RFP 2023-1600-0138

Attachment D – Desired Future Functionality

The State has identified the following potential opportunities and desired functionality that would benefit the State:

1. Provide functionality within the User Interface (UI) to securely map and display member letters associated with the appropriate accounts, in support of member web portal improvements.
2. Provide functionality to link or incorporate provider-specific rates (facility rates) in the enrollment record to be referenced and utilized during the claims processing rather than provider-specific rates within the rules management logic, when appropriate.
3. Provide functionality through the Provider Web Portal to attach electronic documents to claims and Service Authorizations (SAs).
4. Provide functionality to search within Provider Inquiry by state or zip code (i.e., physicians in another state)
5. Provide the ability to add notes to the applicable module without changing security access (improve role-based access controls).
6. Provide functionality through the Provider Web Portal to allow State staff to view the information as it is presented to the providers.
7. Provide functionality to have multiple utilization review (UR) limits applying to same codes; Like 1 per 22 days and no more than 12 in a year to account for early refills without going over annual limits. Accumulation of limits and combination of limits could be applied to the same annual limit (enhance configurability of code and limit combinations).
8. Improve Exception resolution within the MMIS. For manual claim processing during manual claim review, improve functionality to build workflows by code type within the MMIS to assist users work manual claim updates and revisions.
9. Provide functionality to allow Audit log access in human readable and searchable output. At a minimum the following parameters should be easily accessible and reportable: who changed values last, provider, member, screens accessed, reports run – including input parameters, and reference files.
10. Provide functionality to allow see Notes from the Fiscal Agent (access) in all functional areas, especially all Rules Management. Changes to rules, parameters, and other factors that change how claims pay or workflow changes, should be accessible and viewable to all users with the appropriate access, including State staff.
11. Provide functionality to search member by ARIES/EIS case number and return results for only the newest case.
12. Along with member demographics, eligibility, TPL, provide functionality to add notes regarding appeals or hearings to member files. For example, a DME item is allowed with the stipulation that another item couldn't be requested, etc. for a period of 5 years, maintain visibility to the restriction/limitation. Currently, this information is only within case notes on the item that went to hearing.

13. Provide functionality to allow a travel portfolio or quick view of all travels for a recipient in last year with diagnosis code.
14. Improve functionality on the provider search screen to minimize keystrokes and duplicate entry/clicks moving screen to screen, such as using “enter” as a quick-key to move screen to screen when moving through search results.
15. Develop a process/tool that would enable providers to self-select the types of services the provider typically provides, in addition to the typical taxonomy codes. The intent is to improve the ability of staff to provide appropriate referrals to populate tools/reports that would allow members to research similar information. Ideally, this information could be updated by the providers through an on-line tool.
16. Improve the ability for providers to update their demographics without Fiscal Agent staff intervention for some data points (with State approval, and without State approval).
17. Redesign pop-up detail window functionality in claims and service authorization to reduce or eliminate blocking key data elements, such as when claims inquiry or correction hides fields such as age or location, which are needed to process or review the claim.
18. Improve data entry and position management so that users are returned to the last point of data entry or similar, rather than to the top of a given area when save events occur. Within any functional area, there is currently a page save or a portlet save, which saves a small area of information. Every time there is a full save, the user activity is brought to the top of the area, which is a significant loss of time. (page/web navigation improvements)
19. Provide functionality to minimize “small saves” to process a claim or do a Service Authorization (SA). (minimize steps needed to complete workflow processes).
20. Automatically scroll/jump to appropriate data entry location within the functional areas of the MMIS; after trigger event, such as pressing the “notes” button, jumping to the notes entry field/location.
21. Improve the integration between Cognos and the MMIS to ensure that the system(s) do not time out when you are working in the other. As an example, Cognos must be started from within the MMIS tools, while working in Cognos, it is currently possible to time-out on the MMIS so that none of the Cognos work is saved and no time-out warning are presented to users. Activity within Cognos is not recognized as activity within the MMIS currently. Improvement is needed to ensure there is not a loss of work product within Cognos, while ensuring overall system security is maintained.
22. Review and enhance the “leave this page” warning functionality and only present it to users when there will be a loss of data or other problem associated with closing the page or window. It is currently provided too often, even in read-only mode.
23. Improve the number of rate combinations or configuration solution for rate/modifier combos. CPT/HCPCS configuration solution is currently only 5 digits starting with ZZ; over the last few years, many rate/modifier combos have been added. The current solution does not have the capacity to hold the combinations needed (not enough combinations are possible in the system).
24. Improve functionality for Prescriber affiliations within Care Management Program – requiring and/or enforcing a member to go only to one prescriber, this is usually one pharmacy. Only individual provider NPIs are currently being sent to the pharmacy solution, rather than the appropriate group NPI, when applicable. It would be desirable to use the prescriber affiliation from the MMIS when sending provider information to the pharmacy solution to improve claims processing and transmit multiple pharmacies as part of the restriction group.
25. Add functionality to do history-only pharmacy claim merges within the MMIS.
26. Ensure all applicable drug pricing sources are considered and configurable when pricing drug claims to ensure that the lesser-of logic is being used at all times. Add functionality to interface all Commercial Insurance (CI) to the MMIS for deposits to be allocated to all claims impacted, showing the TPL payment was received from a TPL recovery with no impact to the 1099 for History only adjustments.

27. Add functionality to automatically identify claims less than 120 days old with identified TPL/Medicare and recoup the overpayment against claims from provider and identify reason on Remittance Advice (RA).
28. Add functionality to allow recoupment of overpayments to providers to be configurable.
29. Add functionality to automatically identify claims where the need for recoupment is more than 120 days after the date of overpayment related to TPL/Medicare. For these claims, the MMIS will generate and send a notice to the provider including: (1) the reason for the recoupment; (2) the amount of the overpayment that will be recouped; and (3) notice of the provider's right to an appeal.
30. Add functionality to perform the Buy-In Eligibility Code (BIEC) assignment.
31. Add functionality to utilize and apply the Buy-In Transaction Rejects automatically within the MMIS.
32. Add functionality to include the Medicare Buy-In Spans on the Member Summary Screen within the MMIS.
33. Add functionality to allow the Recovery UI to utilize pharmacy claims.
34. Add functionality to allow the Recovery UI to utilize claims prior to 01/01/2014.
35. Add the functionality to allow providers to upload TPL policy information, including updates, in real-time.
36. Add functionality to allow staff to create groups of related TPL entities in order update all members of a group with one action.
37. Add functionality to allow updated TPL information to be applied to individual members or the entire family.
38. Add functionality to retrieve TPL information by policy number and add by client id all household members under policy holder with same start dates.
39. Add functionality to allow multiple addresses for the BIN and/or PCN.
40. Add the functionality to allow closure settings to be configurable for all Medicaid Buy-In cases within the User Interface (UI).
41. Add the ability to completely maintain and operate the Health Insurance Premium Program (HIPP) within the MMIS. This includes determining cost effectiveness, creating and generating claims data history, verifying and adding/updating TPL information, and allowing the reimbursement of Recipients through the User Interface (UI).
42. Add the ability for the MMIS to identify Trauma claims and automatically generate and send letters to members directly to provide notification of payment.
43. Add functionality to perform searches for all payouts and warrants by parameters including, but not limited to: remittance advice, provider name, check amounts.
44. Add functionality to create, generate, and save history reports for all manual payouts and manual warrants.