously analyze the Buy-in process to ensure efficient and maximally appropriate buy-in of eligible Medicaid members into Medicare.

(4) When Medicaid terminates eligibility, create appropriate transactions, and generate follow-up letter to member.

(5) For Medicare eligibility termination, create notification for State case follow-up.

(6) Create and apply memos to the Buy-in History file from CMS Buy-in return data in addition to generating any appropriate transactions and activity.

(7) Prepare the Medicare Buy-in file for both Part A and Part B Buy-in using logically integrated federal Buy-in data and data from MMIS, including Buy-in history, to achieve accretion, deletion and change operations according to the State's priority of these files.

(8) Prepared Medicare Part A and Part B files must also include appropriate actions and responses to State and federal received data together with appropriate notification.

(9) Medicare effective dates for Part A, Part B, and Part D from federal and State sources must be updated to the member file, regardless of Buy-in status, and correctly applied to claims processing.

(10) Provide a file for manual Buy-in transactions scheduled with future transaction dates and send identified transactions to CMS no earlier than the month immediately preceding the transaction date. The Offeror must maintain prioritizing capabilities in the system for waiting transactions over system generated transactions as defined by the State.

(11) Maintain full user access, including update capabilities, to the Buy-in functional area for State Buy-in Program Administrator.

(12) Maintain the daily transaction interface with CMS with update to the MMIS within 24 hours. The transaction data must be maintained in date order for online reference.

(13) Process and reconcile CMS responses to the Buy-in file and provide processing reports to DOH on-line within one business day of receipt.

(14) Maintain 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.

(15) Maintain Buy-in Daily History Log by transaction, MID order, memo activity and other criteria.

(16) Maintain an accurate automated match review processes for the verification of identity of member vs. beneficiary data and maintain in a database.

(17) Maintain an on-line “alias” database that contains matched member/beneficiary data records created from the automated match review process from MMIS and other sources. Once member/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.

(18) 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 member’s Buy-in history which indicates the client has been manually matched and is verified as the same individual.

(19) Maintain on-line access with query capability to Buy-in reports.

(20) Maintain on-line update capability to MMIS member file data for DOH resolution of errors and member file update.

(21) Perform all Buy-in processing in accordance with State and federal requirements.

(22) Produce to State specifications all Buy-in reports, validate, and distribute the reports, including availability online with query function.

(23) Maintain historical Buy-in data and reports on-line with query function.

(24) Maintain multiple notice/letter templates for State created letters integrated with 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 member.

(25) Create Buy-in transactions for matched members using a preset State prioritized order.

(26) Maintain an action alert file with reminder for Buy-in Program Administrator which may be self-set or triggered by other pre-set criteria.

(27) Maintain editable memo capability for individual or grouped member Buy-in files with expanded subject line.

(28) Create statistical data files which capture selected demographic data from MMIS and Buy-in files, and produce reports by calendar, State fiscal, or federal fiscal years

1.3 Maintain System Capabilities for Automated Tracking of Members

(1) Maintain an automated tracking capability to report all member interface activities including telephone inquiries, customer service call center activities, written correspondence, and publications.

(2) Maintain the Department's authorized staff's ability to query and enter information into the above referenced automated tracking system/database.

(3) Maintain the capability to track and report from the automated tracking/database system.

1.4 Maintain System Capabilities for Automated Correspondence Generator for Members

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

(2) Maintain a menu-driven letter generation capability allowing users to choose a standard letter or to develop a customized letter.

1.5 Maintain System Capabilities for Member 1095 Function

(1) Derive months of eligibility to be reported on a 1095 based on unique member ID numbers.

(2) Update the 1095 reporting process to align with the current CY requirements as published by the IRS.

(3) Send the member 1095 information to the IRS in alignment with the methods and timelines published by the IRS.

1.6 Maintain System Capabilities for Member Web Portal and Electronic EOMB

(1) The Offeror is responsible for maintaining the member web portal and producing electronic EOMBs for members registered for access to the web portal.

(2) Irrespective of member's eligibility status, members with valid member ID and PIN combination will be granted access to the member portal.

(3) Members can request a new PIN or reset their existing PIN via the member portal.

(4) Authenticated members will be able to click and generate their rolling 17 months EOMBs.

(5) EOMBs will be generated on demand in downloadable format for the selected month. EOMBs will be generated only when the logged in user chooses to generate one.

(6) Logged in member details will be saved in the MMIS database for auditing and reporting purposes.

(7) "Just Paid Original" and "Adjusted for Payment" claims and member merge History Only Mass Adjustments (HOMA) qualify for EOMB letter generation. Other HOMA claims do not qualify.

(8) When members are merged due to matching first/last names/SSN/DOB details, the details of the source are merged into the target are removed from the MMIS database. Deactivating the source member PIN was included as business rule when members are merged. Once a source member is merged into the target, the source member's PIN is deactivated/disabled.

(9) Members may provide feedback through the portal.

(10) Maintain the capability to generate REOMB for print/mailing.

The portal includes the following interface features:

(1) Member login feature enabled.

(2) Reset PIN, Request to Unlock the PIN features accessible.

(3) Member login and PIN generation implemented.

(4) Email shall be used to send members their PINs.

(5) Members required to change their PIN after they first login with a new PIN.

(6) New User Interface screen to download EOMBs created.

The Offeror is required to provide the following in support of the member web portal:

(1) Provide members with access to member portal

(2) Provide members with ability to download the EOMBs generated on demand.

(3) Save member ID to audit logging tables for record keeping.

(4) Letters mapped to the logged in member IDs are displayed on the UI to ensure that there is no privacy breach. Via the member portal, only logged in members will have access to view/generate the EOMBs. Members are authenticated via two-page member login which includes captcha verification. The member is associated with his/her Medicaid ID which forms the basis of EOMB generation, thereby ensuring that security and privacy are not compromised. The EOMBs can be accessed only via the member portal. There are no URLs, hard copies, or emails of EOMBs that will be sent to members' personal mailboxes.

1.7 Maintain System Capabilities for Interoperability

(1) Maintain claims, member, and provider interfaces with the DOH interoperability vendor in support of the Patient Access Final Rule (CMS-9115-F).

(2) Support API information requests or troubleshooting related to interface details, upon request.

1.8 Member-related Performance Standards

(1) Update the member eligibility database with electronically received data and provide DOH 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 data updates. Maintain eligibility load rules and business processes to ensure only correctly formed records are loaded to the MMIS.

(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 Offeror 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 eligibility systems' reconciliation file monthly by the fifth day of the following month and provide DOH with reconciliation reports within 24 hours of completion of the reconciliation.

(6) Complete the Buy-in processing in accordance with federal and State timeliness requirements.

(7) Provide access to archived data within three (3) business days of receipt of the request.

2.0 Benefit Packages

Benefit Packages encompass those functions necessary to define the services that will be covered by State programs designed for specific member populations.

Providing the functional criteria is the responsibility of DOH. Once the State policy has been defined, DOH communicates the requirements to the Fiscal Agent for implementation in the MMIS.

2.1 Maintain System Capabilities for Managing Benefit Packages

(1) Maintain capability to define the member populations to be covered.

(2) Maintain capability to define the services, their limitations and requirements which are covered.

(3) Maintain capability to determine the payment methodology.

(4) Maintain capability to 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 member enrollments in multiple programs with overlapping begin and end dates.

(7) Maintain the flexibility to make changes quickly and easily to Benefit Packages/Plans.

(8) Maintain the ability to view Benefit Package history on-line.

(9) When changes are needed, identify all system and user components affected by the change to the Benefit Package.

(10) Develop and obtain approval of a requirements document when new functionality is requested by DOH.

(11) Upon approval of the requirements document, prepare the changes for the MMIS.

(12) If system programming changes are required, code and test the changes, and provide test results to DOH.

(13) Update all documentation including system, user staff and provider resources.

(14) Conduct training for user staff.

(15) Upon DOH approval, implement Benefit Package changes.

(16) Monitor quality and identify areas for improvement.

3.0 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 DOH policies. All provider enrollment and relation functions shall be supported using information to uniquely identify each provider.

3.1 Maintain System Capabilities to Support Provider Enrollment

(1) Maintain a timely, accurate, automated, date-sensitive data repository of enrolled providers and their eligibility to render services for specific programs.

- (a) Update provider data received electronically within one (1) business day of receipt of file.
- (b) Identify and correct errors within one (1) business day of error detection.
- (c) Provide backup documentation for provider database updates to DOH within one (1) business day of the written request for the documentation.

(2) Maintain capability to store 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) Maintain capability to store 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.

(4) Maintain capability to store current and historical date sensitive addresses for a provider.

(5) Maintain capability to store multiple telephone numbers and e-mail addresses for a provider.

(6) Maintain capability to store a minimum of five (5) contacts for each provider.

(7) Maintain capability to store 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)

(8) Maintain capability to store 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.

(9) Utilize DOH-approved formats, and automatically enforce consistent, standard formats for entry of data into the provider database.

(10) Maintain on-line access to the provider master file, with updating and inquiry capability. Maintain tools to support user-friendly on-line access and query support to provider data.

(11) Maintain on-line inquiry access to other State Offerors with access only to DOH-specified data.

(12) Maintain capability to identify, on the main provider display screen, whether the owner or provider is cross-referenced to other entities, and the type(s) of entity, associated dates, and cancellation codes.

(13) Accept NPI or Medicaid provider number for rendering or billing provider information for various transactions including claims.

(14) Maintain on-line daily maintenance of provider information.

(15) Provide for mass updates when requested by DOH.

(16) Edit each data field for syntax and paradigmatic validity. Only valid data can update the provider file.

(17) 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.

(18) Support the data requirements for claims processing, timely information access and decision support, utilization review and quality assurance, etc.

(19) Maintain on-line viewing of all MMIS reports except those designated by DOH to be routinely provided in hard copy. On-line reports will be available on request by DOH in the media specified by the user. All MMIS outputs must be archived for permanent storage in electronic media approved by DOH.

(20) Support preparation for biannual CMS data comparison worksheet for delivery to CMS.

(21) Assist in the application of biannual CMS data comparison results.

3.1.1 Maintain System Capabilities to Support Provider Licensure and Certification

(1) Maintain capability to store 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 updates.

    (a) Update the Provider database with Occupational Licensing updates at least twice a month.

    (b) Validate the licensing update process within two (2) business days of application of the update transmission.

    (c) Resolve licensing transactions that fail the update process within two (2) business days of error detection.

    (d) Refer to the State all licensing transactions that fail the update process and cannot be resolved by Offeror staff pursuant to edit update rules or State-approved procedures within two (2) business days of attempted error resolution.

3.1.2 Maintain System Capabilities to Support Entity Cross-Referencing

Capability must 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 capability to store date-sensitive two-way cross-references between an enrolled provider and other entity relationships which apply to the provider.

(2) Maintain capability to store date spans for all affiliations and indicators to identity affiliation types.

(3) Maintain capability to store date sensitive, historical information regarding providers' trading partner relationships and utilize this information to limit electronic transaction receipt/response to the appropriately identified trading partner. Include capability to allow providers to have different electronic submission status and add/change trading partners.

3.1.3 Maintain System Capabilities to Support Archiving the Provider File

(1) Upon request of DOH, the provider file, including all data and attachments can be archived automatically using criteria specified by DOH and including length of period of inactivity and provider type. Criteria for the archive may be changed by DOH.

(2) The process includes the automated production of archive report based on the criteria with review by DOH.

(3) At any time, on-line, DOH can change or request the Fiscal Agent to change the status of a provider and can inquire into providers using the enrollment status. Appropriate security authorization to change such critical information must be required.

3.1.4 Maintain System Capabilities to Support Rate Change Information

(1) Maintain capability to store date-sensitive, historical rate information for any provider reimbursed by an individual or provider type rate.

(2) Maintain the capability to update rates on-line.

(3) With proper security authorization, update prior rates at DOH request at any time. Any previous rate and time periods may be selectively changed. The system can reprocess all claims affected by the retroactive change through an automated mass adjustment system.

(4) All rate change transactions are edited for validity and are subject to on-line audit trail, control totals, balance inquiries, and the Offeror's quality assurance protocols.

(5) Where the rate change affects a group of providers, the Offeror will maintain the functionality to make this type of change through a mass update.

(6) Maintain capability to store multiple provider specific reimbursement rates with begin and end dates.

3.1.5 Maintain System Capabilities to Support Minimum Provider Demographic and Other Data

Maintain capability to store any provider data needed to meet MMIS functional requirements and additional data requirements specified by federal and State law, and at the request of DOH. The Offeror must maintain the record of all relevant provider information including provider enumerations, service types, specialties/taxonomy, owners, affiliations, billing agents, locations, addresses, contacts, etc.

3.1.6 Maintain System Capabilities to Support Minimum Provider Financial Data

Update and maintain automated financial data accessible to on-line inquiry.

3.2 Maintain System Capabilities for Automated Voice Response (AVR)

The AVR is a telephone voice and touch-tone response system maintained by the Offeror 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, the 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 an Offeror-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) Provide capability to make changes to/reprogram AVR recorded voice messages/responses/prompts at any time upon request from DOH.

(4) 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 at least ninety-nine (99%) of the time.

   (c) Receive a busy signal less than five percent (5%) of the time.

   (d) Are not dropped and do not receive a busy signal more than one percent (1%) of the total daily call volume.

   (e) Are successfully transferred to live assistance at the customer service call center

(5) The AVR must be available twenty-three (23) hours a day, seven (7) days a week.

(6) Resolve all AVR system downtimes caused by the AVR hardware, software, or other components under the Offeror's control, within thirty (30) minutes of initial notification of system failure. If the system is not in service within that time frame, the Offeror shall provide an alternative AVR system to ensure that system downtime is limited to a maximum of thirty (30) consecutive minutes.

(7) Alert appropriate department systems unit staff in the event of AVR system failure. Provide notification to the services Offeror responsible for maintaining the IVR system when the MMIS is down or experiencing difficulties including an indication of when the MMIS is expected to be operational.

(8) Maintain and retain for twenty-four (24) months electronic records of all AVR inquiries made, information requested, and information conveyed.

(9) 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.

3.3 Maintain System Capabilities to Support Eligibility Verification

The Offeror must operate an effective means for Medicaid providers, State- designated staff and State-designated Offerors to verify members' eligibility status. Eligibility inquiries may be made by HIPAA electronic transaction, by pharmacy POS networks/systems, via the Web portal, and through the Offeror's AVR system. Eligibility verification should contain lock-in/CMP status and assigned providers, for individuals using this feature.

(1) Maintain automated, secure, eligibility verification system (EVS) capabilities that meet X12 and EDI standards as applicable and accessible via various modes.

(2) Display real time, on-line results of the EVS inquiry when the provider accesses EVS via the Web portal. Display the results of the EVS inquiry when the provider uses a terminal device with display capability on LCD or print roll.

3.4 Common Requirements for both AVR and EVS

The Offeror 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 or member's data and must be based on positive identification of provider and/or member. The response must be in formats approved by the State.

(1) Maintain 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 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) Maintain 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 with the appropriate credentials to verify eligibility through AVR/EVS as designated by the department.

(4) Maintain automated logging of all transactions, maintain an audit trail of all inquiries and responses, and produce reports as required by DOH.

(5) Ensure that the AVR/EVS uses current, updated, accurate information from eligibility files and other MMIS data files.

(6) Maintain access to eighteen (18) months of data:

(a) Member eligibility and benefit information

(b) Health benefit package/program eligibility inquiry and status for multiple programs for the date queried

(c) Provider enrollment and coverage information

(d) Miscellaneous capability:

(i) resetting, ending, adding user password/PIN

(ii) requesting AVR and EVS user guides

(7) Offeror will train providers in the use of EVS/AVR and will respond to questions via a toll-free line.

(8) Maintain and distribute timely and accurate provider AVR and EVS user manuals.

3.5 Maintain System Capabilities for Provider Web Portal

The Offeror must maintain the web portal. The portal must support the following functionality:

(1) Be compatible with modern browsers and accessible via standard internet access methods. Needs to account for state of Alaska latency issues.

(2) Be operational and accessible 24/7, except for DOH approved scheduled downtime.

(3) Provide, review, and periodically update navigation that all users can easily understand, including easy navigation between screens through help menus other user documentation.

(4) Provide the capability to allow internal and provider users to view provider manuals, instructions, bulletins, program descriptions, eligibility criteria, and forms through quick-access links.

(5) Provide hotlinks to frequently visited areas of the Offeror web site.

(6) Maintain HIPAA compliance and support to the access, privacy, and security requirements described later in this section.

3.6 Maintain System Capabilities for Automated Provider Tracking

(1) Maintain 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, and publications.

(2) The Department's authorized staff must be able to query and enter information into the above referenced automated tracking system/database.

(3) Maintain the capability to track and report from automated tracking/database system.

3.7 Maintain System Capabilities for Automated Provider Correspondence

(1) Maintain menu-driven letter generation capability allowing users to choose a standard letter or to develop a customized letter.

(2) Obtain department approval for the content of all letter templates designed for repeated use.

3.8 Maintain System Capabilities for Provider Relations Function

(1) The Offeror must maintain efficient communications with the provider community. Provider inquiries can be received via various modes either to the Offeror(s) or through the Department.

(2) Maintain 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 Offeror-supplied applications, processes, workflow tools, etc.

(3) Provide the services Offeror with capability and access to make updates to content on the primary MMIS website to allow updates to notifications and publications.

(4) In addition to required HIPAA EDI transactions, maintain capability for provider claim status inquiry via AVR, 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.

3.9 Maintain System Capabilities for 1099 Function

(1) Maintain processing rules to determine whether a Financial Reason Code (FRC) will increase or decrease a Provider's 1099 amount.

(2) Calculate 1099s based on tax identification numbers; accumulate all payments to the same tax ID on a single 1099.

(3) Update the cumulative total 1099 payment field including all payments and recoupments for the calendar year. Financial claims processing rules will determine the "Total Financial Amount" used to determine the final 1099 reportable amount

(4) Maintain on-line 1099 history for three years for query and reporting purposes.

(5) Update the 1099 reporting process to align with the current CY requirements as published by the IRS.

(6) Send the provider 1099 information to the IRS in alignment with the methods and timelines published by the IRS.

4.0 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 split between the Services and SYS/Ops Offerors and follows policy decisions made by DOH and State and federal requirements for the coding schemes in the MMIS.

4.1 Maintain System Capabilities to Support Reference Databases

4.1.1 Procedure/Revenue Code Database

(1) The procedure/revenue code database was designed to minimize the impacts of future HIPAA adopted code sets. All data files, database tables, and programs must be maintained with sufficient space to support the required HIPAA adopted code sets.

(2) Maintain current and historical procedure and diagnosis codes using the CMS HCPCS, CPT, and ICD-10-PCS, procedure codes, or the current version as defined by National standards and DOH. Maintain the process to identify, collect, analyze, and update/use within the MMIS, current National standard code sets in a period specified by the State.

(3) Obtain and update procedure codes with HCPCS, CPT data and ICD-10-PCS procedure code data, upon request by the State.

(4) Acquire and update the State of Washington Medicaid Fee Schedule for Physicians for pricing claims from Washington State physicians, upon request by the State.

(5) Acquire the Medicare Fee Schedule including the lab and drug fee schedule and update the Reference Database, upon request by the State, to ensure conformance with federal requirements regarding Medicare pricing.

(6) Maintain pricing data based on RBRVS or other Relative Value Unit (RVU) pricing methodology as well as other pricing methods, such as flat fees.

(7) Maintain current and historical RVU data with special pricing indicators, geographical pricing, and effective dates.

(8) Maintain system capability to store multiple conversion factors and select the appropriate conversion factor.

(9) Maintain current and historical revenue codes in a revenue code database with on-line update, inquiry, and reporting capability.

(10) Obtain and update revenue codes from the National Uniform Billing Committee and the National Standard Maintenance Organization, upon request by the State.

(11) Maintain current and 10 years of historical date-sensitive payment information.

(12) Provide for mass updates upon request by the State.

(13) 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.

(14) Maintain capability to maintain National Drug Code (NDC) relationships to HCPCS and CPT codes and utilize during adjudication (refer to 4.1.6).

4.1.2 Drug Compendium Database

(1) Receive and maintain a database populated from a nationally recognized compendium containing FDA regulated product information including, at minimum, legend and over the counter (OTC) drugs, biologics and vaccines, medical supplies, and imaging products indexed by FDA-defined product code (e.g., NDC, UDI, etc.) for use during adjudication.

(2) Maintain current and historical coverage status, rebate status, and pricing information on legend drugs, selected OTC items, and injection codes on the products contained within the Alaska MMIS drug compendium database utilizing industry standard data elements.

(3) Maintain and provide on-line access to an archive for NDCs that have had a change to a different name.

(4) Update the drug compendium database on a weekly basis.

(5) Notify the State of any newly approved drug products identified during the NDC updates.

(6) Edit all transactions to allow only valid data to update drug compendium database information.

(7) Provide on-line inquiry query capability by product code (e.g., NDC, UDI, etc.), generic name, or brand name.

(8) Provide the capability to request ad hoc reports on-line.

4.1.3 Diagnosis Database

(1) The diagnosis database was designed to minimize the impacts of future HIPAA adopted code sets.

(2) Maintain current and historical diagnosis codes using the International Classification of Diseases version as defined by DOH or as mandated by updated HIPAA regulations.

(3) Maintain current and up to 10 years historical data contained in the Alaska MMIS diagnosis code database.

(4) Maintain the capability to update and use DRG methodology for processing institutional claims.

(5) Obtain and update the diagnosis database with the annual ICD-10-CM updates as approved by the State.

4.1.4 Exception Database

(1) Maintain the capability to store date-sensitive data on exception codes, exception code descriptions, and status by claim type, media, and transaction type on the exception database.

(2) Maintain the capability to store date-sensitive exception criteria and the capability to edit all historical claims against the exception criteria database.

(3) Maintain capability for open-access querying by exception code.

4.1.5 Certified Laboratory Improvement amendments and Mammography Provider Database

(1) Maintain capability to store date sensitive CLIA and mammography certification data.

(2) Maintain capability to capture, maintain, and utilize certification data for additional provider types as required by CMS.

(3) Maintain update capability for CLIA and mammography information using CMS supplied data.

(4) Maintain on-line inquiry capability to CLIA and mammography certification data.

(5) Maintain capability to store effective dates for all items.

4.1.6 Procedure Code - NDC Cross-reference database

(1) Load new and maintain current and historical procedure code NDC cross reference data from various sources utilizing rules defined by DOH.

(2) Acquisition of Procedure Code NDC Cross Reference web portal and data file for use by the Offeror and HCS. The Offeror will enter a sub offeror arrangement to obtain these.

(3) Update the procedure code NDC cross reference database as new updates are available, at least monthly and upon request by DOH. Produce the standard error and update activity reports during the import interface processing.

(4) Maintain on-line access to view the cross-reference database. Produce the monthly Procedure Code NDC Crosswalk report to be posted to the web portal.

4.1.7 Offeror Functions Applicable to All Reference Databases

(1) Maintain current and historical reference database information to be used during claims processing.

(2) On all automated update processes, provide update reports to DOH according to State-supplied specifications for review and approval prior to applying the updates to the database.

(3) Accommodate retroactive rate changes and Medicaid policy changes as they relate to medical procedures and limitations.

(4) Provide the State and authorized State Offerors with on-line inquiry access to all reference databases except during update processing.

(5) Edit all transactions to allow only valid data to update reference databases.

(6) Maintain security procedures to ensure that only authorized personnel have access to the reference databases functions.

(7) Maintain the capability to request reports on-line using data elements in the reference databases as selectable data elements. Allow user specified sorts and sub sorts.

(8) 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.

(9) Maintain on-line update capability to all reference databases to authorized users.

4.2 Reference-related Performance Standards

(1) Update pricing changes to the drug compendium file within one (1) business day from receipt of update from pricing authority; apply effective date defined by the authority.

(2) Update the CLIA laboratory designations within one (1) business day of receipt of file.

(3) 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.

(4) Provide update error reports and audit trails to the State within 24 hours of completion of the update.

(5) Update edits adjudication documentation within three (3) days of the request from DOH.

(6) Maintain a 98% accuracy rate for all reference file updates.

(7) Identify and correct errors within one (1) business day of error detection.

(8) Inform the State and reprocess any claims adversely impacted due to errors.

5.0 Service Authorization

The Service Authorization (SA) function encompasses those functions necessary to process and approve or deny requests for service authorization for services specified by DOH. The responsibility for processing service authorization requests is shared among several entities. The fiscal agent authorizes the services based on policy provided by and procedures approved by DOH. The Sys/Ops Offeror is responsible for maintaining service authorization interfaces with the authorized agencies and Offerors.

The Utilization Review and Management sub offeror authorizes medical inpatient hospital and residential psychiatric services, imaging services, and surgical procedures under a contract with DOH, and the fiscal agent sub offeror authorizes certain inpatient 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 Pharmacy Benefit Management Administrator authorizes covered outpatient drugs dispensed by pharmacies; the fiscal agent and may authorizes certain covered outpatient drugs when administered and billed in a professional or facility setting. All other service authorization requests are evaluated by the fiscal agent.

5.1 Maintain System Capabilities Supporting Service Authorizations

The primary objective of the Service Authorization function is to verify the medical necessity of specified services prior to provision of those services.

5.1.1 General Service Authorization Functions

(1) Maintain the automated system to enter service authorizations.

(2) Receive and process all requests for service authorizations in accordance with federal and State and medical guidelines, procedures, and standards.

(3) Maintain the automated tracking system for receiving, collecting, transmitting, and routing service authorization requests. Designated supervisory personnel must be able to route SAs to the appropriate staff or authorizing agency.

(4) Maintain the capability to appropriately track suspended authorizations.

(5) Assign system-generated unique SA numbers to approved, suspended, and denied SA requests, and maintain all SA data. Identify the status of service authorizations and display the appropriate status on-line.

(6) Edit to ensure that only valid data is entered on the SA file and deny duplicate requests or requests that contain invalid data.

(7) Capture both the requested service unit and dollar amounts, and authorized service unit and dollar amounts on the SA file.

(8) Maintain the capability to authorize services for a specific member 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.

(9) Maintain all data element fields associated with the authorization request/response and claims adjudication rules necessary to enforce service authorization requirements.

(10) Maintain electronic copies of the notification letters and provide a hyperlink from the SA file/record in MMIS to the associated letters in the tracking system.

(11) Maintain the capability to capture and update data for denied service authorizations and deny claims for which service authorization was denied.

(12) Maintain the capability to track modifications to authorization records and pay claims at the appropriate rate or units of service.

(13) Maintain 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 SA file available through on-line inquiry.

(14) 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" and/or "add back" authorized services.

(15) Track and make available on-line, the number of authorized services used based on claims payment activities and show how many services remain. This includes the capability to associate claim TCN data of all claim activities affecting SA record and the resulting effect on SA record data.

(16) Maintain on-line inquiry access to the service authorization file information using data elements as parameters to access only specific service authorizations or only authorizations for a particular service.

(17) Maintain the capability for providers to check the status of SA requests on-line via the web portal. Both the requesting and the servicing provider should have inquiry access to the authorization records for their patients.

(18) Maintain audit trail of file updates, accessible through on-line inquiry. Maintain control totals and provide balance information in response to on-line requests.

5.1.2 Processing Requests Authorized by the Fiscal Agent

(1) Maintain the system capability to apply different SA review criteria based upon program eligibility.

(2) Maintain the capability for on-line entry of telephone requests to the service authorization file.

(3) Maintain the capability to identify clients who abuse travel services and restrict service authorizations for travel for these clients according to State guidelines.

(4) Maintain the capability to accept, process, and respond to service authorization requests in the HIPAA format.

5.1.3 Processing Requests Authorized by Other Agencies and Offerors

(1) Maintain the capability to adjust service authorizations for modifications to the number of certified days/lengths of stay authorized based on assessment reviews by the quality improvement organization Offeror.

(2) Add service authorization requests received through the batch process to the on-line prior authorization file.

(3) Maintain on-line access to service authorization data to authorized personnel from the Offerors, agencies and programs for review and resolution of SA requests.

5.2 Service Authorization-related Performance Standards

(1) Complete all SA interface updates within one (1) business day of receipt of a file if there are no critical errors.

(2) Generate all error reports within one (1) business day of the interface or file update.

6.0 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 includes the capability to match reimbursement methodologies by member, by service, by program for multiple programs, and use geographic differentials for some services.

The DOH will require the Offeror to maintain the capability to support new reimbursement methodologies that may be adopted. System design and development must continue to be structured so that these reimbursement methods can be easily accommodated with minimal change and cost when implementation decisions are made.

DOH and other payer agencies are primarily responsible for establishing the policies included within the reimbursement function. Once the policies have been defined, DOH communicates the requirements to the fiscal agent and/or the systems Offeror for implementation in the MMIS. These vendors may be required to provide technical assistance with cost benefit analyses in support of the development and configuration of new reimbursement methodologies.

6.1 Maintain System Capabilities in Support of the Reimbursement Function

(1) Maintain appropriate DOH defined reimbursement methodology for all services.

(2) Install, test, and confirm reimbursement methodology changes with program data; perform regression analysis to ensure no unintended impacts.

(3) Assist the State in performing impact analyses of new reimbursement methodologies on service delivery, program cost, and provider participation.

(4) At the State’s direction, define the system requirements for new reimbursement methodologies.

(5) Maintain flexibility and configurability in pricing design to support ease of implementing changes to existing and new reimbursement methodologies.

(6) Provide accurate and timely delivery of system solutions for new and modified reimbursement methodologies.

(7) Monitor new and modified reimbursement methodologies post-implementation to assure quality outcomes. Report problems, including a corrective action plan, to the State immediately.

(8) Accommodate variable date-sensitive pricing methodologies for identical procedure codes based on benefit plans, member data, provider types and specialties, and provider specific data.

(9) Accommodate pricing rule changes with ability to perform online changes to methodologies.

(10) Maintain 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.

6.2 Reimbursement-related Performance Standards

The Offeror must meet the performance standards for system maintenance and enhancement when implementing new reimbursement methodologies.

7.0 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 automated functions are primarily the responsibility of the Sys/Ops Offeror and follow policy decisions made by DOH.

7.1 Maintain System Capabilities to Support Claims Processing

(1) Ensure claims and related input is captured in an accurate and timely manner.

(2) Apply systems-based audit stamps to monitor and track the movement and distribution of claims once they are entered into the system to ensure control and provide an accurate audit trail from claims entry to final disposition.

(3) Accept claims and other transactions into the claims processing system via hard copy and electronic media.

(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) Maintain system capability to verify providers are properly enrolled and eligible to bill for the type of service at the time of service.

(7) Maintain system capability to ensure members for whom claims are submitted were eligible for the type of service at the time the service was rendered.

(8) Maintain system capability to 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 decision in accordance with the Alaska MMIS plan and established federal and State guidelines.

(10) Maintain system capability to 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.

7.1.1 Claims Control

(1) Maintain the batch control system to control, track, and reconcile claims input to ensure all claims received by the Offerors are processed, whether electronic or paper.

(2) Maintain the system capability for capturing and processing of paper claim data elements as defined by the State. Maintain and adapt capabilities as revisions are made to these claim forms.

(3) Maintain the capability to capture and process rendering provider information at the line-item level.

(4) Maintain the capability to capture and process third-party payment information at the claim document and line levels.

(5) Maintain the capability to capture and process ordering or prescribing provider information on various claim forms.

(6) Maintain the capability to capture and process service authorization information at the line-item level.

(7) Maintain the capability to capture and process NPI and provider taxonomy information at the claim document and line levels.

7.1.2 Electronic Media Claims

(1) Accept and process electronic claims in batch mode and on a claim-by-claim basis via Internet transmission. All electronic claims must be in the HIPAA compliant format.

(2) Maintain the process for HIPAA-compliant EDI transaction processing. This process must include balancing and control procedures, reporting, testing, privacy, security and recovery standards and processes.

(3) Prescreen electronic media claims prior to control number assignment to ensure the validity of the entire transmission. Validation of HIPAA compliant transactions must meet X12 and CMS standards. 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.

(5) Errors in the interchange envelope will result in a HIPAA compliant acknowledgement transaction response approved by the State. This must be generated to the sender in compliance with HIPAA Operating Rules requirement.

(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 acknowledgments must be generated to the sender in compliance with HIPAA Operating Rules requirements.

(7) Accept and store all fields on the HIPAA claims transactions. Changes to the mapping of claim data elements must be approved by the State. 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.

(9) 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.

(10) Receive and process multi-line HIPAA 837P claims with the ability to capture and process up to 50 lines within a single claim.

(11) Receive and process HIPAA 837I claims with the ability to capture and process up to 99 service/revenue code lines within a single claim.

(12) Receive and process A HIPAA 837D claims with the ability to capture and process up to 50 lines within a single claim.

(13) Enter and assign a unique control number to each submitted claim.

(14) Produce electronic records 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.

(15) 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.

(16) Provide and maintain a process subject to State approval that addresses standards for electronic claims submitters and providers 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.

(17) Test provider electronic claims submissions for new EMC providers and changes in provider software or billing agencies in a test mode prior to authorizing the provider for live submissions.

(18) Accommodate all HIPAA-mandated transaction sets including all standard electronic claims formats. Assure that providers are authorized for the transaction types and appropriate trading partner agreements exist for those providers and submission dates.

(19) Maintain an electronic, HIPAA compliant solution for receipt, tracking and use of claim attachments.

7.1.3 Claims Adjudication and Pricing

(1) Maintain system capability to perform near real-time adjudication for all claims received through Fiscal Agent data entry, electronic media submission, and suspended claims released since the last adjudication cycle.

(2) 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 approvals.

(3) Maintain system capability to edit all State required data elements of the claim record for required presence, format, consistency, reasonableness, and/or allowable values.

(4) Maintain system capability to assure the integrity of the claim record information throughout the receipt, adjudication, and history storage process to prevent corrupting claim information.

(5) Where multiple like data elements exist on a claim record, maintain system capability to edit all occurrences of those data elements.

(6) Maintain system capability to edit data elements of the claim record that are national code sets for national code set validity.

(7) Maintain system capability to edit code sets and code set relationships based on State-defined criteria including the ability to determine inappropriate values based on code set relationships, and ability to restrict code sets to specific provider or client groupings.

(9) Maintain system capability to edit all claims at the service code level for date of service requirements, and appropriateness and conformity to Alaska's drug compendium and policy standards, including covered outpatient drug rules.

(10) Maintain system capability to edit provider ID numbers and member ID numbers for validity and for eligibility for the services provided on the dates of service.

(11) Maintain system capability to edit place of service and provide ability to restrict payment for services for specific provider groupings based on place of service.

(12) Maintain system capability to edit claims against applicable third-party resources, including private insurance and Medicare eligibility for cost avoidance.

(13) Maintain date-specific matrix which allows for the bypass of third-party liability processing for certain services, as specified by the State.

(14) Maintain claim editing flexibility to recognize and avoid third-party rules for known third-party non-covered items or services. Provide single transaction update and mass update ability to these avoidance rules.

(15) Maintain system capability to edit claims, where applicable, against service authorization requirements and status and either approve or deny depending on State policy for each SA element.

(16) Maintain the capability to apply edits based on provider type, provider specialty, category of service, member eligibility code, program, benefit plan, FFP indicator, region code or other data to provide more flexibility in application of the exception codes.

(17) Maintain the capability to pend or deny claims for members assigned to the member Care Management (lock- in) program based on State guidelines.

(18) Maintain the suspense alternative to denying claims that fail certain State specified exceptions.

(19) Maintain 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.

(20) Maintain the capability to apply service limitations based on specified time periods which may differ based on the service.

(21) Maintain 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.

(22) Maintain the ability to cutback to remaining available units or dollars and pay claims that exhaust the defined benefit.

(23) Maintain the capability to exceed service limits based on the presence of valid authorization or other State-specified criteria.

(24) Maintain the capability to edit and report travel claims for members who travel but do not have medical services during the period of approved travel.

(25) Maintain applicable exception codes for claims that fail edits.

(26) Maintain system capability to edit claims against defined service, policy, and payment parameters in accordance with the Alaska MMIS plan and established State and federal guidelines.

(27) Audit claims against historical data from claims history, claims in the current processing cycle, and claims in the Budget Funding File for duplicate checking.

(28) Audit claims against State-defined service limitations including once-in-a-lifetime procedures and other frequency, periodicity, and dollar limitations.

(29) Provide for and process claims against all components of a clinical audit system, including the capability to modify and apply exceptions according to State standards. This clinical auditing application must include the capability to apply NCCI editing in accordance with the federal technical guidance documentation in effect for the date of service.

(30) Maintain the capability to test edits during production processing using reporting exception status codes and provide reports to DOH of all exceptions dispositioned for reporting. Maintain a testing environment with current production coding and data to test various adjudication and payment scenarios in a production-like environment.

(31) Assign claim status based on criteria approved by the State.

(32) For suspended claims, assign the location of the unit that will resolve the suspended claim based on criteria determined by the State. Maintain queues with on-line access to suspended claims in each location, and the capability to re-assign claims to queues as needed.

(33) For claims failing edits determined by DOH, maintain the capability to recycle claims on a schedule to be approved by DOH before denying the claims.

(34) Deny claims that are received past the applicable filing limits according to State specifications.

(35) Maintain the former transaction control number and former paid date on any claim that denies or suspends against another claim.

(36) Assign collocation codes to each claim using State-specified criteria. Maintain the capability to manually assign collocation codes at the direction of DOH.

(37) Suspend claims for review that cannot be assigned a collocation code during the adjudication cycle.

(38) Maintain the on-line claims resolution and claims correction process.

(39) 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.

(40) Maintain the capability to process member cost sharing on any service or client group specified by the State using a fixed amount or percent of charges.

(41) Maintain the capability to easily accommodate processing and paying claims for new service programs. System design and development must be structured to accommodate proposed changes to programs with minimal change and cost.

(42) Maintain the capability to process and pay special claims when requested by DOH, on an exception basis, out of State-specified collocation codes, and maintain 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.

(43) 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. Maintain ability to identify claims associated with a returned warrant.

(44) Maintain the capability to price claims manually or in an automated fashion.

(45) Maintain 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.

(46) Maintain the capability to apply date specific restrictions to new claims submissions, adjustments, and/or voids for specific providers and date ranges for settlements.

(47) Maintain claims pricing functionality that will price all claims in accordance with Alaska Medicaid and State program policy, benefits, and limitations.

(48) Maintain 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 defined criteria.

(49) Maintain the capability to re-bill or adjust claims automatically based on pre-defined criteria supplied by the State.

(50) Maintain the capability to price claims for which Medicare or other third-party was the prior payer.

(51) Maintain the flexibility to perform exception pricing for other specific services regardless of the provider's assigned pricing methodology.

(52) Maintain 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.

(53) Maintain the flexibility to perform hierarchical pricing for specific services and/or provider groupings.

(54) Maintain the capability to perform unique base unit rate plus unique time unit rate pricing from a single claim line for anesthesia services.

(55) Maintain 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.

(56) Maintain an electronic adjustment/void receipt, tracking, and processing capability.

(57) Maintain on-line request capability to receive and enter mass adjustment information and process mass adjustments when requested by the State.

(58) Maintain adjustment reason codes that indicate the reasons for adjustments and the dispositions of the claim for use in reporting adjustments.

(59) 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.

(60) Maintain the financial control number in the claim adjustment record for adjustments that were processed against financial transactions.

(61) Maintain the flexibility to price claims at the service authorization per unit rate.

(62) Price out-of-State claims at the local State Medicaid rate using either an automated or manual process in accordance with DOH regulations.

(63) Accept and process NDCs (and other valid product identifiers) received on required claim types, in both electronic and paper claim format, in addition to the corresponding HCPCS codes. Provide the flexibility to price according to the NDC pricing structure when required by DOH regulations. For Covered Outpatient Drugs, adjudicate claims against a Procedure Code-NDC Cross-reference Database and capture these claims for delivery to the Drug Rebate Program as required by federal law.

(64) Receive information from the EPSDT MMIS component and generate non-payment encounter records from that information.

(65) Send paid EPSDT screening claim information from the Claims Processor to the EPSDT component to support timely and accurate EPSDT data updates.

(66) Maintain the 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.

(67) Maintain the capability to accept and adjudicate claims submitted by another State claims processing system. These claims must process through an amended adjudication process, bypass the payment process, and be included in backend reporting systems as approved by DOH.

(68) Perform claims validation of personal care and home health claims against Electronic Visit Verification (EVV) data as required under the 21st Century Cures Act. Provide ongoing support of EVV interfaces and reports with the DOH EVV vendor and DOH.

7.1.4 Suspense Resolution

(1) Maintain on-line access and resolution capability to claims suspended to State and Offeror locations, sorted by location program manager or other State-defined criteria, with on-line access to the corresponding imaged copies of the claims.

(2) Provide the capability to electronically route claims within locations, and to route claims to other locations when necessary.

(3) Provide a system to track all suspended claims in the routing process so that location of all claims is always known, provide aging reports of all suspended claims by location and by totals, and account for all suspended claims in the balancing and control process.

7.1.5 Information Access

(1) Maintain adjudicated claims history and all claims 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.

(2) Maintain on-line inquiry access to the suspended and in-process claims file, accessible by all elements on the claim record.

(3) Maintain on-line access to the financial transaction file. Maintain the capability to limit the request to show only gross-level transactions or to include both gross-level and claim-specific transactions.

(4) Maintain for the distribution of claims data and reporting to other divisions of DOH, other State agencies, and outside entities as defined and approved by DOH.

7.2 Claims Processing-related 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 via the Internet, return an electronic receipt and/or notification within the HIPAA Operating Rule standards.

(7) Assign a unique control number to every electronic claim submitted by providers within one (1) business day of receipt.

(8) Resolve all rejected batches within three (3) business days of the rejection.

(9) Produce and provide to DOH all daily, weekly, and monthly claims entry statistics reports within one (1) business day of production of the reports.

(10) 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 desktop must not exceed ten (10) seconds.

(11) 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.

(12) 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.

(13) Maintain a 99% accuracy rate for electronic claims receipt and transmission.

(14) Respond within HIPAA Operating Rule standards to provide a HIPAA-compliant acknowledgement transaction response approved by the State when errors occur in the interchange envelope of HIPAA-compliant electronic transaction batch transmissions.

(15) Upon receipt of HIPAA-compliant electronic transaction set batch transmissions, respond within HIPAA Operating Rule standards to provide positive and negative acknowledgement response for each segment within the HIPAA transaction.

(16) Upon receipt of all other electronic batch transmissions, respond within HIPAA Operating Rule standards to provide positive or negative acknowledgement response.

8.0 Claims Payment

The Claims Payment function includes those functions necessary to ensure that payments to providers are accurately and appropriately rendered. This includes the system monitoring of payments to ensure that expenditures do not exceed budget appropriations, system monitoring of accounts receivable to ensure that funds are recovered when necessary and producing 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 Sys/Ops Offeror and follow policy decisions made by DOH.

8.1 Maintain System Capabilities in Support of Claims Payment

(1) Ensure that reimbursements using EFT transactions 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 appropriately tracked and reported when collected.

(4) Ensure that remittance advices and payment instruments are produced accurately and on the schedule specified by DOH.

8.1.1 Budget Monitoring

(1) Maintain system capability to monitor claims and financial transaction payouts for budget appropriations by collocation code. Applying State-specified criteria, match each payment to the collocation code to reduce the balance assigned to the collocation code. Every claim payment must be linked to a collocation code. Maintain the ability to manually assign a collocation code to a claim or financial transaction. Every financial transaction must be linked to a collocation code. 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) Maintain the ability to stop Preliminary Cycle. When year-to-date expenditures exceed budget appropriations, with DOH approval, 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.

(3) Maintain the capability to enter budget data by appropriation, account and collocation code and adjust the data as necessary during the fiscal year.

(4) Maintain 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. Maintain the capability to update the cross-reference on-line and update the cross-reference as authorized by DOH.

(5) Maintain 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) Maintain the capability for authorized DOH staff to enter the adjustments to the budget appropriations on-line.

8.1.2 Weekly Checkwrite Processing

(1) Maintain the capability to run preliminary cycle. Maintain the capability to edit or make changes before final cycle is completed.

(2) Maintain the capability to print informational messages on the remittance advices.

(3) 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.

(4) Update claims 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 capture and display reissued warrant information.

(5) Update claims history and other appropriate files with the results of claims processing activities.

8.1.3 Accounts Receivable Processing

(1) Maintain on-line inquiry access to the accounts receivable database. This database must retain all key data fields Search criteria for access to this database will be defined by the State.

(2) Maintain the capability to identify the claims associated with accounts receivable.

(3) Maintain the capability to identify the fiscal year in which an account receivable was created.

(4) Maintain the capability to automatically send accounts receivable notices to providers at 30 and 60 days.

(5) Maintain the process to research, validate, follow-up and correct returned mail.

8.1.4 EFT Processing

(1) Produce electronic funds transfer provider payments for those providers requesting EFT.

(2) Send EFT authorizations to the State of Alaska Bank for set up of EFT payments.

(3) Send via FTP EFT transaction file to the State of Alaska Bank for weekly checkwrite.

(4) 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.

8.2 Claims Payment-related Performance Standards

(1) Provide payment cycle reports to DOH by 8:00 a.m. on the day following the payment processing cycle.

(2) Transmit the warrant file and accounting interface file to DOA per set guidelines.

(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 DOH of the release of funds.

9.0 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 (IRIS), and that non-claims financial transactions, refunds, and returned warrants are processed according to procedures approved by DOH. These functions are primarily the responsibility of the SYS/OPS Offeror and follow policy decisions made by DOH.

9.1 Maintain System Capabilities to Support Financial Services

(1) Ensure that expenditures and receipts made through the MMIS are accurately reported and interfaced to the IRIS system.

(2) Accept and process non-claim financial transactions according to State and federal guidelines.

(3) Maintain the capability to ensure that all SOA warrants are controlled and processed according to procedures approved by DOH. This includes safeguarding records and controls.

(4) Maintain the capability to process all refund checks and ensure all receipts are dispositioned timely and according to the Alaska Administrative Code Manual.

9.1.1 General Offeror Functions

(1) Maintain the automated financial transaction system to enter and process non-claim-specific financial transactions.

(2) Maintain the manual process of issuing a manual check 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. Manual checks are separate checks from the normal check write process and are not automated. These are special batched and require State approval before processing. Maintain 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.

(4) Maintain on-line entry and inquiry to the financial transaction file. Maintain the drilldown ability to link financial control numbers to their corresponding claim control numbers, when applicable.

(5) Edit all financial transactions for validity and include editing to prevent duplicate transactions from being entered. One unique FCN is required per financial transaction. No override to this rule is permitted.

(6) 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 required financial reports and provide them to DOH accessible on-line.

9.1.2 Accounting Interface

(1) Produce and transmit to the Department of Administration (DOA) a warrant/EFT file and an accounting interface file in the format specified by DOA after each payment cycle for

processing in the State accounting system (IRIS). This accounting interface must be bidirectional to allow for receipt of information regarding the status of warrants which supports the bank account reconciliation process.

9.1.3 Bank Account Reconciliation (follow-up on unredeemed warrants)

(1) Maintain the automated system for performing the monthly bank account reconciliation.

(2) Maintain the automated system for follow-up on outstanding warrants, including receipt and processing of the redeemed warrant file from DOA, capability to delete, adjust, and correct transactions entered in error, and the ability to manually produce letters to providers for warrants which have not been redeemed after 30 and 60 days.

10.0 Third-Party Liability (TPL)

The operation of Third-Party Liability (TPL) encompasses automated functions necessary to maintain third-party resource data on Medicaid members, process claims data against third-party resource information, recover funds from third parties as necessary, and pay insurance premiums for certain members.

10.1 Maintain System Capability to Support Third-Party Liability

10.1.1 Maintaining TPL Member Resource Data

(1) Accept current and historical insurance coverage data. Maintain the capability for updating and applying multiple policies including Medicare for a single member, including the capability to designate the hierarchy of policies.

(2) Accept all types of insurance coverage for each policy with effective dates of coverage for each.

(3) Map and convert coverage codes transferred from the eligibility information systems to coverage types defined by DOH for the MMIS.

(4) Edit TPL data for presence, format, validity, and consistency with other data in the update transaction and in the TPL files.

(5) Maintain data required for billing pharmacy TPL.

(6) Provide copies of the MMIS eligibility file and paid claims file to the TPL Offeror on a schedule determined by DOH.

(7) Maintain the capability to update coverage limits for all insurance coverage types and to pay the claim when benefit limits have been reached. Maintain 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.

10.1.2 Maintaining TPL Insurance Carrier Data

(1) Maintain 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 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) Maintain 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.

10.1.3 Processing Claims with TPL

(1) Edit claims against TPL and Medicare coverage and apply exceptions to the appropriate claim types and only to claims covered by the member's insurance coverage.

(2) Maintain the capability to ignore clients' Public Health Service coverage as a prior resource to Medicaid in the claims processing function. Maintain 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. Maintain the ability to identify this condition on the claim record.

(4) Pay claims for members with third party coverage when the service is not covered by the third-party insurance. Maintain the ability to identify this condition on the claim record.

(5) Deny claims for members covered by other health insurance according to DOH policy.

(6) When a claim is denied because of TPL coverage, notify the provider via a Remittance Advice.

(7) Provide paid claims data to the TPL Offeror when retroactive TPL coverage is identified.

(8) Maintain 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.

(9) Identify and provide claim information to the Fiscal Agent when retroactive TPL coverage is identified from a processed claim but there is no corresponding TPL resource record on the eligibility file.

11.0 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 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 members under the age of 21 with periodic health screen visits. The EPSDT functional area is concerned specifically with tracking and reporting on services to members eligible for the EPSDT program.

11.1 Maintain System Capabilities to Support EPSDT

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.

(1) Identify all individuals eligible for EPSDT services.

(2) Systemically produce customized notification letters to members when a child is due for services based on a State-defined periodicity schedule, and date of last notification sent regarding this member. This notification process includes the capability to exclude by reason codes specific members from the notification process at the State's discretion. Maintain the on-demand function to produce Screening Due lists.

(3) Maintain the capability to perform tracking and monitoring of member screening, referral, and follow-up treatment, and provide linking of costs to specific conditions. Such tracking identifies 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.

(4) Provide reports necessary for the State to effectively monitor the program as well as satisfy all Federal reporting requirements.

(5) Support an automated exchange of data between the MMIS and other databases.

(6) Maintain on-line inquiry access to the EPSDT database. Maintain the capability to update EPSDT member records on-line by DPH or designee. Data entry edits for format and validity will be required for specific fields.

(7) Maintain the process to close EPSDT records for those clients who are deceased based on date provided by 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 members 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.

(8) Maintain context sensitive help on screens for easy point and click access to valid values and code definitions by screen field.

11.2 EPSDT-related Performance Standards

(1) Accept and update EPSDT screening data from claims no less frequently than daily.

(2) Produce EPSDT reports meeting EPSDT program standards.

(3) Manually produce EPSDT outreach letters.

(4) Track unmatched referrals for follow-up and reporting.

(5) Interface with other systems, as necessary.

(6) Track immunization records of members.

12.0 Pharmacy Point of Sale (POS)

The State, or a third-party designated by the State, is responsible for providing a Pharmacy real time Point-of-Sale system that encompasses the automated functions necessary to receive and adjudicate claims submitted by appropriately enrolled pharmacy service providers. Offeror is not responsible for the POS claims adjudication or system management. However, as with many State MMIS systems, the current Alaska system has separate processes for MMIS and POS that require communication activities between both systems. Subject to the dependencies the MMIS has on other modules and State systems, including without limitation the POS, the MMIS must be capable of full compliance with all requirements of the Deficit Reduction Act of 2005 as set forth in the Agreement.

The MMIS must continue to interface with the pharmacy benefit management system to appropriately receive and pay previously adjudicated covered outpatient drug and limited medical supplies pharmacy claims.

12.1 Maintain System Capabilities to Interface with the Pharmacy POS System

(1) Maintain system capability to provide full audit capabilities of pharmacy payment outcomes produced through the MMIS.

(2) Maintain system capability to appropriately coordinate financial transaction processing, including, but not limited to, applying appropriate collocation codes and financial control numbers when applicable.

(3) Maintain/coordinate process to support member merges, as needed.

(4) Coordinate resolution of member, provider, and drug database errors, as needed.

(5) Maintain system capability to perform accounting, payment, and collection processing of pharmacy claim types.

(6) Maintain system capability to handle adjustment processing.

(7) Maintain system capability to meet the State's needs for timely processing.

(8) Maintain system capability to handle Federal, State and Offeror interfaces and reporting.

(9) Maintain interfaces between the MMIS and the POS.

(a) This process provides the interface between the POS with the MMIS for the acceptance and transfer of pharmacy and medical claims data, member eligibility and COB information, provider eligibility, drug compendium reference, prior authorization, claims pricing and other MMIS data needed for MMIS and POS claims adjudication, drug utilization review, and reporting.

(b) This process includes a balancing and reconciliation component between the POS processor and the MMIS source data to maintain the integrity of the data used by the POS processor.

(c) The MMIS receives adjudicated claims data from the POS processor at specified intervals. This process shall include a balancing and reconciliation component between the POS processor and the MMIS, including resolving pharmacy claim load issues.

(10) Maintain internal user access through the MMIS to the POS System module using industry standard SSO connection.

13.0 Drug Rebate

13.1 Maintain System Capabilities to Support Drug Rebating

(1) Ensure compliance with the Centers for Medicare and Medicaid Services (CMS) drug rebate program established under OBRA 90.

(2) Produce a medical claims extract for inclusion in the State's rebate file.

14.0 Data Warehouse (DW)/Decision Support System (DSS)

The DW/DSS function provides analytical and decision-making capabilities to Medicaid data users and the tools to extract and analyze data. The DW/DSS makes data available more quickly and easily, thus eliminating the need to retrieve such information directly from the MMIS.

(1) Maintain on-line access to information through flexible, user-friendly reporting, on-line vendor-provided training, analysis, and modeling functions.

(2) Support multiple levels of users which range from executive users to power users.

(3) Maintain abilities to perform query and analysis, report writing, and tools for data access and modeling.

(4) Maintain decision-making support and standardized reporting with the ability of users to develop semi-structured and non-structured decisions.

(5) Maintain 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.

(6) Maintain on-line report and data extraction capabilities that allow the user to access and manipulate information from claims history, prior authorization, reference, member, 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.

(7) 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.

14.1 Maintain System Capabilities of the DW/DSS

(1) Maintain an on-line library/catalog for storage and retrieval of standardized or frequently used queries, with security levels to eliminate inadvertent changes to the query.

(2) Maintain the flexible and easy to use, on-line capability for specifying query selection criteria, query computation, sort, and format characteristics and the capability to save and view or print the criteria used in the query.

(3) Maintain the users' ability to compare aggregate and summary-level information and to identify problems and opportunities.

(4) Maintain the ability to schedule queries to run during 'off-peak' hours and to save generated data sets automatically in a variety of different formats to a specified directory.

(5) Maintain the capability to estimate the query processing time to pre-define a maximum query processing time for both on-line and batch retrieval requests.

(6) Maintain the capability for automatic and manual termination of queries that exceed State pre-defined processing time thresholds.

(7) Maximize the professional efficiency and effectiveness of managers and professional staff in their access, use, presentation, and reporting of information.

(8) Maintain for non-technical end-users 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.

(9) Maintain significant privacy and security features allowing for the sharing of data among State agencies. Provide support for the de-identified data logic so that members receiving services from multiple agencies can be "linked" without violating any HIPAA or Federal statutes.

(10) Maintain a data model that is flexible and allows for the addition of new data elements with minimal effort.

(11) Maintain a platform that will be reliable, stable and allow for recoverability in any event.

(12) Maintain tools 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.

(13) Load all data necessary to operate the DW/DSS and produce a set of comprehensive balancing reports that demonstrate the conversion was successful and contains the appropriate data.

14.1.1 Extract Data from MMIS and Other State Systems and Update DW/DSS

(1) Application performance and availability requirements for the DW/DSS are the same as the MMIS. The DW/DSS must be available 24 hours except during an agreed upon maintenance window with data loads and offloads being conducted during weekends.

(2) 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 Offeror 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 Offeror 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. Offeror will provide 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. Offeror will notify all users and the State of Alaska - DOH of any problem or issue that affect data accuracy or integrity immediately. The Offeror 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.

(3) The DW/DSS includes the ability to rollback updates as required to maintain the integrity and consistency of the data.

14.2 DW/DSS-related Performance Standards

(1) Update DW/DSS daily with MMIS data. This includes ETL processing. Balancing and validation reports must be prepared and submitted to DOH 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.

15.0 Reporting

The reporting function encompasses both automated processes required to provide Management and Administrative Reporting (MARS), Transformed Medicaid Statistical Information Systems (TMSIS) Reporting, and other federal data reports (e.g., COBA, MMA). These functions are the responsibility of the Offeror and follow DOH policy decisions.

15.1 Maintain System Capabilities to Support MARS

(1) Operate, balance, and maintain the MARS function according to all federal MMIS and State requirements.

(2) Produce MARS reports in the media, format, and schedule needed by the State.

(3) Maintain complete on-line documentation.

15.1.1 Operate and Maintain MARS

(1) Maintain the MARS capability with the flexibility to address both existing and proposed changes in format and data requirements without major reprogramming or expense.

(2) Maintain maximum flexibility to meet the unique reporting needs of the Alaska medical assistance programs.

(3) Maintain information on program status and trends, and the capability to analyze historical trends and predict the impact of policy changes on programs.

(4) Maintain expenditure, eligibility, and utilization data to support budget forecasts, monitoring, and Medicaid program modeling.

(5) Maintain information to support institutional fee setting.

(6) Cross reference State-defined categories of service and eligibility classes to federal classifications for purposes of satisfying Federal statistical and financial reporting requirements.

(7) Make recommendations for improvements to reporting processes and assist the State in maintaining non-federal reports.

(8) Generate reports at frequency specified by the State.

(9) Maintain the flexibility to change or add provider types or specialties, categories of service, programs, member categories of eligibility, and carry through corresponding changes in affected MARS reports.

(10) 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.

(11) 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.

(12) Maintain a MARS database using data elements identified from the various MMIS functional areas.

(13) Capture and maintain the necessary data to meet all federal and State requirements for MARS.

(14) When an error in a MAR report is identified, provide an explanation as to the reason for the error and correct the report.

(15) 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 DOH within 24 hours of the request.

(16) Provide 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.

15.1.2 Produce MARS Reports

(1) Generate reports at frequency specified by the State.

(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) Maintain the system status dashboard available to specified State staff online.

(5) After each MARS run, 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.

(6) Respond to State inquiries and requests for information concerning MARS reports.

(7) 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 for the current period and year-to-date by payment date or service date range.

(8) Produce automated CMS-372 and other specified waiver reports.

(9) Maintain 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.

(11) Perform any necessary corrections and rerun, verify, and distribute corrected MARS reports when problems are identified.

15.1.3 Maintain On-Line Documentation

(1) Maintain complete documentation including formulas and data elements for calculated fields.

(2) Provide training in the use of the reporting function to State personnel on an ongoing, as needed, basis.

15.2 Maintain System Capabilities to Support MMA

(1) Produce all required CMS MMA files in a timely and accurate manner at a frequency defined by the State.

(2) Receive, validate, process, and post the CMS MMA State Response file as directed by the State.

(3) Produce MMA reports, including State Response file (SRF) data, downloadable in a format compatible with desktop software applications.

15.3 Maintain System Capabilities to Support TBQ

(1) Produce all required CMS TBQ files in a timely and accurate manner at a frequency defined by the State.

(2) Receive, validate, process, and post the CMS TBQ State Response file as directed by the State.

(3) Produce TBQ reports, including the response file data, downloadable in a format compatible with desktop software applications.

15.4 Maintain System Capabilities to Support COBA

(1) Provide all files required by CMS to support the Medicare-to-Medicaid crossover claims process, including E01 and E02 transmissions.

(2) Produce E01 and E02 reports, including their respective eligibility response file (ERF) data, downloadable in a format compatible with desktop software applications.

15.5 Maintain System Capabilities to Support Transformed Medicaid Statistical Information System (T-MSIS)

T-MSIS data are submitted to CMS by the State monthly. There are eight data files included in the monthly submission including 4 claims files and 4 non-claims files. The non-claims files include Beneficiary information, Provider information, Managed care organizations, and Third-party liability obligations. The claims files include pharmacy claims, long term care claims, inpatient claims, and all other claims.

The Sys/Ops Offeror supports all business processes required to create and submit the T-MSIS files and support the appropriate record correction and resubmission processes.

The Sys/Ops Offeror is responsible for performing ongoing data extraction processes and maintaining and updating its policy and procedure manuals and Operational Readiness checklist, as necessary.

(1) Load data from MMIS OLTP to ORR daily through Golden Gate replication. Load data from MMIS ORR to T-MSIS data mart weekly for claims and monthly for non-claims.

(2) For Claims functional areas, retain 1 month of ongoing data in the monthly schema and 3 years of ongoing data in the history schema. For Non-Claim data, retain all data that has been active in at least the past 7 years in the monthly schema and 6 instances of data in the history schema.

(3) Validate the data mart loading process upon completion and before the extraction process starts.

(4) Extract data from the T-MSIS Monthly schema via Informatica ETL jobs and send the extracted files to CMS for validation and incorporation within the T-MSIS master system.

(5) Load the error files into the error tables using the Error Correction Framework and evaluate the errors to identify the root cause of the error and initiate the processes to have the updated rule(s) reviewed, approved, and promoted.

(6) Upon correction of errors, re-extract and resubmit impacted files to CMS with corrected data. If the file was previously rejected in entirety, submit a corrected replacement file to CMS for processing.

(7) Track the status of ETL and UNIZ jobs during the data loading/extraction process and track batches through the Batch Control tables. The Offeror will also track the restart process during any job failure through the Batch Control tables.

(8) Run balancing job (ETL) to compare the ORR source and the T-MSIS target segment records after the T-MSIS monthly data mart is loaded weekly for claims after the claims cycle, and monthly for the non-claims areas. Upon successful completion of the balancing job, produce a balancing report which shows whether data is balanced between the ORR and the T-MSIS data mart.

15.6 Reporting-related Performance Standards

The following performance standards apply to all MMIS reports.

All standard production reports must be available online for review by DOH 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 DOH within two (2) business days after completion of the MARS production run.

Ninety-eight percent (98%) accuracy is required on all MMIS reports. The Offeror is expected to identify and correct any errors on reports. For report errors identified by DOH, the Offeror has ten (10) business days to correct the error. Meet all required CMS deadlines for submission of required federal reports.

16.0 Management and Operational Requirements

This section describes the management functions and operational tasks that the Offeror will be responsible for performing during on-going operations of the contract.

16.1 Performance Monitoring and Reporting

This contract will be organized around the delivery of major components of work. For each of these the Offeror and DOH will develop and agree to implement a performance monitoring process similar to the one described below.

(1) The State has identified areas of Offeror 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 Offeror concerning the levels of service delivery and quality for each area.

(3) The Offeror will provide a process and methodology to acquire, aggregate, and report all operational and performance metrics in an automated manner to appropriately identified users.

(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 Offeror.

(6) During the course of the contract, the Offeror will measure performance. State contract management staff will actively participate with the Offeror in the performance reporting process.

(7) Individual metric data collection and reporting schedules will be established dependent 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 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) For any non-SLA 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) Incorporating Payment Error Rate Measurement (PERM) as specified by CMS and the State.

(a) Generate claims and member reports upon request using specifications provided by the PERM audit Offerors.

(b) Provide on-line inquiry capabilities to support research of sampled claims.

(c) Provide on-line access to the imaged claim documents in the sample.

(d) Develop a plan of action to correct system processing errors discovered during the audit review and submit the plan to the State for approval.

(e) Implement a State-approved corrective action plan within the time frame defined by the State.

(f) Provide documentation to the State demonstrating that the corrective action is complete and meets State requirements.

16.2 Internal Quality Assurance

The Offeror is responsible for monitoring its operations to ensure compliance with State- specified performance requirements. A fundamental element of the quality assurance function will be to provide continuous workflow improvement in the contract scope of work. The Offeror will work with DOH 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 Offeror not only meets the performance requirements for each functional area, but also identifies problems and implements improvements to its operations on an ongoing basis.

(1) Establish, document, and maintain internal quality control and assurance procedures to ensure the accuracy and timeliness of all processing.

(2) Provide quality control and assurance reports including tracking and reporting of quality control activities, identified problems, and tracking of corrective action plans.

(3) Provide continuous workflow evaluation and improvement in the performance of Offeror responsibilities. Work with DOH to improve the overall medical assistance program in Alaska with increased focus on proactive improvements rather than retroactive responses.

(4) Develop and implement a DOH approved Quality Assurance Plan.

(5) Maintain 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.

(6) Maintain 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) Provide DOH with a description of any changes to the workflow for approval prior to implementation.

(8) Maintain internal quality control procedures for functionality and data integrity.

(9) Develop and implement quality management and assurance best practices 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 Offeror staff training and motivation for achieving higher quality standards.

(10) Maintain current set of policies and procedures, reviewed no less than annually.

16.3 Management and Operational 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.

(2) Perform quality control sampling as defined in the approved Quality Management Plan that includes monthly audits of 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 approved by DOH.

(4) Initiate, document, notify the State, and implement plans for improvement for any function when quality standards fall below service level requirements for two (2) consecutive months.

17.0 Contract Management

The Contract Management Function encompasses functions necessary to manage the system operations and to report to DOH on the status of these operational activities.

17.1 Project Management and Control Procedures

(1) Establish and maintain project management and control procedures to ensure that Sys/Ops functions are performed in accordance with State specifications. These contract management control procedures must be fully documented in policy and procedures manuals.

(2) Establish and maintain a Sys/Ops organization and provide the levels of staffing required to perform Offeror functions and to meet or exceed all performance standards.

(3) Maintain interface protocols and lines of communication both internally and between Offeror and DOH staff.

(4) Maintain internal quality control and assurance procedures to ensure the accuracy, consistency, timeliness, and quality of all processing. 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 Sys/Ops services including subcontracts and EDI.

(5) Maintain an automated project tracking and control system and performance monitoring system to track and report operational performance and monitor operational activities.

(6) Provide monthly management summary reports to DOH to report on the overall status of the project including, but not limited to the following minimum expectations:

   (a) Status of system operations activities

   (b) Status of system maintenance and modification activities

   (c) Status of internal quality control and assurance activities

   (d) Performance monitoring report card

These reports will include baselines and aging data, as well as prior period performance data.

17.1.1 General Contract Management

(1) Provide the State with reasonable access to Offeror staff during normal business hours. Maintain access to staff for emergencies by designating and publishing an on-call list of Offeror staff with contact information for after business hours.

(2) For all large projects or other projects as determined by the State, the Offeror must create a staffing management plan, including organizational charts with defined responsibilities and contact information, as well as a supporting project plan.

(3) Provide coordination of on-site and any off-site work performed by the staff.

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

(5) Provide contract management reports to DOH within the time frames specified by DOH.

(6) Schedule and conduct monthly project status meetings in conjunction with DOH contract management staff

(7) Monitor quality and work toward continued quality improvement in all contract areas.

17.1.2 Training

(1) Provide initial and ongoing staff training, including 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, mandated HIPAA transaction sets, basic HIPAA code sets applicable to each claim format, etc.

17.1.3 User Support

(1) The Offeror shall provide support for the MMIS and DW/DSS users via (at minimum) a published secure email, or a portal to create tickets for resolution.

(2) The Offeror shall provide timely ongoing education and training of user support procedures and system functionality, particularly when a change in the process is needed or required.

(3) The Offeror shall provide an acknowledgment of the receipt of a user support request by response to the requestor within no greater than 1 business day and indicate the time frame for a resolution to the issue or question.

(4) The Offeror shall provide a resolution within 2 business days of receipt to requests made in any form on routine issues or questions.

(5) The Offeror shall provide a response within 1 business day to requests made on non-routine issues or questions providing the following information:

(a) Time frame for resolution.

(b) Offeror staff names and phone numbers assigned to the task.

(c) A brief description of the activities associated with resolving the issue.

(6) The Offeror shall provide Help Desk performance reports to the State monthly within 3 business days of month end, in a State approved format, on non-routine and routine issues and inquiries, including their status, estimate for completion, progress and open issues.

(7) The Offeror 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 monthly and/or on request.

17.1.4 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 connectivity for the MMIS and participating in troubleshooting efforts for other connectivity issues as they relate to the MMIS and its resources.

(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 Offeror shall provide Database Administration and system support.

17.2 Contract Management 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) Provide training on system changes, upgrades, or other enhancements within two (2) weeks of the upgrade.

18.0 Management of System Change

The Offeror shall be responsible for performing routine maintenance, maintenance modifications, and implementing ongoing upgrades to all software, hardware, and other component parts of the MMIS. Routine maintenance, as defined in 18.1 will be performed at no additional cost to DOH.

DOH and the Offeror will mutually agree on the classification of an issue as either routine maintenance, a system maintenance modification or enhancement, or an emergency request. If the Offeror disagrees with the DOH decision, the Offeror may present information supporting its position for consideration. In consultation with the Offeror, DOH will make the final classification determination.

(1) The Offeror must maintain the issue management system that serves as a project tracking and reporting system for all system changes. The issue management system allows State and Offeror 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.

(2) System changes must be thoroughly tested and validated by the Offeror as defined in the approved Change Management Plan. All test plans and test results will be presented to DOH for review and approval. Test results will be provided in an organized and complete form for ease of review. Each of these requirements is further discussed in the following sections.

18.1 System Routine Maintenance

(1) The Offeror shall be responsible for all routine system maintenance that ensures the continued operation, integrity, and security of the MMIS system for the term of the contract. Routine system maintenance is the activities done in the normal course of business or conducted on a fixed schedule and includes monitoring and diagnostic activities, and scheduled patches.

(2) Emergency patches and upgrades necessary to maintain the system security and integrity are classified as routine maintenance.

(3) All routine maintenance will be performed by the Offeror at no additional cost to DOH.

(4) The Offeror shall develop a schedule for the performance of routine maintenance and present it to the DOH for approval. Routine maintenance should be performed at non-peak hours, as defined by the DOH.

(5) The Offeror shall clearly denote on system notifications the dates and times for the schedule, routine maintenance.

(6) The Offeror shall notify the DOH of any emergency maintenance no later than 24 hours after identifying the need for the emergency maintenance. Emergency maintenance should be conducted after the DOH's business hours, when at all possible.

(a) For any emergency maintenance identified as necessary during the DOH's business hours, the Offeror shall notify the DOH designee of the necessary maintenance, providing the reason for the emergency maintenance, action to be taken, time necessary, and whether any system outages are anticipated.

(b) For any emergency system outages, outside of the routine maintenance window, the Offeror shall develop a notification template, for review and approval of the DOH, that details out the system outage, reason for the outage, and estimated outage time.

18.2 System Maintenance Modifications

(1) The Offeror shall be responsible for all maintenance modifications required ensuring continued operation of the MMIS system for the term of the contract. Maintenance modifications includes implementation of hardware and software version upgrades. In general, the various types of maintenance modifications include:

(a) Activities necessary to correct a deficiency within the operational MMIS, including deficiencies found after implementation of modifications incorporated into the MMIS.

(b) Activities necessary for the system to meet the requirements detailed in the contract such as new edits and program changes.

(c) Activities necessary to ensure that all data, files, programs, and documentation are current and that errors are found and corrected as they are defined.

(d) Activities necessary to meet ongoing CMS certification requirements.

(e) Maintenance activities for updates to tables, databases, and code.

(f) Changes to operating parameters concerning the frequency, quantity, format sorting, media, and distribution of reports.

(7) 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 Offeror. It is the Offeror's responsibility to demonstrate appropriate and successful testing of all proposed changes prior to submission to the DOH MMIS system manager or designee for promotion approval. The Offeror is responsible for ensuring that only authorized changes are made to any system software or component.

18.2.1 Detailed System Maintenance Modification Offeror Activities

(1) Routine, scheduled maintenance modification activities should follow the Management of Change process described herein.

(2) Upon identification or notification of any system maintenance modification affecting the system accuracy, response time, security, effectiveness, or efficiency, execute the Management of Change process described herein. Notify all impacted parties as soon as practicable.

(3) Initiate a new issue research record as problems are found by the Offeror.

(4) As the DOH identifies system changes necessary, the Offeror will receive system modification change requests from DOH for system problems approved to move forward with updates.

(5) Enter the system modification change requests into the issue management system.

(6) The Offeror will ensure provision of the specified number of staff/staff hours required to complete a system modification change request within the specified time frame.

(7) Develop and deliver to the State the design documentation for resolution of issues.

(8) Receive feedback and approval for system modification change design documents from DOH and update the issue tracking and reporting system with modifications or the documented approval.

(9) Perform maintenance activities according to the priorities assigned by DOH.

(10) Submit test plans, including test scenarios, criteria, and test data, to DOH organized in a format such that all information can be completely reviewed without requesting additional information from the Offeror. These test plans must be complete, accurate and of sufficient depth and breadth for the condition(s) being tested.

(11) 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 because of the change. Testing will be reviewed and annotated by quality assurance staff with test files and sources documented.

(12) Perform testing according to the approved test plan. Review, track, and record test results for accuracy, validity, and consistency with the expected outcomes. The QA team will assure internal quality control of testing before submission for State approval.

(13) Perform VeraCode code scanning to ensure code change risks are identified and remediated. Vendor must work with DSO to ensure State's VeraCode configuration is met.

(14) Submit complete test results to DOH for approval, including the data sets and test transactions, outcomes, status, and supporting reports and test files organized in such a way that all information can be completely reviewed without requesting additional information from the Offeror. 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

(15) Submit updates to systems documentation and all other necessary documentation to DOH for approval. Ensure that document updates are a true, complete, and accurate reflection of the current production system.

(16) Implement system changes upon approval from DOH. 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 Offeror'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.

(17) 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. Include VeraCode scan results.

(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 Offeror throughout the life of the contract at no ongoing additional cost to DOH.

(19) Provide weekly reports of maintenance modification activities to DOH. This reporting includes findings of post-implementation review activities.

(20) Support the Fiscal Agent for system configuration related questions or issues.

18.2.2 System Maintenance Modification Hours

(1) Ongoing system maintenance modification hours will be provided to DOH upon requests for change through the State work order process.

(2) The Offeror will provide DOH with rough order of magnitude (ROM) hour estimates for system maintenance modifications prior to work order execution.

(3) Upon identification of the change, the Offeror will notify DOH of deviations from the ROM by 10 percent or greater.

(4) The Offeror will provide DOH with actual system maintenance modification hours worked for each project with the monthly modification hour invoice.

(5) DOH will reimburse the Offeror at an agreed upon hourly rate for subject matter expert, quality assurance, and development staff for actual modification hours worked during the invoice period according to the Rate Card submitted with Cost Proposal.

(6) A cap on the number of maintenance modification hours may be negotiated between DOH and the Offeror during contract negotiations.

18.3 System Enhancements

Enhancements result when the State or the Offeror determines that an opportunity or requirement exists that must be evaluated for inclusion in the MMIS system. In general, the various types of system enhancements 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 required by external entities, program and policy change that represent significant effort.

All requests for system enhancement will be entered into the issue management system provided by the Offeror. The Offeror will be responsible for ensuring that only authorized changes to the production system are made, and then only after complete testing and DOH approval.

18.3.1 Statement of Work (SOW)

For all issues classified as an enhancement, the Offeror is required to develop and deliver Statement of Work (SOW) documentation containing the following:

(1) A section that delineates in detail the required functionality to be developed, anticipated impacts to current systems, operations, and documentation.

(2) A section describing the technical changes required impacts, solutions, and technical requirements based on the functional specification and resulting documentation impacts.

(3) Management summary of the issue and proposed solution with a recommendation as to the most appropriate and efficient course of action

(4) A section detailing resources, and equipment required

(5) A section providing detailed and summary cost based on resources needed and Rate Card

(6) A thorough discussion of development and testing requirements

(7) An acceptance implementation plan and schedule

All SOW documentation will be reviewed by the MMIS management group and incorporated into a contract amendment to include the enhancement scope of work. Upon contract amendment execution, the approved enhancement SOW will be scheduled for design, development, and delivery according to the agreed upon project schedule.

18.3.2 Detailed System Enhancement Offeror Activities

(1) Based on receipt of system enhancements requests approved by DOH staff, prepare the project SOW according to the above listed specifications. Respond to enhancement requests within fifteen (15) business days of receipt.

(2) Upon execution of the agreed upon contract amendment, enter enhancement record into the issue management project tracking and reporting system.

(3) Conduct detailed requirements analysis for major changes.

(4) Submit requirements analysis and specifications, including a final schedule, to DOH for approval. Track and report project status and updated timeline information throughout the project.

(5) 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.

(6) Code modifications.

(a)Perform VeraCode code scanning to ensure code change risks are identified and remediated. Vendor must work with DSO to ensure State’s VeraCode configuration is met.

(b) Code changes enhancement planning must include an evaluation of the Alaska MMIS GRC Authorization Package updates and DSO review for risk acceptance. State will work with vendor to determine level of significance requiring Alaska MMIS GRC Authorization Package review.

(7) Prepare and submit test plans to DOH organized in a format such that all information can be completely reviewed without requesting additional information from the Offeror. These test plans must be complete, accurate and of sufficient depth and breadth for the condition(s) being tested.

(8) 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 because of the change. Testing will be reviewed and annotated by quality assurance staff with test files and sources documented.

(9) Perform and document unit, module, and system tests. Review test results for accuracy, consistency, and validity with expected outcomes. A quality assurance team will assure internal quality control of testing before submission for State approval.

(10) Submit complete test results to DOH for approval, including the data sets and test transactions, outcomes, status, and supporting reports and test files organized in such a way that all information can be completely reviewed without requesting additional information from the Offeror. 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

(f) VeraCode scan results

(11) Submit updates to systems documentation and all other necessary documentation to DOH for approval. Verify that changes to system components of documentation are a true, complete, and accurate reflection of the system.

(12) Submit training plan to DOH 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.

(13) Conduct required training.

(14) Implement system enhancements upon approval of DOH. The State requires coordination across the Offeror'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.

(15) 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.

(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 Offeror throughout the life of the contract.

(17) Maintain a test region or regions necessary for testing current production and enhancements. This test region must be available to designated State staff.

18.4 Issue Management Systems

The Offeror shall maintain an automated issue management system for capturing, tracking, and reporting all known system issues, including maintenance modification and enhancement requests, with full and secure accessibility to DOH. The tracking and reporting system must maintain the following information:

(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 Offeror-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 Modification 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 status of the issue and progress within the status category.

(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.

18.4.1 Issue Management System Capabilities

(1) The issue management system shall provide a view of all issues including, history, a variety of reports to track and trend issues, counts, and summary data.

(2) Provide ad hoc and standard report capabilities using all defined project information.

(3) Allow State and Offeror 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.

(4) Provide reporting and status inquiry for individual system issues, and the ability to filter and sort issues based on any of the input criteria.

(5) Provide automatic notification to appropriate parties based on user selectable issue criteria.

(6) 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.

(7) 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 Offeror related to each system change request.

18.5 System Maintenance Modifications and System Enhancement Change Management Performance Standards

(1) Notify DOH of system problems identified by the Offeror within twenty-four (24) hours of identification of the problem.

(2) Respond to system maintenance requests within ten (10) business 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 enhancements, present the State with an SOW for approval within fifteen (15) business days of receipt except for emergency system change requests for which a response is due within twenty-four (24) hours of receipt. The Offeror 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-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.

(6) Ensure that only authorized changes are made and then only after complete testing.

(7) Ensure that all system changes are completed within the time frames agreed to by DOH.

(8) 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 period agreed to by DOH.

(9) Provide training to Offeror staff, State staff, and providers for any changes affecting these users prior to the implementation of a system change.

(10) Provide monthly reports on the status of system maintenance modification activities and a summary of related updates to system documentation.

(11) Provide monthly reports of modification hours by the fifth calendar day of the month for activity completed in the previous month.

(12) Provide VeraCode code scanning items. System modification and enhancement code scans must show proof of no medium, high or very high risks. VeraCode scanning must be done monthly to capture new risks.

19.0 Other Requirements

This section describes the State of Alaska requirements regarding data processing activities, standards, procedures, and other supporting functions.

19.1 Data Processing

The data processing activities encompass 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)

(6) Alaska Personal Information Protection Act (APIPA)

(7) Medicaid Information Technology Architecture (MITA) Framework 3.0 or most current version.

19.1.1 System Reliability

(1) 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. If the system is down for more than twenty-four (24) hours, DOH will expect the Offeror to employ the procedural steps necessary to switch to a backup system.

(2) The system must be reasonably and adequately protected against hardware, software, and human intervention errors.

(3) Production of checks must not be delayed for more than twenty-four (24) hours from the normal schedule.

(4) Claims processing must not be delayed for more than twenty-four (24) hours from the normal schedule.

(5) 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.

19.1.2 System Access and Navigation

(1) The system must provide standard and consistent use of hot keys and/or other screen navigation mechanisms across functional areas, using techniques such as menus, windowing, and cursor-location sensitive inquiries.

(2) The system must store screen selection parameters to eliminate re-keying elements needed for additional inquiries.

(3) The system must allow forward/backward movement in multiple screen displays.

(4) 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.

(5) 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.

19.1.3 System Auditability

Audit and control considerations are especially important where many staff, with diverse skill levels and responsibilities interface directly with the system. Audit and control features apply to all areas of the system and are considered an integral part of the overall system architecture. Audit trails are 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.

(1) Maintain the ability to trace data from the final place of recording back to its source of entry must exist. These audit trails may be supported by listings, transaction reports, update reports, transaction logs, or error listings.

(2) Maintain the ability to track changes that are made to data or exceptions.

(3) Maintain and provide an automated history (audit trail) of all update transactions, both batch and on-line. These audit trail records must be sorted, stored, and maintained in a timely manner by the Offeror as specified by DOH.

(4) Maintain audit trails that comply with requirements of the Generally Accepted Accounting Principles (GAAP) and DOH internal control objectives.

(5) 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.

(6) Ensure that all images of data prior to updates be retained by the system as defined in the Data Retention requirements.

(7) Provide reports to facilitate control and balancing of all processes as defined by DOH as requested.

(8) Maintain an audit trail showing the actual disposition of each exception posted to a claim.

(9) Produce appropriate information to establish an audit trail of instances where suspended claims with exception conditions are automatically overridden based upon management's authority to make such decisions.

(10) Provide an audit trail for every claim that identifies all exceptions posted from the time of input into the system through the adjudication process as well as the resolution and disposition associated with each exception.

(11) Appropriate audit trails must be created when SQL updates are done to ensure that each claim is flagged with the tracking number for the SQL update. Each SQL must have a record created in the issue management system with a unique tracking number. Documentation associated with the SQL, including the criteria for selecting the claims to which to apply the SQL to, the SQL that was applied, and the identified claims universe, must be stored within the issue management system under the defined tracking number. Manually initiated SQL updates should be kept to a minimum; SQL updates should be programmatically done when possible.

(12) Maintain interfaces with other DOH- approved entities. Exchange of data with many DOH-approved entities require connections with the State Enterprise Service Bus (ESB). The Offeror must maintain appropriate connections to facilitate the smooth exchange of information.

(13) Provide compatibility with the existing State environment. The MMIS must accommodate the hardware and software currently available to DOH staff. Any proposed interfaces with DOH equipment, and integration of DOH equipment resources into proposed solutions, must conform to DOH hardware, software, middleware and telecommunications configurations and standards. During the term of the contract, DOH will consult with the Offeror regarding proposed changes to proposed LAN/WAN, Internet, and desktop standards.

19.1.4 Security and Confidentiality

(1) Provide technical, physical, and administrative mechanisms to ensure the confidentiality, integrity, and availability of data.

(2) 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.

(3) Department, State, and Federal security standards are enforced through State of Alaska and DOH policy and procedure. The procedures leverage the most recent revision of FIPS 199 information security categorization and NIST 800-53 information security controls documentation. The DOH assessment system serves as system of record to capture this documentation in an "assessment package". The vendor must coordinate with the Department Security Office (DSO) to maintain the existing GRC Package for the Alaska Medicaid Management Information System.

(4) Security controls are audited for the DOH Risk Assessment regardless of whether an application/solution is hosted on premise or elsewhere.

(5) The Offeror is expected to work with DOH business, IT and DSO to conduct regular reviews of the AK MMIS assessment package to achieve and maintain the authority to operate the MMIS. The review schedule should not be less than once a year.

(6) The Privacy Plan as established in the Alaska MMIS assessment package must demonstrate how the Offeror and its system meet all requirements of law and supports DOH's objective of ensuring that data is maintained confidentially, and members are accorded appropriate privacy rights.

(7) The Offeror's Security Plan, as established in the Alaska MMIS assessment package, 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.

(8) Regardless of the equipment configuration, effective physical security measures must be implemented and maintained for all proposed MMIS equipment, sites, processing areas and secured storage areas. At a minimum, the MMIS Offeror 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.

(9) The Offeror's facilities must meet approved standards as described in the Alaska MMIS assessment package.

(10) DOH can inspect physical facilities, to include any sub-Offeror's physical facility, at any time with prior notice to Offeror or sub-Offeror as appropriate.

(11) The Offeror, or sub-Offeror, must assure that the system is protected against unauthorized access to services, processes, servers, networks, applications, databases, and devices in accordance with DOH, State, federal guidelines, and the Alaska MMIS assessment package.

(12) The integrity and confidentiality of member and all other data must be protected by safeguards to assure that information is not used or disclosed without proper authorization as established in the Alaska MMIS GRC Authorization Package.

(13) Offeror must follow established procedures for:

(a) Software Program Change Controls

(b) Data Integrity Safeguards

(c) Archive and Purge Controls

(d) System Application Security

(e) Periodic Threat Assessment

(14) The Offeror must coordinate with DOH upon request to gather required documents to support Medicaid Information Technology Architecture Framework State Self-Assessment (MITA SS-A) on an ongoing annual basis.

(15) The Offeror must use the MMIS Multi-factor Authentication (MFA) for the MMIS web portal and the EOMB web portal. This functionality requires authorized users to provide additional verification factors to gain access to the web portal apart from user id and password. Rather than just asking for a username and password, the application requires one or more additional verification factors.

a. Alaska MMIS and EOMB web portals require the additional verification information such as One Time Password (OTP). End users receive a six-digit OTP code via email or SMS, based on the option chosen by the end user. With the OTP code generated each time, an authentication login request is submitted.
b. The end user can request a new OTP code by clicking on the request to resend a new OTP code.
c. If the end user submits the wrong OTP code continuously in three attempts, then the user account will be locked. If the end user does not have an email or phone number in the system, the user will be asked to reach out to register to get the MFA code.
d. The end users must be authorized and authenticated to access the MFA function.
e. The end user enters their username and password on the web portal login page, and the system navigates to the MFA page.

19.2 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 Offeror 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.

19.2.1 Software Version Control

Version control shall be under the jurisdiction of a Offeror team that is separate from the design, coding, and testing teams. At a minimum, the Offeror must provide detailed descriptions of the following that are consistent with system change control requirements:

(1) 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, 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.

(7) Reporting and patching requirements

- (a) Vendor is responsible for keeping abreast of the current information security risk environment. Vendor will reasonably and appropriately mitigate risks via patching, hardening system, or application configurations, and other relevant measures.

- (b) All software (hypervisor, operating system, 3rd party software) must be licensed and currently supported by the vendor and must be under current support contract with the vendor.

- (c) The firmware on the hardware, which should include microcode updates for BIOS and processors.

- (d) All critical security patches must be applied within 72 hours of critical patch availability.

(e) Offeror will supply quarterly report by location, server, vendor, OS name, function, currently operational version and patches, versions available, OS End of Life Date, application name, version.

19.2.2 Hardware Version Control

Periodically new hardware and software versions become available. The Offeror 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 Offeror 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 Offeror 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.

(3) Offeror must provide a quarterly report of hardware inventory at both the main operating site and disaster recovery site. Report should include location, server, vendor, function, patches, and End of Life dates.

19.2.3 Documentation and User Manual Version Control

The Offeror 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 Offeror will also maintain historical document version archives for all documentation.

19.3 Documentation Requirements

The systems, including MMIS, 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.

(1) The Offeror shall publish updated versions of all documentation affected by changes to systems functionality resulting from new development, modification, defect resolution, or other sources. Updated versions of documentation will be made available to DOH no later than the date that the attendant system changes are implemented in the production environment.

(2) Electronic versions of documentation must be accessible from the user's desktop, including hypertext cross-references.

(3) Documentation must be available upon any modification made during the operations phase of the contract.

(4) The Offeror is responsible for preparing documentation and revisions, in final form, prior to State sign off for system and operational changes.

(5) Documentation requirements are defined in three areas:

  (a) User Documentation

  (b) Operating procedures

  (c) System Documentation

(2) Documentation must be organized in a format that facilitates updating; and must include system and functional area narratives that can be understood by non-technical personnel. Each page should be numbered within each section, and a revision date should be included on each page.

(3) The Offeror 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.

19.3.1 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:

(1) Be written for each function in a procedural, step-by-step format.

(2) Be available on-line via the MMIS and facilitate updating.

(3) Have instructions for sequential functions.

(4) Provide consistent use of definitions of codes used in various sections.

(5) Use mnemonics consistent with screens, reports, and the data dictionary.

(6) Use abbreviations consistently.

(7) Use field names consistently for the same fields on different records.

(8) Conform to standards approved by the State.

(9) Include error message descriptions for all fields incurring edits, and the steps necessary to correct such errors.

(10) Include tables of valid values for data fields, including codes and descriptions in English, presented on screens and reports.

(11) Include illustrations of screens used in the functional area, with all data elements on the screens identified by number; and all calculated or generated fields on the screens described clearly.

(12) Include instructions for requesting reports or other outputs with examples of input documents and/or screens.

(13) Include instructions for file maintenance, with descriptions of code values and data element numbers for reference to the data dictionary.

(14) Include in the claims processing function user documentation, a detailed pricing logic for all claims processed by the system and detailed descriptions of each exception.

19.3.2 Operating Procedures

The purpose of the operating procedures is to detail the manual operations of the Offeror and the interface between the manual operations and the system. Operating procedures must:

(1) Be written in a procedural, step by step format.

(2) Include instructions for sequential functions that follow the flow of actual activity.

(3) Include all procedures for all systems manual operations.

(4) Have consistent definitions of codes throughout.

(5) 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.

19.3.3 System Documentation

The systems documentation must meet or exceed the following standards:

(1) Be available to State staff 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.

19.3.5.1 Detailed System Design (DSD)

The DSD is critical to the development cycle. It must be delivered and approved by the State before system development.

(1) The DSD must provide a detailed definition of the MMIS, DW/DSS, AVR, and EVS for State approval.

(2) The DSD must serve as the specifications for Offeror staff to develop the new systems.

(3) 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.

(4) 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.

(5) The DSD must also include a cross-reference to the corresponding sections of Part 11 of the State Medicaid Manual.

19.3.5.2 System Overview

(1) The system overview provides narrative describing the entire system and must include 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.

(2) The system overview must include business Process Models.

(3) The system overview must include data flow diagrams showing data stores and flows.

(4) The system overview must include Entity Relationship Diagrams (ERD).

(5) The system overview must include a description and flow charts showing the flow of major processes in the system.

(6) The system overview must include 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.

(7) The system overview must include a hardware/software platform configuration chart.

19.3.5.3 Functional Documentation

(1) Functional documentation provides function name and numeric identification.

(2) Functional documentation must include function narrative, including each functional area and feature of the function including use for the on-line system or in batch processing.

(3) Functional documentation must include flow charts, identifying each program, input, output, and file.

(4) Functional documentation must include job streams within functions identifying programs, input and output, controls, job stream flow, operation procedures, and error and recovery procedures.

(5) Functional documentation must include 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) Functional documentation must include 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) Functional documentation must include identification and listing of all Offeror internal control reports.

19..3.5.4 Program Documentation

(1) Program documentation provides program narratives including process specifications, purpose, use in on-line system or in batch processing, and relationships between the programs and modules.

(2) Program documentation must include a list of input and output files and reports, including retention.

(3) Program documentation must include file/database layouts.

(4) Program documentation must include file/database names and dispositions.

(5) Program documentation must include specifics of all updates and manipulations.

(6) Program documentation must include comments identifying changes to the program by date, author, and reason.

(7) Program documentation must include detailed program logic descriptions and edit logic or decision tables, including 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) Program documentation must include 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) Program documentation must include detailed pricing logic for all claims processed by the system.

(10) Program documentation must include 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) Program documentation must include lists, by identifying name, of all files, inputs, and outputs with cross-references to the programs in which they are used.

19.3.5.5 Production Control Documentation

(1) Production control documentation provides a description the operation of the system.

(2) Production control documentation must include job streams within subsystems identifying programs, input and output, controls, job stream flow, operating procedures, and error and recovery procedures.

(3) Production control documentation must include input definitions including names, descriptions, sources, and examples.

(4) Production control documentation must include output definitions, including names, numbers, sources, destinations, and examples.

(5) Production control documentation must contain operations run documentation with schedules and dependencies.

(6) Production control documentation must support State monitoring activities and any annual system performance review requirements on an ongoing basis.

19.3.5.6 Data Element Dictionary

(1) The data element dictionary provides a definition of each data element used in the system, identify where and how the element is used, and the values of each data element.

(2) The data element dictionary must include a unique data element number.

(3) The data element dictionary must include a standard data element name.

(4) The data element dictionary must include a narrative description and definition of the data element.

(5) The data element dictionary must include a table of values for each data element.

(6) The data element dictionary must include the source of each data element.

(7) The data element dictionary must include table listings for all table elements.

(8) The data element dictionary must include 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.

(9) The data element dictionary must include descriptions of naming conventions used to create data element names.

(10) The data element dictionary must meet State approved documentation standards and approved conventions.

(11) The data element dictionary must include a cross-reference to the State Medicaid Manual.

19.4.5.7 Table Description

(1) The table descriptions documentation describes each table used in the system, the elements included in the table, and the values of the elements.

(2) The table descriptions documentation must include a description of all tables used in the system which includes, for each functional area:

    (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.

    (c) A business rules repository, if appropriate.

    (d) A table of contents, by function, table, and element.

(3) Each table within the manual shall contain code sets identified by value, description and in which function(s) the code sets apply.

(4) Each table within the manual shall be listed in alphabetical order by title as approved by the State.

(5) 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.

20.0 Emergency Planning

The systems must be protected against hardware and software failures, human errors, natural disasters, and other emergencies that could interrupt services. This emergency 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.

20.1 Disaster Recovery Plan

The Offeror must coordinate with DOH to ensure the AK MMIS Disaster Recovery Plan is updated, maintained, and reviewed yearly, as described in the Alaska MMIS GRC Authorization Package.

20.2 Business Continuity Plan

The Offeror must coordinate with DOH and the fiscal agent to ensure alignment between the Fiscal Agent Operations Business Continuity Plan and the system's Disaster Recovery Plan as described in the Alaska MMIS GRC Authorization Package.

20.3 Back-Up Requirements

System back-up and processing shall include the following:

(1) Weekly Back-up: The Offeror 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. The back-ups must be maintained at a secure off-site location in an organized and controlled manner.

(2) Daily Back-up: The Offeror must establish and maintain an adequate and secure back-up for all computer software and operating programs, databases and systems, operations, and user documentation that can be changed daily as defined in the approved Disaster Recovery/Business Continuity Plan and meet the agreed-upon RTO and RPO objectives. The

backups must be maintained at a secure off-site location in an organized and controlled manner.

(3) Off-Site Storage: The Offeror 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 DOH.

(4) Back-up Processing: The Offeror must provide for a back-up processing capability at a remote site(s) from the Offeror's primary site(s) such that normal payment processing, as well as other system and DOH services deemed necessary by DOH, 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 Offeror must provide documentation defining back-up processing capacity and availability. Included shall be a prioritized listing of all the Offeror'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 Offeror 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 DOH within 30 calendar days of completion of the test.

Back-up demonstrations shall be performed at no additional cost to DOH. In the event the Offeror's test is deemed by DOH to be unsuccessful, the Offeror will continue to perform the test until satisfactory.

21.0 Records Retention

All documents must be imaged and retained securely in the Offeror's electronic document management system in accordance with the State's records retention schedule.

22.0 Turnover

Upon termination of the contract, the Offeror will be required to provide support in turning over the MMIS operations to DOH or its designated agent. DOH will notify the Offeror at least six (6) months prior to the termination of the contract that DOH wants to transfer or replace the system or system modules.

(1) All assistance, including the cost of hardware, software, or staffing will be included under regular operations and subject to State approval.

(2) Turnover of operations, whether to DOH or to another Offeror, must be smooth, timely, and without any adverse impact on the users of MMIS services.

(3) The Offeror must describe their approach to turnover of operations at the termination of the contract. The approach must address the staff proposed, the main tasks for turnover, and a proposed schedule.

(4) The Offeror must 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) The Offeror 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.

22.1 Turnover Activities

(1) Within thirty (30) days after receipt of the notification of intent to transfer or replace, provide a detailed Turnover Plan to DOH. The plan shall include at a minimum:

(a) Approach to Turnover

(b) Schedule for Turnover

(d) Staffing for Turnover

(c) 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 DOH. This document will include Statements regarding overall staffing, equipment, facility, and hardware and software. The intent of this document is to prepare DOH or its agent with adequate resources to manage the operations upon termination of the contract.

(3) Provide the current Offeror 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 Offeror staff.

(8) Provide guided visits to the facilities for State and Offeror staff.

(9) Provide a plan to transfer all current and archived documents.

(10) Transfer all system, user, and operations documentation.

(11) Provide a list of SubOfferors.

(12) Provide a list of hardware, telecommunications, and software resources currently used to manage the operations.

(13) Provide a list of staff, by labor category, required to manage the operations.

(14) Provide a list of proprietary software, if any, with appropriate descriptions.

(15) Provide a complete turnover results report at the end of the Turnover Phase.