STATE OF NORTH DAKOTA
Department of Human Services
Division of Medical Services
600 E. Boulevard Ave., Dept. 325
Bismarck, ND, 58505-0250

Request for Proposal
RFP # 325-05-10-016
Date of Issue: June 1, 2005

For the

North Dakota Medicaid
Systems Replacement Project

Geoff Lowe
Procurement Officer
Department of Human Services

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1.0 INTRODUCTION AND INSTRUCTIONS

1.1   BACKGROUND OF THIS PROCUREMENT

The Medical Services Division of the North Dakota Department of Human Services (DHS or Department) is the State agency responsible for administering the Medicaid program in North Dakota. The North Dakota Information Technology Department (ITD) and the DHS Division of Information Technology (DoIT) are responsible for the operations and maintenance of the Medicaid Management Information System (MMIS). The Medicaid Program provides medical services to eligible Medicaid recipients under Title XIX (Medicaid) of the Social Security Act through enrolled providers and health plans.

The Federal Government amended Title XIX of the Social Security Act in 1972 to allow States to receive 90 percent Federal Financial Participation (FFP) for all expenditures attributable to the design, development, and implementation of mechanized claims processing and information retrieval systems. The legislation also allows States to claim 75 percent FFP for the operation of such systems.

To receive the 75 percent FFP, the developed system must be certified by the Secretary of the Department of Health and Human Services (HHS). An absolute priority of DHS is that the implemented North Dakota MMIS achieve and maintain Centers for Medicare and Medicaid Services (CMS) Certification status.

1.1.1   MEDICAID INFORMATION TECHNOLOGY ARCHITECTURE (MITA)

The Federal Government's Center for Medicaid and State Operations (CMSO) has launched an initiative, known as the Medicaid Information Technology Architecture (MITA), to establish Federal / State partnerships promoting technologies and processes that support flexibility and adaptability, and can rapidly respond to changes in the Medicaid program. The goals of MITA include:

- Reducing costs by integrating interoperable systems that can share data and achieve common Medicaid goals

- "Modularity" through reusable system components, so that a single component can be upgraded or replaced without having to replace the entire "system"

- Adopting and promoting industry standards

- Easy accessibility to timely and accurate data in order to make administrative and program decisions

- Enabling technologies to support Medicaid business processes

- Performance management linking planning, measurement and accountability

- Strategic coordination with healthcare partners to improve Medicaid health outcomes

DHS has made the decision to implement a system environment that adopts the MITA principles, focusing on aligning technological needs with business needs. This will require transforming the architecture and infrastructure of its existing information systems from procedurally programmed, monolithic applications into enterprise-wide, services-oriented components.

A preliminary crosswalk has been developed (see Attachment L) that maps the North Dakota business area RFP requirements to the MITA Business Process Model. Due to the turnkey nature of this RFP, several business area functions will be handled by the State, which results in the appearance of gaps in the preliminary crosswalk.

1.1.2   CURRENT SYSTEMS

The current DHS MMIS is a 1978 Electronic Data Systems (EDS) MMIS transfer system that is operated and maintained by ITD and DoIT. It has evolved continuously since its inception as a result of phased-in developments and enhancements. The North Dakota MMIS is certified and eligible for 75 percent Federal Financial Participation (FFP) under 42 CFR Part 433, Sub-Part 3 and Section 1903 (a) (4) of the Social Security Act.

The Pharmacy Point-of-Sale (POS) system is a mainframe system developed by GTE Data Services, Inc. (now Verizon Data Services, a subsidiary of Verizon Communications) and transferred from Utah to North Dakota in 1996. The POS is also operated and maintained by ITD and DoIT. It has been modified beyond the National Council for Prescription Drug Programs (NCPDP) 5.1 compliance standards that are mandated by the Health Insurance Portability and Accountability Act (HIPAA).

North Dakota currently contracts with Medstat for use of its Decision Support System called DataProbe™.

1.1.3   AUTHORITY FOR THIS RFP

This RFP is issued under the authority of Title XIX of the Social Security Act (as amended), the regulations issued under the authority delegated by the Office of Management and Budget (OMB), and applicable N.D.C.C. 54-44.4 and N.D.A.C. 4-12 regulations. All bidders are charged with presumptive knowledge of all requirements of the cited authorities, as well as any systems services performance review standards. The submission of a valid Bid Proposal by any bidder will constitute admission of such knowledge on the part of the bidder.

1.2   PURPOSE AND SUMMARY OF THIS RFP

This RFP is issued by the State of North Dakota Department of Human Services (DHS) to procure a certifiable Medicaid Management Information System (MMIS), a Pharmacy Point-of-Sale (POS) system, and a Decision Support System / Data Warehouse (DSS/DW). These systems must meet the objectives of MITA, fulfill the requirements outlined in this RFP (therefore exceeding the functionalities and business needs met by the legacy system), and be compliant with all applicable Federal mandates. The systems must also meet the informational,

operational, and administrative needs necessary to support the day-to-day management of the North Dakota Medicaid program and other supported State healthcare programs. The proposals must describe in detail the most cost effective manner to implement and install a system to meet the system descriptions and functional requirements identified in this RFP and associated documents.

*<u>Bidder's Note:</u> Bidders will submit separate Bid Proposals for each system component (i.e., MMIS, POS, and/or DSS/DW) that they are bidding.**

Vendors responding to the MMIS or POS portions of this RFP are required to offer proposals that allow for award of a "turnkey" solution. For these contracts, a turnkey system identifies a solution wherein the MMIS and POS Contractors will design, develop, implement, and install the replacement MMIS and POS systems on State-owned hardware in the State's data center. After the installation of the MMIS and POS, the Contractor(s) will perform appropriate System Maintenance activities for a period of one (1) year and perform Knowledge Transfer / Training activities for a period of six (6) months, and turnover full operations and maintenance responsibilities for the replacement systems over to the State. Once the systems have been turned over to the State, the State will own the implemented MMIS and POS, will have the ongoing responsibility for the operation and maintenance of the replacement MMIS and POS, and will provide all application programming support for ongoing changes and enhancements. All post-DDI MMIS and POS business functions and processes will be the State's responsibility.

A DSS/DW solution will be implemented concurrently with the MMIS and POS solutions. After implementation, however, the ongoing operations for DSS/DW services will be contracted to the successful DSS/DW Contractor. The State's preference is that the DSS/DW Contractor will run the DSS/DW on State hardware, but the State will consider alternatives in its evaluation.

Bidders who have been awarded system component contracts from this procurement will be required to work with State technical staff and the State's Independent Verification and Validation (IV&V) Contractor to support integration of the respective work plans into the overall Implementation and Operations project plans for the North Dakota Medicaid Systems Replacement Project.

1.3   ORGANIZATION OF THIS RFP

This RFP is organized into twelve (12) primary sections plus an Attachments section. The Sections of this RFP, with brief title, are as follows:

- Section 1:   Introduction and Instructions
- Section 2:   Procurement Process
- Section 3:   Contract Terms and Conditions
- Section 4:   Program Description and Background
- Section 5:   Scope of Work and Project Schedule
- Section 6:   General Requirements
- Section 7:   System Requirements

- Section 8:   Start-up Activities

- Section 9:   Ongoing Business Process Requirements

- Section 10:   Format and Content of Bid Proposals

- Section 11:   Evaluation of Bid Proposals

- Section 12:   Attachments

1.4   GLOSSARY OF TERMS AND ACRONYMS

DHS has prepared a Glossary of Terms and Acronyms to familiarize bidders with any North Dakota-specific terms and acronyms that are contained within this RFP. This Glossary is presented as Attachment A to this document.

1.5   GENERAL INSTRUCTIONS

1.5.1   ASSISTANCE TO BIDDERS WITH A DISABILITY

Bidders with a disability needing accommodation should contact the Procurement Officer prior to the deadline for receipt of proposals so that reasonable accommodation(s) can be made.

1.5.2   REQUIRED REVIEW

Bidders should carefully review this solicitation for defects and questionable or objectionable material. Comments concerning defects and objectionable material must be made in writing and received by the Procurement Officer by the time and date indicated for Task E in the Procurement Schedule. This will expedite issuance of any necessary amendments. It will also help prevent the opening of a defective solicitation and unnecessary exposure of bidder's proposals, upon which an award could not be made. Protests based on any omission or error, or on the content of the solicitation, will be disallowed if these faults have not been brought to the attention of the Procurement Officer, in writing, before the time indicated in the Procurement Schedule.

In the event that this RFP is found to contain errors, inconsistencies, or ambiguities, the State reserves the right to correct these, and such corrections will be considered to be part of this RFP.

1.5.3   AUTHORIZED SIGNATURE

An individual that is authorized to bind the bidder to the provisions of the RFP must sign all Bid Proposals.

1.5.4   VENDOR REGISTRATION

VENDORS MUST BE APPROVED BY TIME SET FOR RECEIPT OF BID PROPOSALS

North Dakota law requires that every person or company that desires to submit a Bid Proposal for commodity or service contracts must be an approved vendor in order to be placed on the State's bidders list. For this contract, bidders must be fully registered as "approved vendors" by the time that has been set for receipt of Bid Proposals.

***Bidder's Note: DHS strongly encourages bidders to initiate their registration process upon receipt of the RFP, as this process could potentially be lengthy (based upon the State of origin of the bidder).**

Prospective bidders may access the Procurement Vendor Database at:

  http://www.state.nd.us/csd/spo/csd-spo-public.htm

to verify whether or not their firm is currently on the bidders list. The bidders list that will be used for this solicitation includes vendors listed under NIGP commodity codes 920.40 and 918.67.

To become an approved vendor with the North Dakota State Procurement Office, bidders must: 1) also be registered with the North Dakota Secretary of State (fees apply), and 2) submit a completed Bidders List Application to the State Procurement Office within the North Dakota Office of Management and Budget (OMB). Registration instructions and forms are available on-line at:

  http://www.state.nd.us/csd/spo/vendor-reg-cert.html

Contact the North Dakota State Procurement Office at (701) 328-1726 or *infospo@state.nd.us* for assistance.

A bidder who is not registered by the deadline for receipt of proposal will be determined to be non-responsive, and their proposal will be rejected.

RELATED INFORMATION ABOUT NORTH DAKOTA SECRETARY OF STATE REGISTRATION:

If the scope of the work will require the Contractor to perform work in North Dakota, the successful bidder may also be required to register with the North Dakota Secretary of State prior to award unless the project is an isolated transaction for the vendor and they have not previously done work in North Dakota. Contact the North Dakota Secretary of State at (701) 328-4284.

1.5.5   SUBCONTRACTORS

Subcontractors and/or consultants may be used to perform work under this contract. If a bidder intends to use subcontractors and/or consultants, the bidder must identify in the proposal the names of the subcontractors / consultants and the portions of the work that the subcontractors /

consultants will perform. Additional information requested about subcontractors is further defined in Section 10 of this RFP.

Upon Notice of Intent to Award, if a proposal with subcontractors and/or consultants is selected, the bidder must provide the following detailed information concerning each prospective subcontractors / consultants within **five (5) working days** from the date of the State's request:

(a) Complete name of the subcontractor / consultant,
(b) Complete address of the subcontractor / consultant,
(c) Type and scope of work the subcontractor / consultant will be performing,
(d) Percentage of work the subcontractor / consultant will be providing,
(e) Evidence, as set out in the relevant section of this RFP, that the subcontractor / consultant holds a valid North Dakota business license, and
(f) A written statement, signed by each proposed subcontractor and/or consultant, that clearly validates that the subcontractor / consultant is committed to render the services required by the contract.

The intent of submitting this information during contract negotiations is to confirm the proposal's commitment of the subcontractor(s) / consultant(s) to the project. A bidder's failure to provide this information, within the time set, may cause the State to consider their proposal non-responsive and reject it. The substitution of one subcontractor / consultant for another may be made, only at the discretion and prior written approval of the State's Contract Officer or the Project Directors designated by the State. For additional information on proposal submission requirements for subcontractors / consultants, see Section 10.2.9.1.

1.5.6   JOINT VENTURES

Joint ventures will not be allowed in response to this procurement. For the purposes of this procurement, DHS defines a joint venture as follows:

Joint Venture - A risk sharing partnership arrangement of two (2) or more vendors, who have teamed together to address a project's set of contracted services. In this type of partnership, no single vendor assumes the lead role of "prime contractor" over one or more partner "subcontractors".

1.5.7   CONFLICT OF INTEREST

Bidders must disclose any instances where the firm or any individuals working on the contract has a possible conflict of interest and, if so, the nature of that conflict (e.g., employed by the State of North Dakota). The State reserves the right to cancel the award if any interest disclosed from any source could either give the appearance of a conflict or cause speculation as to the objectivity of the bidder's proposal. The State's determination regarding any questions of conflict of interest shall be final.

1.5.8   OFFER HELD FIRM

Proposals must remain open and valid for at least **120 CALENDAR DAYS** from the deadline specified for submission of proposals. In the event an award is not made within **120 CALENDAR DAYS**, the State will send a written request to all bidders deemed susceptible for award asking bidders to hold their price firm for a longer specified period of time.

1.5.9   BIDDER'S CERTIFICATION

By signature on the proposal, bidders certify that they comply with:

a)   The laws of the State of North Dakota

b)   North Dakota Administrative Code

c)   All applicable local, State, and Federal laws, code, and regulations

d)   The applicable portion of the Federal Civil Rights Act of 1964

e)   The Equal Employment Opportunity Act and the regulations issued thereunder by the Federal government

f)   The Americans with Disabilities Act of 1990 and the regulations issued thereunder by the Federal government

g)   All terms, conditions, and requirements set forth in this RFP

h)   A condition that the proposal submitted was independently arrived at, without collusion,

i)   A condition that the offer will remain open and valid for the period indicated in this solicitation

j)   A condition that programs, services, and activities provided to the general public under the resulting contract conform with the Americans with Disabilities Act of 1990, and the regulations issued thereunder by the Federal government

k)   A condition that the firm and any individuals working on the contract do not have a possible conflict of interest (e.g., employed by the State of North Dakota)

If any bidder fails to comply with the provisions stated in this paragraph, the State reserves the right to reject the Bid Proposal, terminate the contract, or consider the Contractor in default.

1.5.10   STATE NOT RESPONSIBLE FOR PREPARATION COSTS

The State will not pay any cost associated with the preparation, submittal, or presentation of any proposal. This includes any travel costs associated with attending oral presentations and contract negotiation sessions.

1.5.11 DISCLOSURE OF PROPOSAL CONTENTS AND COMPLIANCE WITH ND OPEN RECORDS LAWS

All proposals and other material submitted become the property of the State and may be returned only at the State's option. All proposals and related information, including detailed cost information, will be held in confidence until an award is made.

After award, proposals will be subject to North Dakota open records law. Records are closed or confidential only if specifically stated in law. Bidders may make a written request that trade secrets and other proprietary data contained in proposals be held confidential. Material considered confidential by the bidder must be clearly identified, and the bidder must include a brief statement in their transmittal letter that sets out the statutory basis for confidentiality. The Procurement Officer will respond to the bidder's request, in writing, with a written determination whether the information is an exception to the North Dakota open records law, and the information will be processed appropriately.

1.5.12 PUBLIC NOTICE

Public notice of this solicitation is not required. However, the State does require that DHS send the RFP to all vendors registered on the OMB State Procurement Office's Approved Vendor List for the applicable category of service.

1.5.13 NEWS RELEASES

News releases related to the contracts awarded from this RFP will not be made without prior approval of the Contract Officer or Project Directors designated by the State for the resultant contract(s).

1.5.14 BUDGET

The budget for this project will not be disclosed.

2.0 PROCUREMENT PROCESS

2.1 PROCUREMENT OFFICER AND CONTACT INFORMATION

The Procurement Officer, identified below, is the sole point of contact regarding the RFP from the date of issuance until announcement of the successful bidder.

> Geoff Lowe
> Procurement Officer, RFP# 325-05-10-016
> Division of Information Technology
> Department of Human Services
> 600 E. Boulevard Ave., Dept. 325
> Bismarck, ND, 58505-0250

2.2 RESTRICTIONS ON COMMUNICATION BETWEEN BIDDER AND DHS

From the issue date of this RFP until announcement of the successful bidder, bidders may contact only the designated Procurement Officer. The Procurement Officer will directly respond only to questions regarding the procurement process, which must be submitted in writing via electronic mail to the Procurement Officer. Verbal questions related to the procurement process will not be accepted. Any procurement process questions submitted via electronic mail must be sent to the following email address:

> MedicaidRFP@state.nd.us

Procurement process questions must have a subject line that contains the RFP number assigned to this procurement (RFP# 325-05-10-016). Procurement process questions posed by vendors, along with the corresponding answers provided by the Department, will be provided to all vendors' established point of contact via e-mail. Unauthorized contact regarding the RFP with other State employees of the purchasing agency and ITD may result in the vendor being disqualified.

*Bidder's Note: DHS requires that bidders submit their point of contact with their Letter of Intent to Bid.

Questions related to the interpretation of the RFP follow the protocol set forth by Section 2.7 below.

2.3   DOWNLOADING RFP MATERIALS FROM THE INTERNET

The RFP and all subsequent amendments will be posted on the DHS website at: www.state.nd.us/humanservices. The bidder is advised to check the DHS website periodically for any amendments to this RFP. Bidders will be required to acknowledge all amendments within their proposals.

2.4   PROCUREMENT SCHEDULE OF EVENTS

The procurement schedule of events set out herein represents the State of North Dakota's best estimate of the schedule that will be followed. If any component of this schedule is delayed, such as the closing date for receipt of proposals, dependent tasks in the rest of the schedule will be shifted by the same number of days at the State's discretion.

The present procurement schedule of events is as follows:

Table 1: Procurement Schedule of Events

TASK	KEY PROCUREMENT TASK	DATE
A	NOTICE OF INTENT TO ISSUE RFP	MAY 17, 2005
B	ISSUE RFP	JUNE 1, 2005
C	BIDDERS' LIBRARY AVAILABLE	BEGIN: JUNE 8, 2005 END: DECEMBER 31, 2005
D	MANDATORY LETTERS OF INTENT TO BID DUE	JUNE 22, 2005
E	BIDDERS' CONCERNS ON QUESTIONABLE RFP MATERIAL DUE	JULY 8, 2005
F	BIDDERS' QUESTIONS DUE	JULY 8, 2005
G	WRITTEN RESPONSES TO BIDDERS' QUESTIONS ISSUED	AUGUST 1, 2005
H	CLOSING DATE FOR RECEIPT OF BID PROPOSALS AND AMENDMENTS TO BID PROPOSALS	SEPTEMBER 1, 2005
I	ORAL PRESENTATIONS	BEGIN: OCTOBER 3, 2005 END: OCTOBER 12, 2005
J	BEST AND FINAL OFFERS DUE (AS REQUESTED)	OCTOBER 27, 2005
K	COMPLETION OF CONTRACT NEGOTIATIONS	DECEMBER 8, 2005
L	NOTICE OF INTENT TO AWARD TO SUCCESSFUL BIDDERS	DECEMBER 9, 2005

TASK	KEY PROCUREMENT TASK	DATE
M	CMS CONTRACT APPROVAL	DECEMBER 19, 2005
N	DHS EXECUTION OF CONTRACT	DECEMBER 27, 2005
O	BEGIN DDI PHASE OF CONTRACTS	JANUARY 3, 2006
P	BEGIN OPERATIONAL PHASE OF CONTRACT	APRIL 24, 2008
Q	STATE BEGINS OPERATION OF TURNKEY MMIS AND POS SYSTEMS	APRIL 24, 2008

2.5   BIDDERS' LIBRARY

A Bidders' Library will not be available onsite at the DHS offices for potential bidders to review material relevant to the RFP. However, an Electronic Bidders' Library will be available through the Medicaid Systems Replacement Project hyperlink at:

www.state.nd.us/humanservices

The Electronic Bidders' Library contains items such as:

- Data Element Dictionary Samples from Current MMIS
- Sample Reports from Current MMIS
- Sample Reports from Current POS
- Sample Federal or State-required Reports from Current DSS
- SeeBeyond and VISION / TECS Interface Documentation
- Pricing Manuals
- Edit/Audit Tables Manual
- Other User Manuals
- Provider Services Documentation
- Sample MMIS Notices and Letters

It is the bidder's responsibility to review Bidders' Library materials for relevance to this RFP's Scope of Work.

2.6   MANDATORY LETTERS OF INTENT TO BID

A Letter of Intent to Bid must be mailed, sent via delivery service, or hand delivered by the bidder (or the bidder's representative) to the Procurement Officer by **3:00 p.m., Central Time, on June 22, 2005**. The Letter of Intent to Bid must include:

- Identification of the contract (MMIS, POS, or DSS/DW) for which the bidder intends to submit a Bid Proposal

- The bidder's name and mailing address,

- Name and e-mail address for designated point of contact,

- State of North Dakota Vendor Log-In ID

- Telephone and Fax numbers for designated point of contact,

- A statement verifying the company's intent to bid for the contract, and

- An authorizing signature

*<u>Bidder's Note:</u> State of North Dakota Vendor Log-In IDs and passwords are required to submit Bidders' Questions for this RFP. IDs and passwords are obtained by following the Q/A database Log-In instructions on the Department's website at:

> **http://www.state.nd.us/humanservices/info/mmis.html**

Electronic mail and faxed Letters of Intent to Bid will not be accepted. Bidders who plan to submit Bid Proposals for multiple RFP components (e.g., MMIS <u>and</u> POS) are expected to submit separate Letters of Intent to Bid for each system component for which they intend to bid.

Submitting a Letter of Intent to Bid is a mandatory condition to submitting a Bid Proposal and also ensures receipt of written responses to bidders' questions, comments, and any amendments to the RFP. Failure to submit a Letter of Intent to Bid by the deadline specified will result in the rejection of the bidder's Bid Proposal.

2.7   BIDDERS' QUESTIONS

Bidders are invited to submit written questions regarding the RFP via the Medicaid Systems Replacement Project hyperlink on the DHS website at www.state.nd.us/humanservices. See the Bidders' Note above for information on accessing the Bidders' Questions tool. The questions must be submitted and received by the Procurement Officer before **3:00 p.m., Central Time, on July 8, 2005**. Other instructions are as follows:

- Verbal, fax, and e-mail questions will not be permitted.

- The question must specify the system (i.e., MMIS, POS, or DSS/DW), Section of the RFP, and page number(s).

- Notification regarding the website posting of written responses to bidders' questions will be sent on or before **August 1, 2005** to the established point of contact for bidders who have submitted a Letter of Intent to Bid. Written responses to questions will be available on the DHS website at www.state.nd.us/humanservices.

If the Department modifies the RFP, the Department will issue an appropriate amendment to the RFP. Bidder questions that require an RFP amendment for full clarification will be answered with a reference to the appropriate amendment. The Department's written responses to all questions or clarification requests will be considered part of the RFP.

The Department assumes no responsibility for verbal representations made by its officers or employees, unless such representations are confirmed in writing and incorporated into the RFP.

Oral communications shall be considered unofficial and non-binding on the State. The interested party must confirm telephone conversations in writing.

2.8   AMENDMENTS TO THE RFP

If an amendment to this RFP is issued, it will be posted to the designated website above. All prospective bidders who requested an electronic copy of the RFP and/or submitted a Letter of Intent to Bid will be notified of an update to website materials via e-mail from the Procurement Officer.

2.9   SUBMITTAL OF BID PROPOSALS

The Department must receive the Bid Proposal, addressed as identified below, before **3:00 p.m. Central Time** on **September 1, 2005.**

> Geoff Lowe
> Division of Information Technology
> North Dakota Department of Human Services
> 600 East Boulevard Avenue, Dept. 325
> Bismarck, North Dakota 58505-0250

This is a mandatory requirement and will not be waived by the Department. Any Bid Proposal received after this deadline will be rejected and returned unopened to the bidder. Bidders mailing Bid Proposals must allow ample mail delivery time to ensure timely receipt of their Bid Proposals. It is the bidder's responsibility to ensure that the Bid Proposal is received prior to the deadline. Postmarking by the due date will not substitute for actual receipt of the Bid Proposal by the Department. Electronic mail and faxed Bid Proposals will not be accepted. Bidders who plan to submit Bid Proposals for multiple RFP system components (e.g., MMIS and POS) are expected to submit separately bound and boxed Bid Proposals for each system component for which they intend to bid. Submittal instructions are explained in further detail by Section 10.

Bidders must furnish all information necessary to evaluate the Bid Proposal. Bid Proposals that significantly fail to meet any of the mandatory requirements of the RFP may be disqualified at the State's discretion. Verbal information provided by the bidder shall not be considered part of the bidder's Bid Proposal.

2.10   BID PROPOSAL OPENING

The Department will open Bid Proposals at **4:00 p.m., Central Time, on September 1, 2005**. While Bid Proposal opening by the Procurement Officer is an informal process, the material contained within the Bid Proposals will remain fully confidential until the Evaluation Committee has reviewed all of the Bid Proposals submitted in response to this RFP, contract negotiations have been completed, and the Department has announced a Notice of Intent to Award on each of the contracts.

DHS intends to disclose the identity of bidders who have submitted Letters of Intent to Bid and Bid Proposals on the procurement website. Website posting of the identity of bidders who have submitted Letters of Intent to Bid and who have submitted Bid Proposals will occur on or around **September 6, 2005**.

2.11   AMENDMENTS TO PROPOSALS AND WITHDRAWALS OF PROPOSALS

Bidders may only amend or withdraw submitted proposals prior to the deadline that is set for receipt of proposals. No amendments will be accepted after the deadline, unless they are in response to requests by the State. Any pre-deadline amendments must be in writing, signed by the bidder, and mailed to the Procurement Officer before the time that is set for the final receipt of proposals (unless this date is extended by the Department). Electronic mail and faxed Bid Proposal amendments will not be accepted, unless otherwise requested by the Department.

After the deadline, bidders may make a written request to withdraw proposals if they provide evidence that a substantial mistake has been made. The Procurement Officer may permit withdrawal of the proposal upon verifying that a substantial mistake has been made.

2.12   ALTERNATE PROPOSALS

Bidders may submit only one Bid Proposal for each contract under evaluation. Alternate proposals (proposals that offer something substantially different than what is asked for) will be rejected.

2.13   RIGHT OF REJECTION

The State reserves the right to reject any or all Bid Proposals, in whole or in part. Bid Proposals received from debarred or suspended vendors shall be rejected. The Procurement Officer may reject any proposal that does not comply with all of the material and substantial terms, conditions, and performance requirements of the RFP.

Bidders may not qualify the proposal, nor restrict the rights of the State. If a bidder does so, the Procurement Officer may determine the proposal to be a non-responsive counteroffer and the proposal may be rejected.

The Procurement Officer may waive minor informalities that:

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

- Do not constitute a substantial reservation against a requirement or provision.

The State reserves the right to reject any bidder or Bid Proposal determined to be not responsive. The State also reserves the right to refrain from making an award if it determines that to be in its best interest.

2.14   SUPPLEMENTAL TERMS AND CONDITIONS

Bid Proposals including supplemental terms and conditions will not be accepted. Any proposals with supplemental conditions that conflict with those contained in this RFP or that diminish the State's rights under any contract resulting from the RFP will be considered null and void. The State is not responsible for identifying any conflicting supplemental terms and conditions that have been submitted in Bid Proposals before issuing a contract award. After award of contract:

1.) if conflict arises between a supplemental term or condition included in the Bid Proposal and a term or condition of the RFP, the term or condition of the RFP will prevail; and

2.) if the State's rights would be diminished as a result of application of a supplemental term or condition included in the Bid Proposal, the supplemental term or condition will be considered null and void.

2.15   EVALUATION OF PROPOSALS

An evaluation committee will evaluate proposals. The evaluation will be based on the evaluation factors set forth in Section 11 of this RFP.

2.16   PREFERENCE LAWS

The preference given to a resident North Dakota bidder will be equal to the preference given or required by the State of the non-resident bidder. A "resident" North Dakota bidder, seller, or Contractor is defined as one who has maintained a bona fide place of business within this State for at least one year prior to the date on which a contract was awarded.

For a listing of State preference laws, visit the following website at:

http://tpps.das.state.or.us/purchasing/pref-law/reciprocal_detail.php

or contact the North Dakota State Procurement Office at (701) 328-2683.

2.17   CLARIFICATION OF OFFERS

In order to determine if a Bid Proposal is reasonably susceptible for award, communications by the Procurement Officer or the proposal evaluation committee are permitted with a bidder to clarify uncertainties or eliminate confusion concerning the contents of a proposal and determine

responsiveness to the RFP requirements. Clarifications provided by the bidder may not result in a material or substantive change to the Bid Proposal. The initial evaluation may be adjusted because of a clarification under this section.

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

2.18   DISPOSITION OF BID PROPOSALS

All Bid Proposals become the property of the Department and shall not be returned to the bidder unless all Bid Proposals are rejected or the RFP is cancelled. In either event, bidders will be asked to send prepaid shipping instruments to the Department for return of the Bid Proposals submitted. In the event the Department does not receive shipping instruments, the Department will destroy the Bid Proposals. Otherwise, at the conclusion of the selection process, the contents of all Bid Proposals will be in the public domain and be open to inspection by interested parties subject to exceptions provided in the open records laws of the State of North Dakota.

2.19   PUBLIC RECORDS AND REQUESTS FOR CONFIDENTIAL TREATMENT

The open records laws of the State of North Dakota govern the access to all records and products developed pursuant to the contract.

The laws governing open records can be found in N.D.C.C. 44-04-18 at:

http://www.state.nd.us/lr/cencode/t44c04.pdf

2.20   ORAL PRESENTATIONS

After an initial evaluation of Bid Proposals by the proposal evaluation committee, the State will conduct Oral Presentations with bidders who have submitted Bid Proposals determined to be reasonably susceptible for award. Bidder finalists will be requested to make an Oral Presentation of the Bid Proposal's offering. The presentation will occur in Bismarck, North Dakota. The determination of participants, location, order, agenda, and schedule for the presentations is at the sole discretion of the State and will be provided during the Evaluation process. Bidder staff designated as "Key Personnel" in the bidder's Bid Proposal (including designated Key Personnel from any subcontractor or consultant) will be among those that must attend the Oral Presentation.

The Oral Presentation will include appropriate slides, graphics, handouts, and other media selected by the bidder to illustrate the bidder's Bid Proposal. The presentation must not

materially change the information contained in the Bid Proposal. Additional information on the Oral Presentations process and the subsequent Best and Final Offer process can be found in Section 2.22 and Section 11, respectively.

If modifications to the scope of work are made as a result of Oral Presentation discussions, they will be put in writing as part of an RFP amendment and bidders will be given the opportunity to submit supplements to their original proposals. Material presented in Bid Proposal supplements that materially changes the original submittal will be disallowed.

The State's preferred file format for presentations is Microsoft PowerPoint. A projector and Internet access will be provided by the State. Prior to Oral Presentations, the State will inform bidders of the purpose and scope of the Oral Presentation. All bidders will be asked a common set of questions that will be provided to all bidders prior to presentations. In addition, bidders will be asked a set of bidder-specific questions that will not be provided in advance of the presentation. Following Oral Presentations, bidders will provide an electronic copy of their presentation and related handouts to the Procurement Officer.

2.21 SITE VISITS

The State will not conduct site visits to evaluate the bidder's capacity to perform the contract.

2.22 BEST AND FINAL OFFERS

Following Oral Presentations, the Procurement Officer may set a date and time for Best and Final Offers (BAFOs) on Cost Proposal submissions from those bidders with whom discussions were held. Proposals may be re-evaluated after receipt of BAFO submissions.

If a bidder does not submit a BAFO on its Cost Proposal or a notice of withdrawal, the bidder's immediate previous Cost Proposal is considered the bidder's BAFO. Any oral modification of a Cost Proposal must be reduced to writing by the bidder.

2.23 CONTRACT NEGOTIATIONS

After final evaluation of Technical Proposals and Cost Proposals (including BAFOs), the Procurement Officer, Contract Officer, Project Directors, and other DHS-designated parties may conduct further contract negotiations with the bidder of the highest-ranked proposal. Negotiations, if held, shall be within the scope of the RFP and limited to those items that would not have an effect on the ranking of proposals. If the highest-ranked bidder fails to provide necessary information for negotiations in a timely manner, or fails to negotiate in good faith, the State may terminate negotiations and negotiate with the bidder of the next highest-ranked proposal. If contract negotiations are commenced, they may be held in Bismarck, North Dakota.

For all contract negotiations taking place in Bismarck, North Dakota, the bidder will be responsible for all cost including their travel and per diem expenses.

2.24 FAILURE TO NEGOTIATE

The State may terminate negotiations with the bidder initially selected and commence negotiations with the next highest ranked bidder, if a selected bidder:

- Fails to provide the information required to begin negotiations in a timely manner; or

- Fails to negotiate in good faith; or

- Indicates they cannot perform the contract within the budgeted funds available for the project; or

- The bidder and the State, after a good faith effort, simply cannot come to terms.

2.25 NOTICE OF INTENT TO AWARD

After the completion of contract negotiations, the Procurement Officer will issue a written Notice of Intent to Award and send copies to all bidders who have submitted a Bid Proposal. The Notice of Intent to Award will set out the names of all bidders and identify the Bid Proposal(s) selected for award. The scores and placement of other bidders will not be part of the Notice of Intent to Award. The Notice of Intent to Award is subject to execution of a written contract and, as a result, this notice does not constitute the formation of a contract between the State and the apparent successful bidder.

2.26 ACCEPTANCE PERIOD

Negotiation, Centers for Medicare and Medicaid Services (CMS) approval, and DHS execution of the contract shall be completed no later than **December 27, 2005**. If the apparent successful bidder fails to negotiate and execute a contract, the Department (in its sole discretion) may revoke the award and award the contract to the next highest ranked bidder or withdraw the RFP.

The Department further reserves the right to cancel the award at any time prior to the execution of a written contract.

2.27 DEFINITION OF CONTRACT

The full execution of a written contract shall constitute the inception of a contract for services and no bidder shall acquire any legal or equitable rights relative to the contract services until the contract has been fully executed by both the apparent successful bidder(s) and the Department.

2.28 CHOICE OF LAW AND FORUM

This RFP and the resulting contract are to be governed by the laws of the State of North Dakota. Changes in applicable laws and rules may affect the award process or the resulting contract. Bidders are responsible for ascertaining pertinent legal requirements and restrictions. Any and all litigation or actions commenced in connection with this RFP shall be brought in the appropriate North Dakota forum.

2.29 PROTEST AND APPEAL

North Dakota law provides that an interested party may protest a solicitation, as well as a proposed contract award. If an interested party wishes to protest the content of this RFP, the protest must be received, in writing, by the Procurement Officer at least seven (7) calendar days prior to the deadline for receipt of Bid Proposals.

An interested party may protest the award or proposed award of a contract. If a bidder wishes to protest the award of a contract or proposed award of a contract, the protest must be received (in writing) by the Procurement Officer within seven (7) calendar days after the date the Notice of Intent to Award was issued.

The laws governing protests and appeals are found in N.D.C.C. Section 54-44.4-12 at:

>   http://www.state.nd.us/lr/cencode/t54c444.pdf

and N.D.A.C. chapter 4-12-14 at:

>   http://www.state.nd.us/lr/information/acdata/pdf/4-12-14.pdf

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3.0 CONTRACT TERMS AND CONDITIONS

3.1   PROPOSAL AS A PART OF THE CONTRACT

Part or all of the material from this RFP, any subsequent amendments, and the written responses to bidders' questions, when combined with the bidder's Bid Proposal submitted in response to the RFP, collectively form the Contract between the bidder and the Department and are incorporated herein by reference. The parties are obligated to perform all services described in the RFP and Bid Proposal, unless the Contract is revised and specifically directs otherwise.

3.2   ORDER OF PRIORITY

In the event of a conflict between the Contract, the RFP, and the Bid Proposal, the conflict shall be resolved according to the following priority, ranked in descending order:

1.) The Contract (including approved Change Service Requests)

2.) The RFP (including amendments, responses to Bidders' Questions, and supporting Bidders' Library materials)

3.) The Bid Proposal

3.3   STANDARD CONTRACT PROVISIONS

3.3.1   PURCHASE OF SERVICE AGREEMENT PROVISIONS

The successful bidder will be required to sign and submit a *Purchase of Service Agreement* similar to the one attached to this RFP (see Attachment B). The Contractor must comply with the contract provisions set out in this attachment. No alteration of these provisions will be permitted without prior written approval from the Department of Human Services. Objections to any of the *Purchase of Service Agreement* provisions set forth in Attachment B must be identified in the Bid Proposal.

<u>*Bidder's Note:</u> Upon Notice of Intent to Award, the apparent successful bidder will receive a *Purchase of Service Agreement* that has been customized to fit the context of this RFP. DHS will not have made any customizations that would significantly alter the provisions of the Sample *Purchase of Service Agreement* provided.

3.3.2   ADDITIONAL TERMS AND CONDITIONS

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

3.3.3   CONTRACT APPROVAL

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

3.3.4   CONTRACT CHANGES - UNANTICIPATED AMENDMENTS

During the course of this contract, the Contractor may be required to perform additional work. That work will be within the general scope of the initial contract.

As part of bidder Cost Proposals, DHS is requesting that bidders provide an hourly rate for items that fall outside the scope of the initial contract (i.e., Change Service Requests). Unanticipated amendments to the contract will apply this hourly rate, unless otherwise determined by DHS.

When additional work is required, the Project Directors designated by the State will provide the Contractor with a written description of the additional work using the Project's change management process and request the Contractor to submit a firm cost and time schedule for accomplishing the additional work. Cost and pricing data must be provided to justify the cost of such amendments.

The Contractor will not commence additional work until the Project Directors have secured any required State approvals necessary for the amendment and issued a written contract amendment, approved by the Department of Human Services.

3.3.5   TAXES AND TAXPAYER IDENTIFICATION

The Contractor must provide a valid Vendor Tax Identification (ID) as a provision of the contract.

The State is not responsible for and will not pay local, State, or Federal taxes. The State sales tax exemption number is E-2001, and certificates will be furnished upon request by the purchasing agency.

A Contractor performing any contract, including service contracts, for the United States Government, State of North Dakota, Counties, Cities, Villages, School Districts, Park Board or any other municipal corporations in North Dakota is not exempt from payment of sales or use

tax on material and supplies used or consumed in carrying out such contracts. In these cases, the Contractor is required to file returns and pay sales tax and use tax just as required for contracts with private parties.

Contact the North Dakota Tax Department at (701) 328-3470, or visit their website at www.ndtaxdepartment.com for more information.

3.4   TERM OF CONTRACT AND RENEWAL OPTIONS

3.4.1   BASE CONTRACT

The State intends to enter into Design, Development, and Implementation (DDI) contracts with an effective period of January 3, 2006 through April 24, 2008. The DSS/DW contract includes an Operations Phase that begins on April 24, 2008. Timeframes for the contract phases and dates are shown in the table below:

Table 2: Contract Phase Timeframes

CONTRACT	DDI PHASE	KNOWLEDGE TRANSFER / TRAINING PERIOD	SYSTEM WARRANTY PERIOD	OPERATIONS PHASE	OPTION YEAR(S)
MMIS	1/3/06 – 4/24/08	4/24/08 – 10/31/08	4/24/08 – 4/30/09	N/A	N/A
POS	1/3/06 – 4/24/08	4/24/08 – 10/31/08	4/24/08 – 4/30/09	N/A	N/A
DSS/DW	1/3/06 – 4/24/08	Month-by-month, as needed, from 4/24/08 – 10/31/08	4/24/08 – 4/30/09	4/24/08 – 6/30/09	Two 2-year Options: 1.) 7/1/09 – 6/30/11 2.) 7/1/11 – 6/30/13

3.4.2   RENEWAL OPTIONS

Due to the "turnkey" nature of the MMIS and POS contracts, there are no renewal options in those contracts. In the event of unforeseen delays, however, the State reserves the right to extend the DDI contract period for an additional period of time that is not to exceed 12 months beyond the normal expiration date of the contract (upon mutual written agreement by both parties). The contract will not automatically be extended. The State will provide written notice to the Contractor of its intent to extend this contract at least thirty (30) days before the scheduled contract expiration date.

Available renewal options for the DSS/DW contract are identified in the table above.

3.5   CONTRACT TYPE

The contracts resulting from this procurement will be firm, fixed price contracts. Contract adjustments will occur only through the Change Service Request and Contract Enhancement processes defined in Section 3.6 below.

The bidder will identify appropriate fixed prices for the deliverables and services, as described by the relevant material in Sections 6, 7, 8, and 9, and as defined in the Pricing Schedules. No separate payment will be made for bidder-specified DDI tasks, since these tasks are all considered part of the Contractor's responsibilities to produce the identified DDI deliverables.

3.6   CHANGE SERVICE REQUESTS / CONTRACT ENHANCEMENTS

DHS reserves the right to request changes to the requirements and specifications of the Contract and the work to be performed by the Contractor under the Contract, including the timing of deliverables.

3.6.1   CHANGE SERVICE REQUESTS

3.6.1.1   PROCEDURE

DHS shall submit a Change Service Request (CSR) to the Contractor, which shall include a detailed description of the requested service, the priority of the service, a date the service is needed, and a date for submission of a CSR response by the Contractor. In its CSR response, the Contractor shall describe the tasks and schedule to be employed for the requested service(s) and identify the number of hours necessary to complete the service(s) by labor category. The Contractor will also identify an associated cost to implement the change request, using the negotiated CSR rate from the vendor's Cost Proposal (or any subsequent rate modification that has occurred during BAFOs or contract negotiations). If necessary, the Contractor and the Department shall meet to discuss and clarify any issues related to the requested service(s). Upon written approval by the Department, the Contractor must perform the requested service(s) and receive payment according to the terms of the CSR and the agreed upon rate specified in the Contractor's cost and time estimate.

If DHS does not accept the Contractor's proposal, the Department may withdraw or modify its CSR. If DHS modifies its CSR, the procedures set forth above shall apply.

3.6.1.2   NO AGREEMENT ON CHANGE SERVICE REQUEST

If the parties are unable to reach an agreement in writing within fifteen (15) days of receipt of the Contractor's proposal or modified proposal, the Project Directors shall make a determination of the compensation, procedure or schedule, and the Contractor must proceed with the work according to the Project Directors' decision, subject to the Contractor's right to appeal the decision pursuant to State law.

3.6.1.3   ADDITIONAL SERVICES

If the Department requests or directs the Contractor to perform any service or function that is consistent with and similar to the services being provided by the Contractor under the Contract, but which the Contractor reasonably and in good faith believes is not included within the scope of the Contractor's responsibilities set forth in the Contract, then prior to performing such service or function, the Contractor shall promptly notify the Project Directors designated by the State, in writing, within 3 days that it considers the service or function to be an "Additional Service" for which the Contractor should receive additional compensation. If the Contractor does not so notify the Project Directors, the Contractor shall have no right to claim thereafter that it is entitled to additional compensation for performing the service or function. If the Contractor does notify the Project Directors the service or function shall be governed by the CSR procedure.

3.6.2   CONTRACTOR-PROPOSED ENHANCEMENTS TO CONTRACT

DHS grants its contractors the ability to request changes to the requirements and specifications of the Contract and the work to be performed by the Contractor under the Contract, including the timing of deliverables.

3.6.2.1   PROCEDURE

In the event that the Contractor wishes to propose an enhancement to the current requirements or specifications of the Contract, the Contractor shall submit a Contract Enhancement Request to the Department. This Contract Enhancement Request shall include a detailed description of the requested enhancement, the priority of the enhancement, a date that the new service(s) could be provided, and a date for submission of a proposal by the Contractor. In its enhancement proposal, the Contractor shall describe the procedure and schedule to be employed for the requested service and identify the number of hours necessary to complete the service by labor category and the associated cost to implement the Contract Enhancement Request. If necessary, the Contractor and the Department shall meet to discuss and clarify any issues related to the requested enhancement(s) and develop the appropriate language and terms for a Change Service Request. Upon written approval by the Department, the Contractor must perform the requested service(s) and receive payment according to the terms of the Change Service Request and the approved CSR rate for the contract.

If the Department does not accept the Contractor's proposal, the Contractor may withdraw or modify its Contract Enhancement Request. If the Department requests that the Contractor modify its Contract Enhancement Request, the procedures set forth above shall apply.

3.7   CONTRACT PAYMENT

3.7.1   PROPOSED PAYMENT PROCEDURES

The State will make a single payment when each of the DDI deliverables is received, is considered completed, and is approved by the Project Directors designated by the State.

3.7.2   PAYMENT TERMS

No payment will be made until the Department of Human Services approves the contract.

Payment for commodities and services received under contracts will normally be made within thirty (30) calendar days after receipt and acceptance of an invoice by the Department of Human Services, or after receipt of a corrected invoice, whichever is later.

3.7.3   INSPECTION & MODIFICATION - REIMBURSEMENT FOR UNACCEPTABLE DELIVERABLES

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

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

3.7.4   CONTRACT FUNDING

Approval or continuation of a contract resulting from this RFP is contingent upon continuing appropriation. The contract may be terminated by the State or modified by agreement of both parties in the event funding from Federal, State, or other sources is not obtained and continued at sufficient levels.

3.8   PROJECT MANAGEMENT

3.8.1   CONTRACT PERSONNEL

The State's Project Directors must approve any change of the Contractor's Key Personnel (or other project team members named in the proposal), including any Key Personnel employed by a subcontractor, in advance and in writing. Personnel changes that are not approved by the State may be grounds for the State to terminate the contract.

Key Personnel named in the proposal must be committed to the project from the start date identified in the procurement schedule through at least the first six (6) months of the contract. Key Personnel may not be reassigned during this period. Key Personnel may not be replaced

during this period, except in cases of resignation or termination from the Contractor's organization or in the unfortunate event of the death of the named individual. Staff members designated as Key Personnel, whose activities do not begin until after the six month timeframe, may be replaced during the first six months. However, DHS retains the right of final approval for this replacement since such Key Personnel were a factor in the evaluation.

The Contractor must use best efforts to find replacement personnel and to have replacement personnel begin work before the incumbent personnel departs, ensuring compliance with Section 6.2.3 of this RFP.

3.8.2   RIGHT TO INSPECT PLACE OF BUSINESS

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

3.8.3   DISPUTES - APPLICABLE LAW AND VENUE

Any dispute arising out of this agreement will be resolved under the laws of the State of North Dakota.

3.9   INDEMNIFICATION AND INSURANCE REQUIREMENTS

Bidders must review Sections X and XI of Attachment B for Indemnification and Insurance requirements.

Objections to any of the provisions of the Indemnification and Insurance Requirements must be made in writing to the attention of the Procurement Officer by the time and date set for receipt of bidder's questions. No alteration of these provisions will be permitted without prior written approval from the Department of Human Services in consultation with the DHS Legal Advisory Division.

Upon receipt of the Notice of Intent to Award, the successful bidder must obtain the required insurance coverage and provide the Procurement Officer with proof of such coverage prior to contract approval. The coverage must be satisfactory to the purchasing agency, in consultation with the DHS Legal Advisory Division. A bidder's failure to provide evidence of such insurance coverage is a material breach and grounds for withdrawal of the award or termination of the contract.

3.10   BOND REQUIREMENTS

3.10.1   BID BOND

DHS is not requiring a bid bond as part of Bid Proposals submitted in response to this RFP.

3.10.2 PERFORMANCE BOND

Bidders must obtain a letter of commitment for a performance bond from a bonding company and submit it with the Cost Proposal. The amount of the performance bond must be equal to ten percent (10%) of the total dollar value of the bidder's Cost Proposal for the full term of the contract. For the DSS/DW Contractor, this performance bond must also cover the Operations Phase.

If the Contractor fails to satisfactorily perform the contract, payment from the bonding company that provided the performance bond will be required to obtain timely performance of the contract.

The actual performance bond must be obtained from a bonding company acceptable to the State and must be provided to the State within **ten (10) calendar days** of the date of the Notice of Intent to Award. A bidder's failure to provide the performance bond within the required time will cause the State to reject the proposal.

3.11 TERMINATION

3.11.1 IMMEDIATE TERMINATION

The Department may immediately terminate this Contract for any of the following reasons upon written notice to the Contractor:

   a) The Contractor furnishes a statement, representation, warranty, or certification in connection with the RFP or the Contract which is materially false or incorrect;

   b) The Contractor or any subcontractor, or an officer or owner of a five percent (5%) or greater share of either, is convicted of a criminal offense which in the sole discretion of the Department reflects on the Contractor's integrity;

   c) If the Contractor or any subcontractor is required to be certified or licensed and the certification or license is revoked or suspended; termination shall be effective as of the date on which the certification or license is no longer in effect;

   d) The actions of the Contractor, its agents, employees or subcontractors have caused, or reasonably could cause, a recipient's life, health or safety to be jeopardized;

   e) The Contractor fails to comply with confidentiality laws or provisions of the Contract.

The Department shall not be liable for any costs incurred if termination is for any of the causes stated above. In addition, the Department shall have the right to procure similar services on the open market pursuant to Subsection 3.11.2.3 below.

3.11.2 *TERMINATION FOR DEFAULT*

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

This clause does not restrict the State's right to termination under the contract provisions of the attached *Purchase of Service Agreement*.

3.11.2.1 CONTRACTOR'S DEFAULT AND OPPORTUNITY TO CURE

Failure of the Contractor to comply with any material term, condition or provision of the Contract shall constitute default by the Contractor. The Department shall notify the Contractor in writing of the nature of the default. The Contractor shall have thirty (30) days after such notice, unless otherwise notified, to correct the problem(s) that resulted in the default notice. If the default is not corrected to the satisfaction of the Department within the specified time, the Department may immediately terminate the contract.

3.11.2.2 CONTRACTOR'S DEFAULT CURED BY THE DEPARTMENT

If, in the reasonable judgment of the Department, a default by the Contractor is not so substantial as to require termination, reasonable efforts to induce the Contractor to cure the default are unsuccessful, and the default is capable of being cured by the Department or another resource without unduly interfering with continued performance by the Contractor, then the Department may provide or procure the service to cure the default, in which event, the Contractor shall reimburse the Department for the reasonable cost of the service.

3.11.2.3 PROCUREMENT OF SIMILAR SERVICES

In the event of termination under this Subsection, the Department shall have the right to procure similar contracted services on the open market. The Contractor shall be liable for the difference between the original Contract price of services and the cost of such services from another bidder, and any other costs directly related to the Contractor's breach such as costs of competitive bidding, mailing, advertising, Department staff time, and attorney's fees. The Contractor shall have thirty (30) days after notice from the Department of the amount of such costs in which to submit payment, unless an additional period of time is agreed to by the parties, or the Department may deduct the amount of such costs from any charges payable to the Contractor.

3.11.2.4 DELAY OR IMPOSSIBILITY OF PERFORMANCE

Neither party shall be in default under the Contract if performance is prevented, delayed or made impossible by forces of nature during continuance of the force of nature. The delay or impossibility of performance must be beyond the control and without the fault or negligence of

the parties. If delay results from a subcontractor's conduct, negligence, or failure to perform, the Contractor shall not be excused from compliance with the terms and obligations of the Contract. This Subsection shall not become operative until the party whose performance is delayed or made impossible notifies the other party of the occurrence and reason for the delay. The parties shall make every effort to minimize the time of nonperformance and the scope of services not being performed due to the force of nature.

3.11.3 TERMINATION UPON NOTICE

The Department may terminate the Contract for any reason without penalty by giving written notice to the Contractor at least thirty (30) days before the effective date of termination.

3.11.4 TERMINATION FOR INSOLVENCY OR BANKRUPTCY

In the event the Contractor ceases conducting business in the normal course, becomes insolvent, makes a general assignment for the benefit of creditors, suffers or permits the appointment of a receiver for its business or its assets, or avails itself of or becomes subject to, any proceeding under the Federal Bankruptcy Act or any other statute of any state related to insolvency or the protection of the rights of creditors, then the Department may (at its option) terminate the Contract. In the event the Department elects to terminate the Contract under this provision, it shall do so by sending written notice of termination to the Contractor. The date of termination shall be deemed to be the date such notice is mailed to the Contractor, unless otherwise specified in the notice.

3.11.5 TERMINATION FOR WITHDRAWAL OF DEPARTMENT'S AUTHORITY

In the event the authority of the Department to perform its duties is withdrawn or limited, or services under the Contract are no longer a responsibility of the Department due to Federal or State mandate, then the Department shall have the right to terminate the Contract without penalty on or before the date the Department's authority is withdrawn or limited. The Department shall use best efforts to provide thirty (30) days' written notice to the Contractor. The obligations of the parties shall end as of the date specified in the termination notice, and the Contract shall be considered canceled. The exclusive, sole and complete remedy of the Contractor in the event of termination under this Subsection shall be payment for services completed through the effective date of termination.

3.11.6 TERMINATION OR CONTRACT MODIFICATIONS DUE TO UNAVAILABILITY OF FUNDS

The performance by the Department of any of its obligations under the Contract shall be subject to and contingent upon the availability of Federal and State funds lawfully applicable for such purposes. If funds applicable to the Contract are not appropriated or otherwise made available at any time during the Contract term, the Department, without penalty, may terminate the Contract.

However, should funds be appropriated in some form by either State or Federal funding sources that are sufficient to implement and/or operate the systems requested for the Department, the parties agree to negotiate in good faith all modifications to this contract which will allow the parties to continue contractual obligations.

The Department shall use best efforts to provide thirty (30) days' written notice of termination or contract modification to the Contractor. The specified obligations of the parties shall end as of the date provided in the termination notice, and the specified portions of the Contract shall be considered cancelled. The exclusive, sole and complete remedy of the Contractor shall be payment for services completed through the effective date of termination.

3.11.7 RIGHTS UPON TERMINATION

In the event the Department terminates the Contract prior to planned expiration, the Department shall pay the Contractor for any partially completed deliverables that the Department desires to have the Contractor turn over to the Department on a percentage of completion basis and for any required operating services provided by the Contractor through the effective date of termination, prorated for any partial month. The Department shall make no payments for unfurnished work, work in progress, or raw materials acquired unnecessarily in advance, in excess of the Department's delivery requirements, or initiated after the notice of termination. In no event shall the Department be obliged to pay or otherwise compensate the Contractor for any lost or expected future profits, or costs or expenses incurred with respect to services not actually performed or deliverables not actually provided to the Department.

Upon termination, the Department shall have the right to assume, at its option, any and all subcontracts for services and materials provided under the Contract. In the event of termination, the Department shall also have the right to make offers of employment to any or all employees of the Contractor and its subcontractors who are performing services under the Contract. The Contractor shall provide the Department with names, resumes, and other information reasonably requested by the Department for the purpose of exercising this right, providing that fulfilling this requirement will not be in violation of Federal or State employment law.

3.12 DAMAGES

3.12.1 ACTUAL DAMAGES

The following activities are subject to actual damages, since failure to meet the performance standard will result in a specific loss of Federal matching dollars.

3.12.1.1 SYSTEMS CERTIFICATION

Section 1903(a)(3)(B) of Title XIX[1] of the Social Security Act provides seventy-five percent (75%) Federal Financial Participation (FFP) for operation of mechanized claims payment and information retrieval systems approved by the Federal Department of Health and Human Services (HHS). Up to ninety percent (90%) FFP is available for MMIS-related development costs[2] receiving prior approval by CMS. The North Dakota MMIS must be able to meet all certification and re-certification requirements established by CMS.

The MMIS Contractor will assume the lead role in ensuring that CMS Certification approval for the maximum allowable enhanced FFP for the North Dakota MMIS is obtained retroactive to the day the system becomes operational and can be maintained throughout the term of the Contract.
The MMIS Contractor will be liable for the difference between the maximum allowable enhanced FFP and that actually received by the State, including any losses due to loss of certification, failure to obtain approval retroactive to the operational start date, or delays in readiness to support certification.

All FFP penalty claims assessed by CMS will be first withheld from any remaining amounts payable to the MMIS Contractor and remaining dollars will be assessed by invoice until all such damages are satisfied. Damage assessments will not be made by the State until CMS has completed its certification approval process and notified the State of its decision in writing.

3.12.1.2 OPERATIONS START DATE

3.12.1.2.1   MMIS and POS

It is the State's intent to have the North Dakota MMIS and POS fully operational on April 24, 2008. "Fully operational" is defined as having the MMIS and POS:

- Established and operational with at least three (3) years of claim data on-line
- Processing correctly all claim types, claims adjustments, payments, and other financial transactions
- Maintaining all system files
- Producing acceptable versions of all required reports
- Meeting all system specifications
- Supporting all required interfaces
- Performing all other contractor responsibilities specified in this RFP

Compliance with the April 24, 2008 date, or a later date set by DHS, is critical to the State's interest. Therefore, the Contractor will be liable for resulting damages if this date is not met. The Contractor's capability to meet this date will be determined by DHS during the systems implementation.

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[1] http://www.ssa.gov/OP_Home/ssact/title19/1903.htm
[2] ibid.

If, for any reason, the Contractor does not fully meet the operational start date then the Contractor will forfeit all claims to reimbursement of monthly expenses or contractual payments for that month and each month thereafter, until DHS approves the start of operations of the failing system(s).

3.12.1.2.2   DSS/DW

In addition, if DHS has not approved the start of operations of the DSS/DW as of April 24, 2008, the DSS/DW Contractor may be liable for additional costs incurred by the State to continue current operations. The additional cost could include an interface between the replacement MMIS and the current DSS (Medstat DataProbe®), development of the interface to other DHS systems, any contingency costs associated with extending the contract with the current DSS vendor, and any increase in the operating payments to the current DSS vendor, from the monthly operating payments (after April 24, 2008), resulting from the emergency extension.

Should the winning bidder propose and obtain DHS approval of an implementation schedule of less than twenty-four (24) months, the above dates will be adjusted accordingly.

3.12.1.3   ERRONEOUS PAYMENTS

During DDI testing activities, the MMIS Contractor has the sole responsibility to ensure that erroneous payments from the MMIS and all manually priced claims can be quickly identified, reported to DHS, and corrected to ensure that no overpayments or underpayments are made from State or Federal funds. During DDI testing activities, the POS Contractor will work with the MMIS Contractor to ensure that erroneous payments for pharmacy claims can be quickly identified, reported to DHS, and corrected so that no overpayments or underpayments are made from State of Federal funds.

During the one (1) year System Warranty period, if an overpayment, underpayment, or duplicate payment is made where the payment error is the result of the Contractor's design and development failure, then the MMIS and/or POS Contractor (whichever is relevant) will be liable for the difference between the amount paid erroneously and the amount that should have been paid using the correct guidelines. The Contractor(s) will also be held responsible for recovery of the overpayment or payment of the underpayment. The Contractor(s) may be liable to the State for the value of the overpayment or underpayment, if the Contractor is not able to recover the funds or remit the underpayment within sixty (60) calendar days.

3.12.2   LIQUIDATED DAMAGES

The State will include liquidated damages in this contract to assure its timely completion. The parties agree that failure of the Contractor's system and personnel to perform may result in loss and damage to the Department. The parties further agree that the amounts of damages which will be sustained from any such failures are not calculable with any degree of certainty and thus will be the amounts set forth in the sections that follow. Assessments under these sections are cumulative and may be in addition to other remedies available to the Department. The State will review status reports and other documentation in order to assess damages as appropriate, and

notify the Contractor in writing of damage assessments. The Contractor must automatically deduct the damage assessments from the monthly invoice, specifically itemizing the assessment deduction(s) on the invoice.

The cause and amount of other liquidated damages may be determined during contract negotiations.

Table 3: Identified Liquidated Damages and Relevant Triggers

Title	Trigger / Perf Std.	Damage	Relevant Contracts
Key Personnel	Key Personnel commitments identified by the RFP and the Contractor's Proposal are considered essential to the work to be performed under the Contract. Prior to diverting any Key Personnel to other roles or contracts, or changing the level of effort of the specified individuals, the Contractor is required to submit justification (including his/her proposed substitution), in sufficient detail, to permit evaluation of the impact on the contract. No diversion shall be made by the Contractor without prior written consent of the Department other than for reasons of resignation without notice, death, immediate termination, or military recall. Replacements for any Key Personnel must be personnel of equal ability and qualifications, as determined by the Department. If the Contractor proposes to change personnel to another functional area, the number, names, and anticipated duration of the transfer shall be required (in writing) for the Department to evaluate the impact on the contract. No transfer of staff to a different functional area shall be made without prior written consent of the Department.	A maximum of ten thousand dollars ($10,000.00) damages per occurrence may be assessed for each named Key Person proposed who is changed or reassigned without proper notice and approval for reasons other than death, resignation without notice, immediate termination, or military recall. Damages in the amount of five hundred dollars ($500.00) per day may be assessed for each day a key position is vacant after the process under Section 6.2.3 is exhausted.	All
System Maintenance	During the course of the contract, the Contractor must provide routine maintenance of the system at no charge to the State and not through use of the system modification change control process. The State will notify the Contractor in writing of identified system problems. The Contractor must respond in writing to notices of system problems with a Corrective Action Plan, which will include a timeframe for completion, within five (5) calendar days of receipt of the notice. The Contractor must initiate the Corrective Action Plan within twenty-four (24) hours after receiving State approval. The Contractor's performance will be measured by administrative status reports, change request reports, and by direct measurement by the State.	Damages may be assessed upon failure to correct a system problem or complete a Corrective Action Plan by the agreed upon completion date, where failure to complete was not due to action or inaction on the State's part (as documented in writing by the Contractor): 1.) > 1 < 30 calendar days late = two hundred and fifty dollars ($250) per calendar day; 2.) > 30 < 60 calendar days late = five hundred dollars ($500) per calendar day; and 3.) > 60 calendar days late = one thousand ($1,000) dollars per calendar day. Payment of any liquidated damages will not relieve the Contractor from its obligation to meet RFP requirements. Damages assessed here may be in addition to damages assessed under other provisions (e.g., if a system problem causes the system to fail availability or response standards, a damage assessment may be made under both provisions.	All

Title	Trigger / Perf Std.	Damage	Relevant Contracts
Timeliness and Accuracy of Report Production	During the Contractor's Operations Phase, reports must be produced in the format and type of media approved by DHS. The Contractor shall be responsible for the accuracy of all reports, including calculations and completeness of data used as input. The data definitions and report requirements will be defined during the Design, Development, and Implementation Phase. Descriptions, timing, and reconciliation of on-line and Data Warehouse reports will also be finalized. The State shall notify the Contractor, in writing, of any inaccuracies or discrepancies. The Contractor shall deliver a notification specifying a new report's availability for users defined within the report distribution list. The report distribution list will be further defined by the State during the Design, Development, and Implementation Phase. The Contractor shall be required to update and maintain the report distribution list during the Operations Phase to incorporate any changes to existing reports as part of its contracted services to DHS. At a minimum, the Contractor will be required to produce reports and publish them to their appropriate server or on-line location according to the following schedule: • Standard weekly reports and cycle processing reports by noon of the next State of North Dakota business day after the scheduled run; • Standard monthly reports by noon of the fifth State of North Dakota business day after the end of the month; • Standard quarterly reports by noon of the fifth State of North Dakota business day after the end of the quarter; • Standard annual reports by noon of the tenth State of North Dakota business day following the end of the year (whether Federal fiscal year, State fiscal year, waiver year, or other annual period); and • Ad-hoc and on-request reports on the date specified in the report request.	Up to two hundred fifty dollars ($250.00) damages may be assessed for each State of North Dakota business day, or part thereof, that any report is delivered late. If a report containing incorrect information is not corrected within ten (10) State of North Dakota business days of the State's notice of failure to meet the reporting accuracy requirements, then up to two hundred fifty dollars ($250.00) per day damages may be assessed for each report that has been identified as inaccurate from the date of the notification until the date the corrected report is delivered. These damages are cumulative, such that a late and inaccurate report will be subject to an assessment for lateness and an assessment for inaccuracy.	DSS/DW
Data Refresh Requirements	The Contractor must refresh Data Warehouse tables, including but not limited to recipient eligibility and reference data files, in accordance with the data refresh schedule designated by the State.	Up to two thousand five hundred dollars ($2500.00) per day may be assessed for a verified period of time when the data refresh was not performed within the time requirements.	DSS/DW

Title	Trigger / Perf Std.	Damage	Relevant Contracts
Compliance with Other Material Contract Provisions	The objective of this standard is to provide the State with an administrative procedure to address general contract compliance issues which are not specifically defined as performance requirements listed above, but are Contractor responsibilities contained in the RFP. DHS staff may identify contract compliance issues resulting from the Contractor's performance of its responsibilities through routine contract monitoring activities. If this occurs, DHS will notify the Contractor in writing of the nature of the performance issue. The State will also designate a period of time in which the Contractor must provide a written response to the notification and will recommend, when appropriate, a reasonable period of time in which the Contractor must remedy the non-compliance.	If the non-compliance is not corrected by an agreed upon date, DHS may assess damages up to the amount of one thousand dollars ($1,000.00) per State of North Dakota business day after the due date until the non-compliance is corrected.	All

3.13 GENERAL PROVISIONS

3.13.1 INDEPENDENT ENTITY

Each system contractor is considered an independent entity under this contract and is not a State employee for any purpose. The Contractor retains primary discretion in the manner and means of carrying out the Contractor's activities and responsibilities under the contract, except to the extent specified in the contract.

3.13.2 ASSIGNMENT

The Contractor may not assign or otherwise transfer or delegate any right or duty of its contract without the State's express written consent. However, the Contractor may enter into subcontracts provided that any such subcontract acknowledges the binding nature of this contract and incorporates this contract, including any attachments.

3.13.3 CONFIDENTIALITY

Any records that are obtained or generated by the Contractor under this contract are subject to North Dakota open records law regarding public records and handling of confidential information.

The laws governing open records can be found in N.D.C.C. 44-04-18 at:

http://www.state.nd.us/lr/cencode/t44c04.pdf

3.13.4 WORK PRODUCT, EQUIPMENT, AND MATERIAL

All work product, equipment, or materials created or purchased under this contract belong to the State and must be delivered to the State at the State's request upon termination of this contract, unless otherwise agreed to in writing by the Department of Human Services.

3.13.5 INFORMAL DEBRIEFING

When the contract is completed, an informal debriefing may be performed at the discretion of the Procurement Officer or the Project Directors designated by the State. If performed, the scope of the debriefing will be limited to the work performed by the Contractor.

4.0 PROGRAM DESCRIPTION & BACKGROUND

4.1 ORGANIZATIONAL STRUCTURE

The figures in this section illustrate the organizational structures of North Dakota Department of Human Services (DHS), the DHS Medical Services Division, Division of Information Technology (DoIT), and the Information Technology Department (ITD).

Figure 1: DHS Organizational Chart

Figure 2: Medical Services Division Organizational Chart

North Dakota Department of Human Services
Medical Services Division

Carol K. Olson	*Executive Director*

Yvonne M. Smith	*Deputy Director*

D. Zentner	*Director*

M. Anderson	*Asst. Director*

K. Tescher
Utilization Review

- Pharmacy Services
- Out-of-State Approvals
- Prior Authorizations
- PASAAR
- North Dakota Healthcare Review
- Transportation Management
- Third Party Liability
- Fraud & Abuse
- Medical, Dental, Optometric Consultants

D. Skalsky
Healthy Steps

- SCHIP
- Assisted Living

C. Volesky
Medicaid Eligibility

- Medicaid Eligibility
- SCHIP Eligibility
- Workers with Disabilities
- QMB / SLMB
- Medicare Part D
- Medicare Buy-In
- Recipient Liability

C. Eisenmann
ND Health Tracks

- EPSDT
- Preventive health for children
- Screening service coordination

M. Thompson
Office Support

- State Plan Amendments
- Project Support

T. Gallup-Millner
CSHS

- Title V program
- State Systems Development Initiative
- Specialty Care Program

E. Elkins
MMIS Manager

- Claims Processing
- Provider Relations
- Provider Enrollment
- HIPAA Transactions
- Business Analysis
- System Maintenance
- Reimbursement rates
- Reference File Maintenance
- Mailroom Functions
- DSS Administration

TBD
Managed Care

- Managed Care Organization (MCO)
- Primary care case management (PCCM)
- Managed Care Contract

B. Fischer
LTC; Hospitals

- Rate Setting for LTC, Hospitals
- Minimum Data Set (MDS Administration
- RHC/FQHC management

Figure 3: Division of Information Technology Organizational Chart

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                                    ┌─────────────────────┐
                                    │      Director       │
                                    │    Jenny Witham      │
                                    └─────────────────────┘

┌──────────────────────┐  ┌──────────────────────┐  ┌──────────────────────┐  ┌──────────────────────────────────┐
│ System Support        │  │ Consulting Services  │  │ Administrative Staff │  │ Medicaid Systems Replacement     │
│ Services              │  │                      │  │ Officer              │  │ Project                          │
│                       │  │                      │  │                      │  │ Karalee Adam                     │
└──────────────────────┘  └──────────────────────┘  └──────────────────────┘  └──────────────────────────────────┘

   ┌──────────────────┐      ┌──────────────────────┐     ┌──────────────────────┐     ┌──────────────────┐
   │ Desktop Services │      │ Medical Services /   │     │ Fiscal Administration│     │ Project Manager  │
   └──────────────────┘      │ Data Entry           │     └──────────────────────┘     └──────────────────┘
                             └──────────────────────┘
   ┌──────────────────┐      ┌──────────────────────┐     ┌──────────────────────┐     ┌──────────────────┐
   │ EDMS             │      │ Economic Assistance  │     │ Performance          │     │ System Support   │
   └──────────────────┘      └──────────────────────┘     │ Measurement          │     │ Lead             │
                                                          └──────────────────────┘     └──────────────────┘
   ┌──────────────────┐      ┌──────────────────────┐     ┌──────────────────────┐
   │ Groupware        │      │ Child Support        │     │ Contract Management  │
   └──────────────────┘      └──────────────────────┘     └──────────────────────┘

   ┌──────────────────┐      ┌──────────────────────┐
   │ Security         │      │ Institutions         │
   └──────────────────┘      └──────────────────────┘

                             ┌──────────────────────┐
                             │ Human Svc Centers    │
                             └──────────────────────┘

                             ┌──────────────────────┐
                             │ Administrative       │
                             │ Systems              │
                             └──────────────────────┘

                             ┌──────────────────────┐
                             │ Other Central Office │
                             │ Systems              │
                             └──────────────────────┘
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Figure 4: Information Technology Department Organizational Chart

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                        ┌─────────────────┐
                        │  John Hoeven    │
                        │  Governor       │
                        └────────┬────────┘
                                 │
                        ┌────────┴────────┐
                        │ Curtis L. Wolfe │
                        │ Chief Information│
                        │ Officer         │
                        └────────┬────────┘
          ┌──────────────────────┼──────────────────────┐
┌─────────┴─────────┐  ┌─────────┴─────────┐  ┌──────────┴────────┐
│ Darlene Wolfgram  │  │ Mike Ressler      │  │ Nancy Walz        │
│ Administrative    │  │ Deputy CIO,       │  │ Policy and        │
│ Staff Officer     │  │ Director of ITD   │  │ Planning Division │
└───────────────────┘  └─────────┬─────────┘  └───────────────────┘
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Andy Pfaff, Director Human Resources Divsion	Dan Sipes Director Administrative Services Division	Vern Welder Director Software Development Division	Gery Vetter Director Customer Service Division	Jerry Fossum Director Telecommunications Divsion	L. Dean Glatt Director Computer Systems Division

Under Vern Welder (Director Software Development Division):

Doran Eberle
Enterprise Applications Development Manager

Brenda Haugen Team Leader, Senior Programmer/ Analyst	Leroy Jacobs Team Leader, Programmer/ Analyst III	Jean Churchill Team Leader, Programmer/ Analyst III

4.2　PROJECT GOVERNANCE

The following tables present the project governance structure, as well as the roles and responsibilities for the North Dakota Medicaid Systems Replacement Project. As shown in the table, DHS will be hiring an IV&V Contractor to team with the selected MMIS Contractor, POS Contractor, DSS/DW Contractor, DHS, and ITD to ensure the successful implementation of all three systems. Identified State staff will also be responsible for Project Governance on an ongoing basis for the DSS/DW Contractor's operational phase.

Table 4: State Project Governance Team

EXECUTIVE STEERING COMMITTEE		
Carol Olson, Executive Director, Department of Human Services Tove Mandigo, Special Assistant to Executive Director, Executive Office Brenda Weisz, Chief Financial Officer, Financial Administration Dave Zentner, Director, Medical Services Division Blaine Nordwall, Director, Economic Assistance Division Jennifer Witham, Director, Division of Information Technology Mike Ressler, Deputy Chief Information Officer, Information Technology Department		
PROJECT DIRECTORS		
Maggie Anderson, Assistant Director, Medical Services Division Karalee Adam, Deputy Director, Division of Information Technology Project Team Support Geoff Lowe, Project Execution and Control, Division of Information Technology TBD, Administrative Support, Division of Information Technology Mary Lou Thompson, Administrative Support, Medical Services Division		
PROJECT OVERSIGHT		
Dzung Hoang, Centers for Medicare & Medicaid Services, Region VIII Mark Molesworth, Information Technology Department, Policy and Planning Division Melissa Hauer, Department of Human Services, Legal Division Rhonda Obrigewitch, Department of Human Services, Fiscal Administration Division Independent Verification and Validation Contractor – *To Be Determined*		
PROJECT MANAGEMENT		
DEPARTMENT OF HUMAN SERVICES	**INFORMATION TECHNOLOGY DEPARTMENT**	**VENDORS**
Erik Elkins, Business Process Lead Becky Blees, System Support Lead Cherie Kraft, MMIS Business Analyst Deb Dietz, MMIS Business Analyst	TBD, Project Execution and Control TBD, System Architecture	TBD, Project Execution and Control TBD, System Architecture

Table 5: Roles and Responsibilities of State Project Governance Team

POSITION	RESPONSIBILITY
DHS Executive Steering Committee	The Steering Committee will meet regularly during the project life cycle to monitor overall project status, address escalated issues that cannot be resolved at another level of project management, and other areas as deemed appropriate. The goal of the committee is to provide leadership and support to the project team. Major responsibilities include: • Establish a project vision that supports the strategic direction for the project. • Develop and recommend a set of planning and implementation principles that will help define the scope and character of the project as well as provide the means to evaluate its outcomes. • Champion the need to change by rethinking current business processes and implementing new processes appropriate to the project vision and objectives. • Review, approve, and monitor a project communication plan. • Participate in communication as required. • Assist the efforts of the entire project staff in developing momentum and a cooperative spirit. • Review, approve, and monitor project budget, implementation plan timelines, and milestones. • Monitor project costs and project risk assessment. • Report regularly to the IT Legislative Committee on project status. • Help identify and solicit project resources. • Oversee periodic external project management audits. • Review and approve the plan for transition to production, and monitor that transition. • Review Quality Assurance deliverables on a periodic basis. • Review milestone progress and signoff. • Final escalation point for project issues. • Some issues, due to their significance and impact, may need to be resolved by the Governor and/or the Legislature.
Project Directors	• Update project Executive Management of project progress. • Ensure the appropriate State of North Dakota resources are involved in the project. ▪ Oversee the management of the vendor resources. • Provide issue resolution procedures. • Second escalation point for project issues. • Provide quality assessments of project deliverables. • Approve project expenditures. • Ensure effective communication with all internal and external MMIS stakeholders.
Project Support	• Administer and oversee the execution of project management standards and controls. • Assess and report project feedback and status to Project Directors. • Utilize and enforce change control procedures. Document and archive project decisions. • Conduct regular and ongoing review of the project to confirm that it meets original objectives and requirements. • Develop communication tools that will be used for internal and external project communications. • Assist project team in determining audience, content and frequency for defined communication methods. • Arrange, schedule and facilitate staff attendance at all project meetings. Distribute project documents and materials.

POSITION	RESPONSIBILITY
Project Management	Serve as the point person for all project issues. (First escalation point). ▪ Oversee the day-to-day project activities of the project functional teams. ▪ Escalate project issues, project risks, and other concerns to Project Directors. ▪ Review all project deliverables and provide feedback. ▪ Manage project risks and issues and proactively propose/suggest options and alternatives for consideration. • Resolve system and process issues and provide the project team members with updated procedures. • Assist with the dissemination of timely information to the user community related to implementation status and business decisions. • Coordinate and participate in execution of a user acceptance test (UAT) for system verification. • Assist in migration planning and execution tasks.

Table 6: General Project Responsibilities

POSITION	DHS RESPONSIBILITY	ITD RESPONSIBILITY	IV&V CONTRACTOR RESPONSIBILITY
Project Oversight	• Assist with vendor contract execution and control. • Provide financial accounting, reporting and procurement oversight.	• Provide ITD project oversight and assist with reporting project status to the Legislative Information Technology Committee. • Receive assurances from Auditor's office that proper internal controls are in place. Auditor's Office will also obtain familiarity with the system that will help with post production audits.	• Review contractor documents to validate and verify compliance with the implementation plan and system specifications. • Provide assessment reports, focusing on the review of contractor documents. • Provide guidance to DHS and ITD regarding all necessary requirements that ultimately lead to MMIS Certification by CMS.
Subject Matter Experts	• Have a thorough understanding of their areas of expertise. • When called upon by the Project Team, assist with the assessment of business processes and identifying ways the new system can be utilized to fulfill those requirements. • When called upon by the Project Team, assist in the resolution of issues impacting their areas of expertise. • Conduct system review, acceptance and parallel testing through the execution of test scripts and documentation of results.		

4.3   MEDICAID PROGRAM ADMINISTRATION

4.3.1   STATE OF NORTH DAKOTA

The North Dakota Department of Human Services (DHS) is responsible for the administration of the North Dakota Medicaid program, including the claims processing function. Primary responsibility for policy and decision making rests with the Medical Services Division. Data entry, imaging, and coordination with ITD are the responsibility of the Division of Information Technology (DoIT). ITD and DoIT are responsible for the ongoing systems operations and maintenance, including the current MMIS and POS.

4.3.2   U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Three agencies within the U.S. Department of Health and Human Services (HHS) have important roles relative to the North Dakota Medicaid program.

The Centers for Medicare and Medicaid Services (CMS) is responsible for promulgating Title XIX regulations and determining State compliance with regulations. CMS is responsible for certifying and re-certifying the States' MMIS.

The Office of Inspector General (OIG) is responsible for identifying and investigating instances of fraud and abuse in the States' Medicaid programs. The Inspector General's office also performs audits of the States' Medicaid programs.

The Social Security Administration (SSA) is responsible for Supplemental Security Income (SSI) eligibility determination. SSA transmits this information via a State Data Exchange (SDX) tape to the State for updating the eligibility system. Information is also provided on Medicare eligibility through Beneficiary Data Exchange (BENDEX) and Buy-In tapes.

4.4   OVERVIEW OF PRESENT OPERATION

This section provides a high-level description of North Dakota's current operations. A more detailed document, the North Dakota MMIS Analysis and Evaluation, is available in the bidder's library.

4.4.1   MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS)

The current DHS MMIS is a 1978 EDS MMIS transfer system maintained by the North Dakota Information Technology Department and the DHS Division of Information Technology. It was designed as a batch payment system for Medicaid providers rendering services to recipients.

4.4.1.1   CLAIMS

Claims are submitted electronically and on paper. HIPAA standard formats and proprietary formats are both being used for claim submission. An analysis of paper versus electronic

claims in June 2004 indicated that 85% of the June 2004 claims were submitted electronically. Approximately 2.5 million claims are processed annually by the MMIS.

The media used for claim submission are listed below:

- Paper: UB-92, CMS1500, American Dental Association (ADA) forms, Turn Around Documents (TADs), and proprietary pharmacy claim forms.

- Pharmacy Claims: Pharmacy claims are adjudicated by the Point-of-Sale (POS) system and then paid through the MMIS. Paper claims are keyed into the Phoenix Software Data Entry System, converted to an MMIS proprietary format, validated, and converted to the Point-of-Sale system format.

- Provider Claims Submission Software: Providers utilize various software packages (e.g., PC-ACE) to submit claims through the DHS Translator.

- Web-based file transfer (Medicaid Claims): A HIPAA X12 837 claims transaction from the provider is uploaded to an Oracle database. The translator converts the data in the standard transaction into a file format that MMIS recognizes, and loads the data into the MMIS. Any dropped data fields from the 837 go into the Health Insurance Portability and Accountability Act (HIPAA) data repository, which is an Oracle database.

- Web-based file transfer (Non-Medicaid Claims): Qualified Service Providers, Basic Care Providers, Developmental Disability (DD) Providers for non-ICF/MR (Intermediate Care Facility for the Mentally Retarded) services can bill through Web-based file transfer with a proprietary Disk Operating System (DOS) based format.

- Fax: Special circumstances only.

- Cartridges (crossover claims): Received in National Standard format (NSF) until Medicare intermediaries are prepared to submit HIPAA compliant 837 transaction claims.

4.4.1.2   HIPAA TRANSACTIONS

The MMIS is using the SeeBeyond translator to process HIPAA transactions. DHS revised the current MMIS to accept and receive the following HIPAA transactions: 820 Premium Payment, 834 Benefit Enrollment and Maintenance, 835 Remittance Advice, 837 Professional Claim, 837 Institutional Claim, 837 Dental Claim, 276 Claim Status Inquiry, 277 Claim Status Response, 270 Eligibility and Benefits Inquiry, 271 Eligibility and Benefits Response, 278 Referral and Authorization Inquiry and Response, and 997 Functional Acknowledgement.

4.4.1.3   DATA ENTRY

There are currently two processes for entering paper claim and attachment data into the MMIS, depending on the type of claim form. The Phoenix Data Entry System is used to enter data from pharmacy, Home and Community Based Services (HCBS) and waiver claims on Turn Around Documents, eligibility forms, and other miscellaneous data sources into the MMIS. UB-92 and CMS1500 forms, as well as any associated attachments, are scanned using a Kodak i260 and a Fujitsu fi-4860C scanner and processed through the Cardiff Teleform Optical

Character Recognition (OCR) process. Because there are a number of different dental claim forms, dental claims cannot go through the OCR process, but are considered to be "Scan and Key from Image" (SKFI) claims. These claims are keyed from the scanned image rather than a paper document.

Data entry operators key the information from the forms, and the information is then verified by a different operator.   There are approximately 18,300 paper claims manually entered monthly into the MMIS. In addition to the paper claims, approximately 54,500 claims and attachments are scanned monthly and approximately 4,570 SKFI claims are keyed monthly. Significant manual quality control occurs to ensure that the imaged claims are legible, that the system has identified claims and attachments appropriately, and that the counts are accurate.

4.4.2   ELIGIBILITY

There is not a Medicaid eligibility Recipient subsystem in the North Dakota MMIS. However, the non-Medicaid eligibility is contained in the MMIS. Full recipient eligibility information for Medicaid is stored in the Technical Eligibility Computer Systems (TECS) and VISION systems, which are operated by the Temporary Assistance to Needy Families (TANF) program. Both Medicaid and non-Medicaid eligibility are read directly by the MMIS during the weekly batch adjudication cycle. An eligibility file for Medicaid recipients with a limited amount of data (name, eligibility period) is updated weekly in the MMIS by VISION and TECS.

Eligibility technicians in the County offices determine eligibility for Medicaid and other non-Medicaid programs. Eligibility information is entered directly into VISION or TECS or the MMIS, depending on the program.

1. TECS is an application written using ADABAS, Natural and COBOL.
   - Eligibility for Qualified Medicare Beneficiary (QMB), Specified Low-income Medicare Beneficiary (SLMB), Buy-In, and other Medicaid eligibility (may be moved to VISION by June 2007)

2. MMIS on Virtual Storage Access Method (VSAM)
   - Eligibility for non Medicaid DHS programs
     o Department of Corrections
     o Disability Determination Services
     o State Hospital Institutions Psychiatric Services
     o Vocational Rehabilitation
     o Children's Special Health Services
     o Developmental Disabilities
     o Service Payments for the Elderly and Disabled (SPED) and Expanded SPED
     o Women's Way
     o North Dakota Youth Correctional Center

3. VISION is an application written in COBOL, C++, AllFusion Gen and uses the DB2 Relational Database Management System
   - Medicaid eligibility, including managed care enrollment. Healthy Steps (State Children's Health Insurance Program - SCHIP) eligibility will be in the VISION system by June 2005.

The recipient eligibility information is utilized for claims processing and supports the Medifax and VERIFY eligibility verification systems. Providers can access Medifax to obtain a print-out of eligibility information or access electronic eligibility information through Medifax's Web portal. They can also verify eligibility through the VERIFY automated voice response system. There are approximately 53,000 Medicaid eligibles. Of those, 33,600 are in managed care Primary Care Provider (PCP) or Managed Care Organization (MCO) programs.

4.4.2.1 COVERED PROGRAMS

The MMIS processes claims for medical and non-medical services for Medicaid and other State programs. Covered programs and their services include:

- Medicaid

- Medicaid Expansion: Pays for Medicaid services for children who meet Medicaid eligibility but exceed the asset level test.

- Health Tracks [formerly Early and Periodic Screening, Diagnostic and Treatment (EPSDT)]: A preventive health program that pays for screenings, diagnosis, and treatment services for children age 0 to 21 who are eligible for Medicaid.

- Developmental Disabilities Family Subsidy: State-funded program that pays costs in excess of Medicaid in order to keep the child in the home.

- Disability Determination Services: Pays for the consultative exams, the Medical Evidence of Record (MER), and travel expenses for persons applying for Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI).

- Children's Special Health Services (CSHS): Pays for specialty care for children under 21 that is needed to treat an eligible diagnosed condition, such as cerebral palsy. Primary funding sources include the Maternal and Child Health Block Grant and Federal funds.

- Aging and Disabled Programs:
  o Service Payments for the Elderly and Disabled Program (SPED) – Payments for in-home and community based services for older or physically disabled persons – may or may not be Medicaid eligible. SPED is funded primarily with State general funds.
  o Expanded-SPED – Pays for the same services as SPED, with different eligibility requirements. Expanded SPED is funded through State general funds.
  o Waivers [Aged and Disabled, Traumatic Brain Injury Waiver (TBI)] – Pays for services to Medicaid eligible persons who would otherwise require nursing home services.
  o Developmental Disability (DD) Waiver – Pays for an array of residential services, day services, and family support services.

- Healthy Steps (SCHIP Program): Pays for services for children in families who cannot afford health insurance, but do not qualify for Medicaid.

- Vocational Rehabilitation: Pays for services related to assisting individuals with mental or physical disabilities obtain and maintain employment.

- Department of Corrections: Pays for services authorized by the Department of Corrections for prisoners in a correctional facility.

- Women's Way: Pays for services for women who are not eligible for Medicaid and who have been diagnosed with breast or cervical cancer.

- Aid to the Blind: Pays for services for people 55+ who have vision impairments.

- State Hospital: Pays for institutional psychiatric services for persons who are not eligible for Medicaid-ages 21 and under and 65 and older.

- Qualified Medicare Beneficiaries (QMB): Pays for Medicare Part A premiums, coinsurance and deductible for aged, blind or disabled individuals who meet the non-financial criteria for medically needy, and other financial criteria.

- Specified Low Income Medicare Beneficiaries (SLMB): Pays for Medicare Part B premiums for aged, blind or disabled individuals who meet the non-financial criteria for medically needy, and other financial criteria.

- Qualifying Individuals (Buy-In): Pays for Medicare Part B premiums for aged, blind or disabled individuals who meet the non-financial criteria for medically needy, and other financial criteria, and cannot be receiving Medicaid benefits.

- North Dakota Youth Correctional Center (YCC): Pays for services authorized by YCC for juveniles in a correctional institution.

4.4.2.2   STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)

Healthy Steps, North Dakota's SCHIP program, serves approximately 2,400 children.
The State contracts with Noridian Mutual Insurance Company to process and pay SCHIP claims.   Noridian pays the providers directly, and sends a remittance advice. Enrollment data and premium payments are sent to Noridian from the MMIS on a monthly basis[3]. These transactions are in the 834 and 820 HIPAA compliant formats. Noridian sends hard copy claims payment summary reports and utilization reports to the Medical Services Division.

4.4.2.3   MANAGED CARE

North Dakota requires that Medicaid eligible recipients meeting certain criteria enroll in the managed care program. Approximately 63% of North Dakota's Medicaid recipients participate in managed care. Of those recipients participating in managed care, 2% belong to a Managed Care Organization (MCO), and 98% are in the Primary Care Case Management (PCCM) program. Upon meeting the eligibility criteria for managed care, the recipient must choose a primary care provider (PCP) or choose between a PCP and the MCO if they live in one of the three (3) counties designated for MCO service.

Primary care providers receive a $2 administration fee each month for each recipient in their care, and their claims are paid on a fee-for-service basis. North Dakota contracts with Noridian Mutual Insurance Company (Noridian) which in turn subcontracts with Altru Health System for the MCO. Noridian submits encounter claims on a monthly basis. At this time, Noridian uses

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[3] Beginning June 2005, MMIS will be sending HIPAA 834 transactions to Noridian on a daily basis representing changes to enrollment data for SCHIP.

the NSF format to submit encounter claims. The MMIS processes the encounters the same as fee-for-services claims for pricing and utilization information, but no payment is made.

Enrollment data and premium payments are generated through the MMIS and sent to Noridian. These transactions are in the 834 and 820 HIPAA compliant formats.

4.4.3   COVERED SERVICES

The North Dakota Medicaid program covers all federally mandated services as well as a number of optional services. The following services are currently covered under the program:

- Inpatient Hospital
- Outpatient Hospital
- Nursing Facility
- Clinics, Rural Health Clinics
- Hospice
- Physicians
- Prescription Drugs
- Chiropractor
- Health Tracks (EPDST)
- Home Health
- Durable Medical Equipment and Supplies
- Dental
- Family Planning
- Sterilization
- Podiatry
- Mental Health
- Ambulance
- Transportation
- Vision
- Physical and Occupational Therapy
- Speech and Language Pathology
- Waivered Services - Home and Community Based Services, Traumatic Brain Injury
- Out-of-State Services

4.4.4   PROVIDER SERVICES

There are currently approximately 15,800 providers enrolled; about 9,300 of the enrolled providers are active, having billed Medicaid in the last 2 years.   Provider enrollment and provider relations services are managed by the State. Fee-for-service providers receive direct reimbursement from North Dakota Medicaid for submitted claims.

4.4.4.1   PROVIDER ENROLLMENT

Providers submit an application for enrollment, indicating their provider type and specialty, to the provider enrollment specialist in the Medical Services Division. In addition to the enrollment

form, providers are required to send a copy of their current license, a W-9 form and a signed Provider Agreement, agreeing to the policies and procedures for billing North Dakota Medicaid. The State verifies licensure with the State Board of Examiners.

*Bidder's Note: As part of this contract, the MMIS Contractor will be responsible for re-enrolling all providers with the North Dakota Medicaid program 6 months prior to the system's "Go Live" date.

4.4.5   CUSTOMER RELATIONS

The Department currently has 2 full-time and 4 back-up staff members performing Customer Relations services. Provider (and recipient) phone inquiries are handled by the Customer Relations staff. There are approximately 80-200 calls per day. Written correspondence is triaged in the mailroom.

Providers receive billing manuals and bulletins to assist them with billing North Dakota Medicaid.

4.4.6   PROVIDER REIMBURSEMENT

Multiple reimbursement methodologies are supported by the MMIS, based on the type of service, including:

Table 7: Service Reimbursement Methodologies

TYPE OF SERVICE	REIMBURSEMENT METHODOLOGY
Inpatient Hospital	Diagnostic Related Groups (DRG)
Psychiatric and Rehab. Hospitals; Immediate Care Facility for Persons with Mental Retardation (ICF-MR) facilities; Residential Treatment Centers; Basic Care; Hospice; Aging Waivers	Per Diem or Per Unit
Outpatient Services; Out-of-State Hospitals	Cost to Charge Ratio
Lab Services	Medicare Fee Schedule
Ambulatory Surgical Centers	Medicare Ambulatory Surgical Center (ASC) Grouping
Physicians, Council on Naturopathic Registration and Accreditation (CRNAs); Nurse Practitioners; Physician Assistants; Dentists; and other practitioners	Fee Schedule

TYPE OF SERVICE	REIMBURSEMENT METHODOLOGY
Indian Health Services (IHS) facilities	Encounter Rates
Long Term Care and Swing Beds	Minimum Data Set Resource Utilization Groups (MDS RUG) Case Mix Payment System
Federal Qualified Health Centers (FQHC); Rural Health Centers (RHC).	Prospective Payment System (PPS) Encounter Rate
DD Waiver, DD Family Subsidy	Actual Charges
Miscellaneous Services	Manual Pricing

4.4.7 *COST CONTAINMENT*

In an effort to control the costs of the North Dakota Medicaid program, the following restrictions or limitations on reimbursement have been implemented:

4.4.7.1 RECIPIENT LIABILITY AND RECIPIENT RESPONSIBILITY

4.4.7.1.1 Recipient Liability

Some of North Dakota's Medicaid recipients are responsible for a portion of their medical expenses each month, based on their monthly income. Recipient Liability (RL) is determined by the TECS and VISION systems along with the Medicaid eligibility. The system calculates and stores the amount of RL based on the information that the County eligibility workers enter into the systems. The amount of medical expense incurred to date is also maintained on the VISION and TECS systems, and can be updated by MMIS or manually through the eligibility system by the DHS RL staff. When a claim is processed through the MMIS, the system checks the RL balance, and if the recipient liability has not been met for the time period the service was delivered in, the claim is processed with no payment or reduced payment. The MMIS updates the RL balances in VISION and TECS with the unpaid amount. In addition, recipients or providers may submit medical bills to the RL staff, who then update the recipient liability balances with the amount of the bills. Once the spend-down or deductible amount has been met for a period, claims for that period process and pay without failing this edit. Each Internal Control Number (ICN) that affects the Recipient Liability is listed in the VISION or TECS systems.

4.4.7.1.2 Recipient Responsibility

In the Basic Care Program, North Dakota DHS provides residential coverage for aged, blind, and disabled SSI recipients. Coverage is limited to persons in licensed basic care facilities. In this program, the State subsidizes non-Medicaid services (referred to as Room and Board) provided by a basic care facility for Medicaid eligible individuals. All but $60 of a recipient's SSI

income or medically needy income level is used to pay room and board. The amount the recipient must pay for room and board is identified as Recipient Responsibility (RR). If the recipient has insufficient RR to pay the room and board charges, any additional costs are then subsidized by the State. If the recipient has recipient responsibility remaining after paying room and board charges, the remainder is applied as other income to charges for personal care.

4.4.7.1.3   Recipient Co-pay

Some of North Dakota's Medicaid recipients are responsible for a small part of the cost (co-payment) for some medical services. Co-payments are deducted on claims for certain services and recipient groups, according to the co-payment policy set by the State. Co-payment amounts are applied to recipients based on, but not limited to: type of provider, diagnosis codes, place of service, procedure code, etc. Co-pays are excluded from some Federal and State-defined recipient groups. There are also some specific services excluded from the co-payment requirement. Other non-Medicaid programs may apply co-payments as well. For example, in some instances those participating in the DD waiver program may be responsible for a co-payment.

4.4.7.2   SURVEILLANCE AND UTILIZATION REVIEW

DHS is responsible for Surveillance and Utilization Review functions, including report production, analysis of exceptions, on-site provider audits and referrals of suspected fraudulent activities to legal authorities. DHS specifies the parameters and criteria to develop exception, profile, and informational reports, and those reports are created in Medstat DataProbe®. The DataProbe® System is supplemented with ad-hoc reports. The Department can also request assistance from Medstat to create reports.

If a provider deviates significantly from the peer group norm, further review of claims history is warranted. If the claims history indicates suspicious billing practices, the information is reviewed by the coding specialist at the State, and review of medical records may be necessary if there is suspicion of fraud. Consultants or other professionals may become involved with the investigation. If indicated, corrective action may take place in the form of edits, recoupments, policy decisions, sanctions (suspension, termination), or referrals to the State's attorneys or the U.S. Attorney General.

Various preventive measures, exception review, and post utilization review are methods used to monitor utilization of Medicaid services, control costs, and to prevent and detect fraudulent billing.

Preventive Measures

- MMIS claims edits

- Prior Authorization – Requires that services be prior authorized based on medical necessity. Areas where Prior Authorizations are required include:
    1. Medicaid
        a. Certain surgical procedures
        b. Long Term Care (LTC), ICF-MR, (including waiver) admissions

      c. Personal care

      d. Certain dental procedures

      e. Certain drugs

      f. Any services over designated dollar limits or limits on number of services

      g. Psych services for children under 21

      h. Home health services

      i. Out-of-State services

      j. Partial hospitalization

      k. Hospice

2. Service Plans

      a. DD Waiver

          i. Family Support Services uses a contract

         ii. Individual Supported Living Arrangement (ISLA) uses a contract

      b. Aging Waiver

      c. State-funded Aging Services

- Coordinated Services Program (CSP – formerly Recipient Lock-In) – Restricts recipients who have demonstrated over-utilization to certain physicians and pharmacies.

- Service Limits - Currently only applies to a procedure code, and identifies a claim with a specific procedure when the limit has been exceeded.

- Nursing Home admissions – Captured in MDS.

- Certificate of Need (CON) for residential treatment services.

- Outpatient (OP) Partial Hospitalization (Ambulatory Behavioral Health Care) – A request is submitted for length of stay determination (CAL LOCUS).

- Out-of-State Providers – A letter of explanation is required from an In-State physician when a referral is made to an Out-of-State provider.

- Transplants – Requires a letter requesting authorization for a transplant.

- North Dakota Health Care Review – Authorizations for services such as gastric bypass surgery and cosmetic surgery. These authorizations are received as letters and are filed. This information is not currently captured in the MMIS.

- Prospective Drug Utilization Review (ProDUR) and Retrospective Drug Utilization Review (RetroDUR) for pharmacy claims.

4.4.7.3　THIRD PARTY LIABILITY

The State has the responsibility to collect payments from third party payers when it is reasonable to do so. At times, it may be necessary to pay a claim and later recover the money from the third party payer (i.e., pay and chase). In some cases, it may benefit the State to pay the recipient's premium to another insurance payer to offset some of the costs of medical care.

4.4.7.3.1   Cost Avoidance

In most cases, Medicaid is the payer of last resort for medical claims. For the majority of medical claims, North Dakota requires providers to attempt to collect payment from other payers before submitting a claim to Medicaid for payment. If third party coverage is identified retroactively, an automated process is initiated to adjust claims.

4.4.7.3.2   Recoveries (Pay and Chase)

In some situations, such as pharmacy claims, liability claims, and trauma claims, Medicaid pays the medical claims and attempts to recover from the liable third parties. Recovery billing may be sent to providers, insurers, attorneys, recipients, or any other liable entity.

4.4.7.3.3   Estate Recovery

Upon the death of a Medicaid recipient age 55 and over, the State can file claims against the estate. If the recipient has a spouse that is living, the claim does not have to be paid until the death of the spouse. The claim against the estate is for the cost of Medicaid services that occurred between the recipient's 55th birthday and the date of death. DHS receives probate notices for North Dakota residents from attorneys and DHS determines whether the person has received Medicaid benefits. Probate is not filed for every individual, so obituaries are also monitored to determine whether the deceased individuals received Medicaid.

The current process for determining the dollars paid from age 55 until death is calculated manually, based on review of the records. Any recovered funds are entered into the TECS system, which sends an adjustment to the MMIS.

4.4.7.4   COST SHARING

4.4.7.4.1   Medicare Buy-In

Eligible individuals that wish to participate in Medicare Part B must pay a monthly premium. Under the Buy-In Program, however, states may pay the premium on their behalf. This arrangement transfers some medical costs for this population from the Medicaid Program, which is financed in part by the state and counties, to the Title XVIII Medicare Program for which the Federal government assumes responsibility.

4.4.7.4.2   Workers with Disabilities

The Medicaid Buy-In program enables people with disabilities who are between the ages of 18 and 65 to enroll in Medicaid if their net household income is at or below 225 percent of poverty. Qualifying individuals pay a one-time $100 enrollment fee and are responsible for a monthly premium equal to 5 percent of the disabled individual's monthly income.

4.4.8   PHARMACY POINT-OF-SALE

The Pharmacy Point-of-Sale (POS) system is a mainframe Customer Information Control System (CICS)/COBOL system first developed by GTE for Missouri that was transferred to Utah. It was transferred from Utah to North Dakota in 1996. It has been modified beyond the National Council for Prescription Drug Programs (NCPDP) version 5.1 compliance that is mandated by HIPAA, and is compatible up to version 5.5. It is compliant for batch version 1.1, but batch claims are only typically used by nursing home pharmacies. The Point-of-Sale system uses the same eligibility interfaces as MMIS (i.e., TECS, VISION) for a combined / virtual MMIS eligibility, and reads directly from the MMIS provider file. Two years of drug history is maintained in a VSAM file.   The system has the capability to classify claims as new claims, reversals (voids), and re-billed claims. Pharmacy claims are adjudicated on-line in the POS and paid through the MMIS.

North Dakota DHS offers pharmacy benefits to Medicaid and claims processing for non-Medicaid recipients. Claims processing for other entities is done to a varying degree. These other entities include:

- AIDS Drug Assistance Program - A Ryan White Federal Grant program; strictly follows formulary.

- Children's Special Health Services - State-funded program; follows formulary, with diagnosis screening for various disease states.

- Vocational Rehabilitation – Coverage is based on the details of the claim.

- Youth Correctional Centers - Contracting done with retail pharmacy; will pay for any prescription prescribed (No Adult Corrections coverage).

- Indian Health Services (IHS) - Payment per encounter; IHS does not use POS, but utilizes the UB-92 form and processes the claims through the MMIS.

4.4.8.1   DRUG REBATE

North Dakota Medicaid participates in the Drug Rebate program with drug manufacturers. CMS sends a quarterly tape identifying drug manufacturers participating in the Drug Rebate program. Invoices are created and mailed to the manufacturers. Refunds are credited to the State accounting system and the adjustments are made in the MMIS.

4.4.9   DECISION SUPPORT SYSTEM

The Department contracts with Medstat for Decision Support System services. Claims data from the MMIS and limited eligibility from the eligibility systems feed into the Medstat DSS. Healthy Steps claim data is sent to Medstat directly from Noridian. There are currently 7 years of data stored in the data warehouse. The Medstat DSS also houses data from the Department of Health.

Certain Management and Administrative Reporting (MAR) and Surveillance and Utilization Review (SUR) reports are generated from the Decision Support System, as well as standard reports for Finance and the other programs within the Department.

4.4.10   MANAGEMENT AND ADMINISTRATIVE REPORTING (MAR)

Standard management and administrative reports are generated within the MMIS by the Division of Information Technology, and through the Decision Support System. MAR reports primarily give an account on the way the Medicaid dollars were spent in a given time period.

4.4.11   CURRENT MMIS INTERFACES WITH OTHER SYSTEMS

A number of external and internal interfaces exist between the MMIS, VISION / TECS, the Point-of-Sale system, and other systems. A comprehensive list of current interfaces is contained in the North Dakota MMIS Analysis and Evaluation document, which is available in the bidder's library. Attachment H details non-Medicaid program related interface requirements for the new system.

5.0 SCOPE OF WORK & PROJECT SCHEDULE

5.1 PROCUREMENT VISION

DHS intends to replace its existing Medicaid Management Information System (MMIS), Pharmacy Point-of-Sale (POS) system, and Decision Support System (DSS). Over the past several months, DHS has fully explored numerous options for replacing its current systems. In conducting this analysis, DHS weighed the cost of each alternative against the State's business and technology requirements and the principles set forth by CMS in the Medicaid Information Technology Architecture (MITA). As a result, it is DHS's goal to implement a systems environment (MMIS, POS and DSS/DW) that supports:

- *Flexibility* **–** The system architecture must allow DHS to rapidly respond to change in terms of adaptability, changing functionality, extensibility, and added functionality. Each change in a law or regulation often means multiple changes to system software. A major goal of this replacement effort is to reduce the time and cost associated with future system enhancements.

- *Enterprise View to Align Technology and Business Needs* – The system must be based on technology that will support the enterprise into the future, in such a manner that business requirements drive enhancements rather than system limitations driving business decisions.

- *Data Analysis and Decision Making* – Effective management of Medicaid requires a system that supports data analysis across the enterprise and effectively supports performance measurement and planning. It also requires the ability to share data with providers and other stakeholders.

- *Integration and Interoperability* - The system must work with other systems without special user effort to support coordination with providers and other stakeholders.

- *Access* – The system must support Web-based self service to allow providers / pharmacists to submit claims and inquiries.

- *Multi-Payer Capability* - North Dakota, like most states, has several programs such as SCHIP that have business requirements almost identical to Medicaid. In addition, recipients move in and out of these programs as their financial circumstances change.

- *Operating Costs* - North Dakota experiences low administrative costs compared to other states of similar size. This is in part because the State rather than a fiscal agent manages the MMIS. The State intends to implement MMIS, POS and DSS/DW systems that meet the above-listed goals without substantially increasing operating costs.

Note that in the following discussions, the State has endeavored to follow Federal contract language guidelines, especially regarding the use of the word "shall". In each case, a stipulation using "shall" indicates a mandatory requirement.

5.2   BUSINESS NEEDS

This section focuses on the business needs of DHS, in support of the administration of the Medicaid program for the State of North Dakota. Business needs have first been sorted according to the "Scope of Work" (i.e., MMIS Replacement, POS Replacement, or DSS Replacement). The information has been further sorted according to the business area within the Scope of Work (e.g., Provider Services, Recipient Services, etc.).

5.2.1   MMIS REPLACEMENT

5.2.1.1   PROVIDER SERVICES

DHS enrolls providers that are eligible to participate in Title XIX or other programs served by the MMIS. The MMIS must facilitate the entry of all providers and support their interaction with DHS or other covered programs (as defined by Section 4.4.2.1).

The MMIS will provide Web-based system access to providers of medical services. The Web-based MMIS will be accessible to providers by using industry standard browsers (e.g., Internet Explorer, Netscape Navigator, etc.) without loading any additional software on their computers. Providers will be able to browse general purpose MMIS information Web areas or, if they are registered for on-line access, will be able to access secure data specific to their own practice.

Providers will be able to enroll on-line through a Web-based system and indicate which programs they wish to participate in and which services they will provide. Providers will enter all data on-line that is normally required of an application for participation and submit the application for consideration to DHS. DHS will subsequently process the provider's application, confirm licenses and certifications, review sanction history of the provider, and reply on-line to the provider with a provider number and access instructions.

As much as possible, DHS will automate the management of provider licensing and certification. The system must be able to track the status of licenses and certifications that are required to provide certain services, and alert staff to pending certification lapses. Staff will manage the certification process and inactivate those licenses or certifications that no longer apply. The system will automatically eliminate services from the provider's service set if the services require, but are no longer supported by, a valid license or certification. The systems will also be able to track the status of all providers and register sanctions, penalties, or service limitations of providers.

The MMIS will also support management of provider relationships by tracking ownership and practice and payment relationships between individuals and groups. The system will maintain a unique identifier for each provider, and indicate each provider's service locations and which services may be rendered at each location. Duplicate provider records will be identified, reconciled, and integrated into a single logical record. Claims records will be adjusted to reflect the integrated Provider ID and re-audited to identify and reverse any payment errors. These capabilities are required to support the National Provider Identifier (NPI) when it is implemented. Providers began applying for NPI numbers on May 23, 2005, so the replacement MMIS must be prepared to accommodate these numbers. By May 23, 2007, the NPI must be used in standard electronic transactions for all covered providers. At that time, the use of other provider

identifiers, such as the UPIN, Medicare ID, or Medicaid ID, will no longer be considered compliant on standard transactions.

Once a provider is registered, the system will also provide on-line access to MMIS data that is required to support their business. Using a secure sign on, the provider will be able to submit claims and authorizations, inquire regarding the status of claims and prior authorizations, and receive electronic reports.

The Provider Web Portal will provide on-line, automated training for providers to access as their needs require. These resources will include on-line Provider Manuals, computer-based training for North Dakota Medicaid providers, and other on-line services as defined by DHS. This capability will reduce the need for some providers to attend formal classes, thereby reducing the staff time and costs associated with participation in DHS or other covered programs (as defined by Section 4.4.2.1). Overall, the improved access provided by a Web-based MMIS will improve communications with providers and reduce the cost of effective provider management.

5.2.1.2   RECIPIENT SERVICES

The processes that support recipient data and services will draw upon sophisticated technology to manage a very complex set of programs and benefit structures. Recipient processes must reflect multiple sets of business rules, and apply them correctly in each situation. The rules definition process must be flexible enough to adapt to changes in State or Federal policies, and incorporate or exclude programs or benefits with minimal delays and costs.

The MMIS must support several State programs. These include all Title XIX programs, certain services paid for Developmentally Disabled recipients, services paid for Aging Services recipients, Children's Special Health Services, the Department of Corrections, Basic Care, Vocational Rehabilitation, and Disability Determination Services. The wide variety of programs supported by the MMIS requires that the system be able to easily accommodate variations in benefits and recipient liability across these programs. In addition, new programs and changes to existing benefit plans are likely to be implemented over time and the MMIS must be able to accommodate these new programs and benefit packages with a minimal amount of change to the system.

MMIS ID

The MMIS will include a master index file that assigns an MMIS ID to all recipients added to the MMIS system. The first time that VISION adds a new recipient to MMIS, MMIS will assign the ID to the recipient from a sequential number generator and populate the MMIS ID and the cross-reference to VISION ID. This will establish the master index of all recipients maintained in MMIS. Recipients added to MMIS will have cross-references to IDs in other programs or systems. As other systems add recipients or the recipients are added manually, the IDs of other programs will be added to the MMIS ID cross-reference. This ID cross-reference must indicate which numbers are active, representing which programs a recipient participates in. For all recipients added through automated interfaces, MMIS must have the ability to return the MMIS ID to the originating system. Manual additions will display the MMIS ID on the user interface.

When a new recipient is added to MMIS, the system will automatically execute a duplicate check based on name, Date of Birth (DOB), gender, Social Security Number (SSN), and address. Searches on name must be based on like-sounding or spelled names. If an exact duplicate is found, the record must automatically cross-reference the new recipient to the existing record, and must not create a new record. An exact duplicate is a match on name, DOB and SSN. Near Duplicates must pend for review before having a permanent record added. Near duplicates would be matches on SSN without a match on name or DOB; matches on name and DOB without a match on SSN, or match on name and address without a match on SSN.

The MMIS ID becomes the internal, operable ID for the MMIS system. MMIS would read through its ID index to find program-specific IDs and subsequently use that ID to find records in other systems. In most cases, program-specific IDs are drawn from interfacing systems (e.g., VISION and TECS), but some non-Medicaid programs will have their program-specific ID maintained within MMIS. For example, if the MMIS system needs a VISION record it would read the MMIS ID index to find the corresponding VISION ID, then read the VISION record with that VISION ID. If more than one VISION ID exists in the cross-reference, active VISION IDs for the period being examined would have to be identified and all records related to those IDs would be read. If County staff find a duplicate recipient in VISION, and inactivate or end date a record, the corresponding VISION ID in MMIS must be inactivated (either automatically by VISION or manually by the County staff). If an ID becomes inactive in an external system the status would have to be changed in MMIS and the date it is effectively inactive would have to be entered.

Eligibility Data

The MMIS will continue to read eligibility from the VISION / TECS systems (via the metadata layer) for recipients who have Medicaid IDs (as maintained in the ES100000 ADABAS file). In the immediate future, this will be recipients who are eligible for Title XIX or one of the programs supported by VISION / TECS. The MMIS will also have an internal Recipient subsystem that will contain eligibility records. All recipients with eligibility for programs not in VISION / TECS will have eligibility records in MMIS, entered through interfaces or manually on MMIS windows. For example, recipients that are eligible for both TANF and DD services will have records in both places.

MMIS will use a metadata layer or Application Programming Interface (API) to read data from the VISION / TECS tables, the MMIS recipient tables, or both. Which data is read would depend on which active IDs exist in the MMIS ID index. If the only active ID is in VISION / TECS, MMIS would read VISION / TECS based on that program-specific ID. If more than one active ID exists, it would read all applicable program-specific IDs. For example, if the claim is based on an ASSIST authorization, the system would look for an ASSIST ID and read the MMIS recipient file for DD eligibility. If there is also a Medicaid ID it would read VISION / TECS for Medicaid eligibility. If more than one active eligibility can support a claim or authorization, the system would use eligibility based on a hierarchy of payment sources.

The data layer does not preclude future integration of data. In the future, additional programs could move into VISION and recipients would no longer have to be entered into the MMIS recipient files. In addition, at some point the MMIS may read data from external tables other than the VISION / TECS system. For example, if the metadata layer can be configured to read

directly from ASSIST, entering ASSIST data into MMIS would no longer be necessary. The metadata layer will add flexibility and the ability to integrate data. The metadata tool must be an industry standard tool that can easily accommodate the addition of external eligibility sources in the future.

A recipient's eligibility for benefits under one or more waiver programs is an example of a situation where additional benefits available to residents must be supported by the MMIS. Waiver eligibility must be identified on the MMIS and service types and levels associated with the waiver must also be recognized. The combination of services available through program eligibility and those available through waivers is the total benefit package available to the recipient. A recipient who is Medicaid eligible, qualifies for waiver services, and participates in a non-Medicaid program, has benefit packages available from all of those programs that must be recognized and reconciled by the MMIS.

The MMIS must minimize the need to manually import or manipulate recipient data required to perform its business functions. The external systems that support MMIS processes will be evaluated to determine which eligibility, prior authorization, claims processing and query and reporting processes can be automatically interfaced with MMIS. The elimination of manual re-entry of recipient, authorization or claim data will reduce maintenance expenses and the time required to add new recipients.

Because services may be available from multiple benefit packages simultaneously, the MMIS must maintain a hierarchy of funding sources and select the correct source for any particular claim. That is, a Vocational Rehabilitation (VR) recipient who is Medicaid eligible may receive a service that can be funded under either Title XIX or VR services. If Medicaid is the first payment source to be used, the system must be able to attempt to pay first from that source. All possible funding sources for services must be prioritized in the hierarchy, and the highest possible source must be chosen for any payment.

The MMIS will also support correct application of eligibility and enrollment rules to different programs and automatically determine benefits and enrollment requirements. DHS intends to improve management of benefits with the MMIS. Recipients whose eligibility and physical location requires enrollment in some form of managed care program will be tracked to ensure that a choice of entity is made. If no choice is made, the recipient will be automatically enrolled based on a hierarchy of enrollment rules. This capability must eliminate the lack of timely enrollment by recipients. Such delays in enrollment can cause delays in receiving benefits, poor provider relations, and significant staff resource issues.

Interfaces with other State and Federal systems will be automated to reduce manual intervention to add or update MMIS records.

DHS expects the MMIS to improve the management of services to recipients, including case management and EPSDT services. The MMIS must automatically identify EPSDT eligible children and automatically produce notifications of screenings and follow-up visits for those children. The MMIS must be able to automatically track and report on all EPSDT services. Similarly, recipients identified for targeted case management must be identified in MMIS and the appropriate services automatically tracked for compliance with case plans.

With the new systems environment, DHS staff will have an improved ability to track and report recipient benefit delivery and cost sharing. Reporting on services provided to recipients from

both claim and encounter data will be available as on-line queries and reports or as standard printed reports. Data on Recipient Liability and cost sharing for each month must also be available on-line to support response to inquiries.

The MMIS will identify what premiums are required for each recipient based on the programs for which they are eligible, location, and personal data. The system will be able to manage, track, and record multi-level recipient premiums due and payment of premiums. The management will include suspension of benefits, as required by DHS policy.

In DHS's vision of future MMIS business processes, the system will identify third party resources coverage for new recipients and routinely initiate coverage validation. The MMIS must also support capture of data related to Third Party Liability (TPL) and Recipient Liability (RL) for existing recipients from claims and encounters and update all files that store that data. The MMIS must communicate with the VISION / TECS system to initiate updates to TPL and RL recipient records with data identified during claims processing.

The MMIS must automate Member Services support with real-time, Web-based inquiry into recipient eligibility and benefits. A Web Portal that supports inquiry by State staff, recipients, and providers must minimize delays in obtaining information and reduce the cost to the State of providing that data. The MMIS will support the receipt of the 270 Eligibility Benefit Inquiry transaction and respond with a 271 Eligibility Benefit Response transaction.

The MMIS must support Member Services, including support for call systems and the integration of recipient and provider contact management. For these functions, the system must:

- Support and interface with a call management tracking system that supports call resolution & follow-up

- Provide Web access for recipients and recipient advocates for assistance in finding a provider near their home, viewing enrollment records for their family, and for viewing benefits provided by their eligibility and enrollment

- Provide Web access to DHS policies and procedures, forms, computer-based education, health education programs, and Recipient Explanation of Medical Benefits (REOMB)

- Provide correspondence management, including the ability to target specific populations for recipient notices, support mass mailings to recipients, and track all correspondence related to recipients

- Support consolidated tracking of all recipient and provider events, including: phone calls, incoming and outgoing correspondence, complaints, and grievances

Shared Tables

Some data would be shared between VISION / TECS and MMIS. Users of both systems will read and update data, rather than try to maintain two repositories of the data. DHS has determined that the data must be shared so that both systems use current and correct data.

TPL data represents a function that requires shared data. TPL tables will be accessed by both MMIS and VISION / TECS systems. VISION staff would enter TPL data at intake and re-

determination while MMIS staff would enter potential TPL sources received on claims or received from a 270/271 transaction. MMIS would read the table in processing claims and encounters.   Both MMIS and VISION / TECS users would read the table directly and both set of users would feel like the data is within their own system.

Tables that store enrollment data would also be shared between VISION / TECS and MMIS. County users will enter enrollment selections through the VISION / TECS data entry screens. MMIS will automatically select a PCP or MCO for recipients who do not make a timely choice, and populate the enrollment tables. Enrollment would be viewed from either VISION / TECS or MMIS.

Recipient Liability (RL) is another example of tables that must be shared between VISION / TECS and MMIS. County Eligibility staff establish the RL amounts during eligibility determination and re-determination. The tables would be updated through VISION / TECS when a recipient brings evidence of payment for medical care to a County worker. Claims that indicate payment by the recipient would be used to update the amount of recipient liability incurred in the tables. RL data would be viewed from either VISION / TECS or MMIS.

In order to implement shared tables for the data identified above, the MMIS would also require:

- Clear audit trails regarding users who add or update data, including system adds and updates

- Status values that support suspending a change for review by a case manager

- Some method of alert or display sent by MMIS to tell staff they must confirm a change in TPL data

5.2.1.3   DATA MANAGEMENT

The MMIS will be table-driven to the greatest extent that is feasible to maximize flexibility and will also have the ability to quickly accommodate policy and rule changes. The Data Management functionality will maintain and support the management of all reference data used by the system, as well as maintain rates to be paid for services. Edits and audits for claims and other subsystems must be table-driven and the edit/audit parameters must be maintained by the Data Management processes.

5.2.1.4   PRIOR AUTHORIZATION

Prior Authorization business processes within the MMIS will become a central point for control of service delivery and implementation of benefit policies. Services and pricing exceptions that require authorization under State policy will be entered and either authorized or denied authorization in this process.

The scope of Prior Authorization will include both traditional service authorizations for Title XIX recipients, and services that are authorized in service planning outside of the Medicaid program. For example, services for Developmentally Disabled recipients that have been approved as part of service plans in ASSIST will be automatically entered into the prior authorization queue through an interface with MMIS. This approach will be used, whenever possible, where

services are approved as part of a service plan that is external to the MMIS. Services authorized through screening evaluations will also be automatically entered as authorizations in the MMIS.

The Prior Authorization process will be automated by offering real-time Web access to providers to enter Prior Authorization requests. The provider will use a Web Portal to enter the Prior Authorization request and any supporting documentation, and the provider will receive responses through e-mail and direct lookups on the Web Portal. This Web Portal would also integrate any Pharmacy Prior Authorizations that presently do not have an automated process. Providers will also have the capability to submit and receive a response to a prior authorization request on the 278 Health Care Services Review transactions.

DHS staff will also be able to enter prior authorizations directly into the system. The future MMIS will support service authorization by various DHS staff and providers in accordance with their level of security for authorizations. Security levels will be maintained by security tables that can be modified to change staff security without system coding.

DHS staff and providers will be able to track authorizations and services delivered to recipients. The system will track (and make available on-line):

- All services authorized for a recipient or case management plan

- Use of services to date

- Services remaining under each authorization

The system will also support case management by supporting the creation of authorizations with multiple services, providers, and timeframes.

Claims processing business processes will use prior authorization data in the adjudication and pricing of claims.

5.2.1.5   CLAIMS

The DHS vision for Claims business processes requires a more open, automated claims system. The MMIS and POS systems will continue to allow providers to submit claims via point-of-sale and electronic submission [i.e., Web or Electronic Data Interchange (EDI)]. DHS will support and encourage providers to submit electronic claims whenever possible and will continue to encourage non-Title XIX programs to submit electronic claims directly or through interfaces with other systems. To support this initiative, the MMIS must facilitate electronic submission and on-line claim correction and adjudication. DHS will require systems that support on-line entry and adjudication of claims through a Web Portal that is accessible to both DHS and service providers.

The MMIS will continue to process claims and initiate payment for multiple State programs, including both Medicaid eligible and non-Medicaid eligible recipients. The rules-based processing of the MMIS will support the addition or deletion of recipient groups to accommodate changes in the populations served.

The system will also continue to support claims for which no payment is made by DHS (i.e., claims that are processed and adjudicated according to rules contained in the MMIS and a payment file is created for the paying program). This will include claims for waiver and other programs where an adjudicated claim is required for Federal cost participation.

Internally, the MMIS must be automated for the management and adjudication of claims. This will include an automated Workflow Management System that allows users with proper security to determine edit and audit disposition without system reprogramming. The disposition must include routing to appropriate logical locations or areas that can be accessed by staff based on skills or adjudication levels.

The DHS vision for claims includes interactive, on-line communication with providers to facilitate management of claims adjudication. The system will include a Web Portal where providers can view results of claims processing at specific points in the process. This Web Portal will permit providers to submit, update, re-submit, and void claims and encounters.

Claims processing logic, including edits and audits, must be table-driven or controlled by business rules engines as much as possible. DHS must be able to add, change, or delete edits and audits (as necessary) without significant reprogramming of the system. Prior to any edit/audit modification becoming effective, the system will provide detailed information to DHS regarding the number of claims that would be affected by the modification and the effect on program costs. Claim routing and disposition must also be table-driven and adjustable without additional system coding.

DHS will require an integrated rate setting process that will ease updates and accommodate multiple reimbursement methodologies for claims pricing. The business rules engine will drive pricing logic, based on a hierarchy that governs which pricing rules have precedence for each program and payment type.

Creation and distribution of claims reports must be flexible and controlled by users. Users must have the option of viewing reports on-line or in hard copy whenever possible. In addition, the availability of user friendly reporting tools should support the creation of ad-hoc reports by users when appropriate.

5.2.1.6   ADMINISTRATIVE REPORTING

Departmental goals for administrative reporting require user friendly reporting tools and data stores that are easily accessed by users. Several levels of administrative reporting must be supported by the MMIS, POS, and DSS/DW. DHS will continue to design and develop standard reports required for policy review and analysis, financial reporting, and Federal reporting [including Medicaid Statistical Information System (MSIS) 2082 requirements]. These standard reports will be made available for specified users to run, but only a limited number of staff will have the ability to modify the standard reports. At a second level of reporting, users with an acceptable level of skill and certification will be able to create and produce ad hoc reports for their own data needs. Generated ad hoc reports will reside in MMIS libraries and can be marked by the users as "private" or "for review by other users". Ad hoc reports will be open to modification or deletion only by their creator or system administrators. Finally, simple queries and reports will be created by users with an acceptable level of certification to satisfy their own data requirements. As mentioned above, all of these levels will be supported by the MMIS,

POS, and DSS/DW. Depending on the need for current data, the first two levels may be drawn from either the DSS/DW or from live production data in MMIS and/or POS. Ad hoc queries and reports (the third level) would generally use the DSS/DW as their data source.

5.2.1.7   UTILIZATION MANAGEMENT

Utilization Management will employ flexible, parameter-driven query and reporting systems to identify and assess utilization patterns by recipients and providers. It will also be used to identify potential fraud situations for referral to fraud investigation agencies. The system must be based on user friendly reporting systems that support parameter-based inquiries. Staff must be able to begin with high-level reporting patterns that identify potential fraud and abuse, and subsequently drill down to examine the details of cases identified at the higher level. Consultants, other medical management professionals, and/or DHS-approved stakeholders may also become involved in cases when fraud or abuse is suspected. As such, data from the system must also be made readily available in the DSS/DW for approved entities outside of DHS.

Processes in the MMIS must enhance pre- and post- payment review analysis to identify patterns of potential fraud and abuse. These reviews will be based on user defined profiles that can be entered and searched. These processes will identify high users of Medicaid services and patterns that suggest possible fraud or abuse of services.   These capabilities will enhance DHS's ability to produce reports that track and trend provider practice patterns and utilization and monitor primary care case management.

The systems will capture data necessary to monitor prescription patterns and communicate warnings to pharmacists, regarding potential problems such as drug-drug interactions and therapeutic appropriateness. This will be provided through the POS system prior to dispensing the prescription and, subsequently, when claims are paid through the MMIS. Data residing in the DSS/DW will be used for non-real-time utilization related analysis.

5.2.1.8   FINANCIAL MANAGEMENT

DHS will continue to initiate payment for services provided under programs supported by MMIS. The DHS financial staff must be able to implement an account coding structure that supports all business and financial reporting requirements. The number of coding levels within the account hierarchy must not be limited, with "n" levels available. The individual levels must automatically roll-up to higher levels without manual intervention, and the hierarchy of codes and roll-up of data must be user-driven and adjustable without additional system coding.

Automatic reporting of expenditures, by appropriation line and by sub-accounts within an appropriation line, must be available from the financial management business process without manual intervention. The system must report "expenditure data to date", in relation to budget lines, but does not have to control adjudication or payment initiation of claims based on budget or cash availability.

Financial Management processes will maintain credits for recovery against future payments. When payments for either claims or capitation payments are adjusted, the system must automatically create credits to be offset against future payments to the provider.

The MMIS will send payment information to the PeopleSoft financial system. The processes of "voiding" or "stale dating" of checks will continue to be performed in the Treasurer's Office, and the results of the actions will be reported to DHS through the interface.

The MMIS, POS, and DSS/DW must support the Department's budget development and implementation. This includes reporting on actual expenditure levels, projections based on alternate assumptions, Per Member Per Month calculations, and simulations based on a range of policy options. In the simulation capacity, DHS staff must be able to specify changes in policy parameters, such as benefit coverage, recipient liability, pricing, service limits, etc. and view the impact of those changes on expenditures and budget requirements.

Financial Management processes will be supported by technically current reporting tools that support both standard report development and ad-hoc reporting. Financial staff will be able to design and implement the reports required to manage the DHS Medical Services budget.

The MMIS will enhance Accounts Receivable tracking with full reporting and reconciliation capabilities. This will include all receivables, including those related to sanctions and recovery of overpayments. The system will enhance collection capabilities for Third Party Resources and all other Accounts Receivables.

5.2.1.9   MANAGED CARE

The DHS vision for managed care processes includes greatly enhanced capacity to manage and evaluate managed care programs. While the State's enrollment with MCOs is relatively small, the PCCM and MCO enrollments together represent a significant portion of the eligible population. The DHS vision also includes the ability to support expansion of managed care through non-traditional arrangements, such as enrollment with tribes and large provider groups. In addition, the ability to support specialty managed care options, such as mental health or long term care enrollment must be included in the MMIS.

As part of the requirements to support managed care options, the system must be able to define benefit packages and rates with flexibility. Users must be able to specify managed care groups, benefit packages, inclusion and exclusion of services, riders for optional services, pricing, and exclusiveness between benefit packages without extensive system coding. This could be accomplished through table-driven architecture or through the use of business rules engines that permit users to maintain managed care rules.

The system must provide for automatic enrollment of recipients based on DHS policies. If recipients who are required to select a managed care entity have not done so within specified timeframes, the system will automatically enroll them based on a hierarchy of user defined rules. These rules must be entered, maintained, and deleted by users without extensive system coding. The results of the auto-enrollment will update enrollment on the VISION system through an automated interface.

DHS will require an integrated rate setting process that will ease updates and accommodate multiple reimbursement methodologies for capitation pricing. The business rules engine will drive pricing logic, based on a hierarchy that governs which pricing rules have precedence for each program and payment type.

DHS will require that the MMIS processes will support risk-based contracts for specialty provider carve-outs. These contracts will specify benefit packages, recipient qualifications, capitation rates and stop loss or shared liability provisions. The administration of these contracts will be supported through rules-based processing in the MMIS.

As part of its long range strategic approach to medical services, DHS requires that MMIS processes support flexible benefit structures to administer all types of plans. DHS will add or delete programs over time, and must be able to do so quickly with a minimum of delay or cost. The rules-based processing of the MMIS will accommodate such changes with little or no system coding.

Administration of managed care processes will require sophisticated processing of encounters. Department procedures for receiving, adjudicating and correcting encounters will be supported by the system. The system must support processes, edits, and audits required by encounter processing rather than being an adjunct to standard paid claims processing. Control of encounter processing must be table- or rules-driven and adjustable without additional system coding.

Using geo coding capacity, the MMIS will support contract planning by tracking PCP and plan enrollment capacity by recipient groups served, services covered, and geographic area, in order to identify those areas that are under-served by managed care. This tracking will include all types of managed care options that may emerge in the future.

The system must support reporting of managed care results and comparison of service levels and adequacy between various managed care approaches as well as with Fee-for-Service (FFS) programs. This may include compliance with DHS policies in areas such as EPSDT services, prenatal care, or disease management. This will require that the managed care staff have access to user friendly reporting tools and the ability to design and implement the levels of reports described under Administrative Reporting.

The system must also provide the tools to support performance-based contracts for managed care entities. The MMIS must be able to track the terms of the performance-based contracts, provide data to document performance, and implement sanctions or penalties that result from the contracts.

The vision for managed care is that it also must support PCP authorizations in accordance with standard industry practices. The PCP may be part of a group or, in some cases, may be a group. The system must recognize affiliations and support designation of alternate PCPs or approval by group members who have the appropriate specialties or certifications.

5.2.2   POS REPLACEMENT

5.2.2.1   PHARMACY CLAIMS

For pharmacy claims, DHS's goal is to integrate the POS with the MMIS in a manner that is as seamless as possible. The POS will take advantage of current technologies in order to provide the physician / pharmacist with a greater level of access to information on their submitted claims. This includes the provision of Web-based access to the POS for both the pharmacy/pharmacist and State staff to view adjudicated and "in process" claims. For non-electronic claims, the claim submittal process could also benefit greatly from Web-based direct data entry (DDE) of claims that would otherwise be submitted on paper.

Many of the current needs for a POS system are administrative. For example, the system must be able to manage multiple drug benefit packages. This is due to the fact that the POS will process non-Medicaid pharmacy claims for other State programs (e.g., AIDS Drug Assistance Program). Multiple formularies may exist for these programs and benefit packages, so the POS must also be capable of handling this information. Likewise, the POS must be able to pay at program-specific rates while considering specified dispensing fees, co-pays, allowed amounts for drugs, etc. The system must also be flexible enough to add one or many Preferred Drug Lists (PDLs) at a later time. Additional data or claims-related business needs for the North Dakota MMIS include:

- Smart edits/audits that are tied to formulary, prior authorization, or benefit restriction may link to relevant demographic info (e.g., gender, age, etc.)

- Secure pricing adjustment capabilities and inclusion of pricing edits in the drug file

- Improved tracking of prior authorizations (e.g., efficiency reports, utilization, physician, pharmacy, etc.)

- Cost avoidance for drugs to be covered by Medicare and other insurance

- Capture of Universal Provider Identification Number (UPIN) for prescribing physician AND pharmacist; full movement and compliance with NPI standards as they become effective

With the growing prevalence of physician-administered drugs, the State needs to reference these against claims histories containing National Drug Codes (NDC) or process them through the POS. At a minimum, the desired reference is a crosswalk between Healthcare Common Procedure Coding System (HCPCS) codes and NDCs. Crosswalks exist for this, but most NDCs don't match up correctly. Ideally, a process for "splitting" 837 transactions that come into MMIS would be instituted so that duplicate checking for NDCs could occur.

DHS also needs the capability to automatically recycle pended claims and their matching Prior Authorization (PA) requests to see if new data allows for authorization and adjudication.

5.2.2.2   DRUG UTILIZATION REVIEW (DUR)

For Prospective Drug Utilization Review (ProDUR), edit and audit criteria are presently received from First DataBank. However, DHS is open to changing its source for ProDUR criteria. The greatest needs for ProDUR are data management related. DHS would like the ability to modify the system's edit and audit criteria. ProDUR and RetroDUR edits must be synchronized with one another. Furthermore, the POS must be capable of avoiding any overwrite to criteria changes once the next criteria update is received from the source (e.g., First DataBank). Another DHS need is the establishment of early refill thresholds. Such thresholds would identify the point during an existing prescription when a recipient can get their early refill of a follow-up prescription. Finally, DHS recognizes a need to improve its methodology and notification processes for ProDUR denials.

Retrospective Drug Utilization Review (RetroDUR) analysis is presently contracted out to Health Information Designs, Inc. (HID). Primarily, HID is responsible for analyzing UB-92s and CMS-1500s. At the present time, no analysis is done on Nursing Home data. Other than expanding the scope of RetroDUR data analysis to other data, the primary business need for RetroDUR is the enhancement of reporting capabilities. DHS seeks added flexibility in cost reporting on drug data. Examples include the development of cost reports that identify both "pre-" and "post-" rebate dollars spent on pharmaceuticals or cost/benefit analysis capabilities that could be tied in with Preferred Drug List (PDL) efforts. Ideally, such information would also be broken out by program and/or benefit package. DHS has also experienced timeliness issues in getting data to its RetroDUR vendor. DHS is interested in having the DSS/DW be the source of RetroDUR data in order to improve timeliness.

5.2.2.3   DRUG REBATE

DHS would like to establish a more efficient process to receive drug product data and drug rebate data from CMS [including Drug Efficacy Study Implementation (DESI) rating flags / indicators], perhaps through direct interface with CMS's system(s) that maintain this information. Presently, this information is received by tape and is run against the drug history file to produce test invoices. Once the test invoices are reviewed by DHS and necessary modifications are made, invoices are reproduced and sent to manufacturers.

The new drug rebate application for DHS would also be flexible enough to adopt different drug rebate programs such as Supplemental Rebate and a State-specific drug rebate program, in which manufacturer rebates have been negotiated separately by the State or by a consortium of states.

For the drug rebate tracking function, DHS desires a better process for making adjustments to amounts due. For example, when claims are adjusted, DHS must be able to see the impact of the adjustment on any due drug rebate payments. Improved processes for adjustments will also be beneficial when adjustments are made to drug rebate amounts in response to invoice disputes. When tracking overdue drug rebate payments, DHS needs the ability to capture invoice dates and T-Bill rates, calculate any interest due on overdue payments, and continuously track this data until the appropriate payment is received. In addition, DHS needs

to have the ability to capture "interest due" and "interest paid" information as line items in Accounts Receivable and the State's accounting systems.

If possible, DHS would like to institute a payment process where manufacturers break down their total rebate payment into an allocation at the NDC level. Ideally, DHS's drug rebate application would also interface with electronic Resolutions of State Invoices (ROSI) and accept Prior Quarter Adjustment Summaries (PQAS) electronically, in order to provide more comprehensive, NDC-specific Accounts Receivable tracking. This entire process would significantly aid DHS efforts for cost reporting on pharmaceuticals.

Drug rebate invoicing and payment are functions that could see dramatic improvement with a move toward electronic invoicing and payment. Electronic invoicing would be best instituted at a program-specific level, where the State would have the ability to do separate electronic invoice generation runs for different types of aid programs (e.g., Children's Special Health Services or AIDS Drug Assistance Program) or even the different types of rebate agreements (e.g., standard drug rebate, supplemental rebate, or State-negotiated rebates). Electronic invoices would be sent to manufacturers and, ideally, an Electronic Funds Transfer (EFT) payment would be reciprocated back to DHS once the manufacturer has reviewed the invoice for accuracy and determined if any disputable amounts exist. EFT payments would relieve some administrative burden inherent in drug rebate functions, as the State presently receives approximately 400-500 rebate payment checks during a given quarter. In tandem with these electronic improvements, DHS also desires Web-based dispute resolution capability for drug manufacturers participating in the State's rebate programs. This functionality would offer claim-level detail to providers only for claims that are tied to each manufacturer's rebate invoice.

5.2.3   DSS REPLACEMENT

Concurrent with the implementation of the MMIS, DHS seeks to move to an enterprise-based decision support and data management system. Decision support business processes will expand from their current scope to one that supports the data needs of all Department processes, including financial, administrative, and medical programs. This system will incorporate the most current technology available in data warehouses and reporting tools, to provide a powerful, user friendly environment for data queries, data mining, and reporting.

North Dakota plans to replace the current DSS by loading Medicaid data on an enterprise Data Warehouse, while utilizing a replacement Decision Support System or other decision support alternatives as a front-end for building analytical capability to support user requests. DHS and ITD will provide their existing set of query and analysis tools, report writing tools, and other tools (e.g., Crystal Reports, Business Objects, Microsoft Access, etc.) for data access, modeling, and manipulation of the data.

The DSS/DW will utilize a relational database that includes the full claim record for adjudicated and suspended claims and other recipient, provider, reference, prior authorization, and financial transaction data from the MMIS. The DSS/DW must utilize industry standard importing, cleansing, and dimensional storage of data from the MMIS and related systems. The front-end DSS will be deployed through the use of a staging server and database for data integration and cleansing with production data being made available through production data marts (physical databases). The number of data marts along with the size and data contained within each data

mart will be determined as part of the analysis and reporting requirements discovery during Start-up Activities. The DSS/DW Contractor will be responsible for:

- Analyzing existing architecture and query/report capability
- Comparing this current capability with the functionality requested by this RFP
- Collaborating with ITD and DHS in order to develop the enhanced functionalities requested
- Developing standard queries and reports that fulfill the analytical needs for North Dakota Medicaid
- Providing technical support and training to DSS/DW users

The DSS/DW must incorporate industry standard, user friendly reporting tools to support inquiries, data extraction, and reporting by DHS staff and other approved stakeholders. The DSS/DW solution must include current data tools such as Open Database Connectivity (ODBC) drivers to integrate data from different tables and external databases and have cross-platform connectivity to such data, as required by DHS. The DSS/DW must include summary level databases from extracts to provide quick response times for reports. The system must be able to create fact tables available for extraction of data by a wide range of users, depending on the ability and experience with query and reporting tools. On-line and computer-based training classes for the reporting tools must be available through a Web-based user interface.

The structure of the data must facilitate both standard and ad-hoc reporting required by DHS and other designated State users. DHS anticipates that a significant level of data modeling / statistical modeling requests (internal or external to DHS) will occur, where stakeholders want to view and analyze the impact that any policy change, claim adjustment, edit/audit, and other business rules modification would have on program expenditures or service. Furthermore, the new DSS/DW is expected to be particularly helpful for:

- *Support of Legislative Sessions* – During Legislative Session, DHS staff members may get decision support requests on a daily basis. This includes both standard reports and ad hoc requests of various "what if" scenarios.

- *RetroDUR Business Functions* – Retrospective Drug Utilization Review (RetroDUR) is a Federally required program component that enhances the State's ability to look at drug prescription patterns among physicians and identify drug classes, individual drugs, and individual physicians where education and intervention may be necessary to improve quality of care, curb program costs, or both. The primary goal for the replacement DSS/DW, with regard to RetroDUR, is to provide data and processes that allow the State, its contractors, or committees to evaluate drug utilization and test assumptions on interventions.

- *Analysis by P & T Committee* – The DSS/DW will support ongoing analysis of the pharmacy program by a Pharmacy and Therapeutics (P & T) Committee. This includes the review and maintenance of therapeutic drug classes, formularies or Preferred Drug Lists (PDLs), and business rules and criteria for pharmacy prior authorization.

- *CMS Reporting* – The Medicaid segment of the Data Warehouse must have the flexibility to meet both current requirements and proposed changes in the format and data requirements of Federal statistical reporting without major reprogramming expense. The reports must be in a format acceptable to the State and/or CMS and must not require manual intervention or manipulation of data.

- *Operational and Financial Reporting* – The data provided by the DSS/DW supports group and independent decision-making and integrates decision making among organizational levels. DHS desires enhanced support of budget review and forecasting, grant applications, actuarial reports, population comparisons. The DSS/DW must also offer 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. North Dakota may eventually include on the DSS/DW all State-provided funding source data, financial adjustments, and other expenditures that are not processed in the MMIS.

- *Utilization Review / Fraud & Abuse* – Development and analysis of program, provider, or recipient trends/projections in order to detect potential fraudulent or abusive utilization or billing activity.

- *Disease Management* – DHS is looking to the DSS/DW system to provide capability in data analysis for use in disease management protocols. North Dakota is particularly interested in the potential of disease management as a tool for improving quality of care and promoting cost containment.

DHS expects users to be able to view reports at a workstation, eliminating the need to print and distribute reports.

5.3   TECHNICAL NEEDS

Over the past year, DHS has fully explored numerous options for replacing its current systems. In conducting this analysis, DHS weighed the cost of each alternative against the State's business and technology requirements and the principles set forth by CMS in the Medicaid Information Technology Architecture (MITA). As a result, it is DHS's goal to implement a systems environment (MMIS, POS and DSS/DW) that supports:

- *Medicaid Information Technology Architecture (MITA)* – The Center for Medicaid & State Operations (CMSO) envisions the fusion of complex program needs with the possibilities created by technology. This fusion produces a vision of the future of Medicaid achievable through the definition and implementation of a Medicaid Information Technology Architecture (MITA) framework. MITA will enable Federal and State Medicaid administrators to achieve their program goals and surmount the increasing challenges of rapidly changing policies and programs by utilizing a modular, service-oriented architecture. Adaptability and extensibility are built into this architecture, and data is easily shared between programs.

- *HIPAA Continuity* – The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 require the Department of Health and Human Services to establish national standards for electronic healthcare transactions and national identifiers for providers, health plans, and employers. The HIPAA rules are not yet completed and continue to evolve. Recently finalized regulations and proposed regulations will impact the North Dakota MMIS for the foreseeable future. These include, but are not limited to:

  o   National Provider Identifier

  o   275 Transaction – Additional Information to Support a Healthcare Claim or Encounter

- o National Health Plan Identifier

- o Modifications to Electronic Transactions, Codes Sets, and Values

- o Current Procedure Terminology 5th Edition

- o International Classification of Diagnosis 10th Revision, Clinical Modifications

- o International Classification of Diagnosis 10th Revision, Procedure Coding System

- o Other HIPAA Transactions

North Dakota currently utilizes a SeeBeyond translator that translates both inbound and outbound HIPAA transactions. The MMIS Contractor will be responsible for utilizing the State's HIPAA translator solution as a HIPAA compliant "front end" to meet requirements for accepting and processing all ANSI X12 standard transactions, and will also be responsible for using HIPAA compliant code sets. If the Contractor can prove to the State that it is resource prohibitive (i.e., time, cost, staff support, technology, etc.) to utilize SeeBeyond with its solution, the State may entertain an alternative proposal during contract negotiations.

- • *North Dakota Technology Standards* – The Information Technology Department (ITD) is responsible for developing statewide technology standards. As of June 2002, standards and policies began development under the governance structure for Enterprise Architecture (EA), which defines the team concept. The structure provides for a proactive model to manage and govern technology efforts in the State of North Dakota. This section contains the Standards as defined under EA. The currently approved standards are accessible via the Web. The link to the North Dakota Technology Standards is:

  http://www.state.nd.us/ea/standards/.

  The proposed technology standards are available at:

  http://www.state.nd.us/ea/standards/recommendations/.

  North Dakota Technology standards include, but are not limited to:
  - o Security
  - o Application Software Team Standards
  - o Data Information Team Standards
  - o Electronic Data Backup
  - o Document Management Team Standards
  - o Workflow Technology Standards
  - o e-Government Team Standards
  - o Network Team Standards
  - o Office Automation Team Standards
  - o Platform Operating Systems Team Standards

- • *Web-Based MMIS* – A Web-based, n-tier MMIS that runs on hardware compatible with North Dakota's present and future non-mainframe hardware. This environment provides

the flexibility and expandability required to meet the present and future needs for the North Dakota MMIS and the associated healthcare delivery for other public assistance programs. On n-tier systems, different parts of the system, such as the database, application server, Web server, and clients, can be distributed onto different tiers, or platforms. This results in the distribution of responsibility, and therefore the amount of work, that each of these systems must perform. Multi-tier architectures are designed to be scalable. Increasing workloads can be accommodated by adding components to meet increased demand for access or computing power.

- *J2EE* – The Java 2 Platform, Enterprise Edition (J2EE) is a platform-independent, Java-centric environment developed by Sun Microsystems for developing, building and deploying Web-based enterprise applications. The J2EE platform consists of a set of services, APIs, and protocols that provide the functionality for developing multi-tiered, Web-based applications. The J2EE standard represents collaboration between leaders from throughout the enterprise software arena. The J2EE partners include OS and database management system providers, middleware and tool vendors, and vertical market applications and component developers. Working with these partners, Sun has defined a robust, flexible platform that can be implemented on the wide variety of existing enterprise systems currently available, and that supports the range of applications IT organizations need to keep their enterprises competitive. J2EE is one of the preferred environments for North Dakota.

- *.NET* – Microsoft® .NET is a set of software technologies for connecting information people, systems and devices. This new generation of technologies is based on Web services – small building blocks applications that can connect to each other as to other, larger applications over the Internet. North Dakota ITD supports the .NET environment as it is realized that there will be applications that are available only under .NET; however, ITD prefers J2EE.

- *Relational Database Management System* – To meet the needs of a flexible production MMIS, a relational database management system (RDBMS) is needed. Using a RDBMS within the MMIS provides flexibility in the storage and access of MMIS data. Not only do RDBMS tools provide for data usage within production, RDBMS tools provide ad hoc query capability and extract of data to standards desktop applications such as Microsoft Word, Excel or Access. All of the leading vendors of RDBMS also produce tools designed to work in conjunction with their RDBMS for the development of custom applications. These tools are typically in the form of a high capacity/performance database engine (the RDBMS itself), a tool for developing user interface components, and proprietary middleware for the purpose of joining the pieces together. ITD has experience with several RDBMS, including the VISION database in DB2. Use of relational databases follows the State's Enterprise Architecture direction for databases and supports the MITA framework.

- *Continue Utilizing State's Eligibility Systems* – North Dakota's approach to accessing eligibility data is unique in two respects. First, it takes an enterprise-oriented approach by considering the State's eligibility determination systems, VISION / TECS, to be directly accessible. Eligibility data is read directly from VISION / TECS rather than being stored redundantly within the MMIS. This eliminates the cost of maintaining a separate eligibility store in MMIS, and provides real-time access to eligibility data. The data is not only timelier, but it is also more reliable because it is closer to the point of data collection.   The second aspect of North Dakota's approach to recipient data is that the State takes a user based, service oriented approach to recording recipient data. Data is

stored in the systems closest to the user, and accessed by whatever system requires it. The result is an architecture that is truly interoperable, and designed to maximize usability rather than replicating data across multiple systems. This interoperability and service-oriented design reflect, in an existing system, some of the characteristics that are being proposed for the MITA model. Current technology will provide enormous improvements in the ability to access data across systems and should greatly improve these features. Similarly, the service-oriented aspect of this architecture reduces staff time required to enter data and eliminates the need to train staff on multiple systems.

In order to implement this interoperability in the MMIS, DHS strongly supports the use of a metadata engine to access data both within and outside the formal MMIS boundaries. Over time, DHS expects to access data in systems such as ASSIST. Having a metadata layer in place will greatly facilitate that access.

- *Enterprise Application Integration (EAI)* – EAI is an emerging methodology for integrating large systems that involve stronger solutions than the typical use of middleware. EAI is the use of common information and processes across the systems in a large application to facilitate better sharing of information between systems. This integration involves defining the processes and data that work in a system across multiple platforms and across multiple applications. The North Dakota MMIS, in addition to processing claims for the Medicaid program, also processes claims for State programs. Through EAI, common information, such as eligibility verification, and processes, such as claim adjudication and payment can be shared between the MMIS and other State programs, eliminating redundancies in data and processes.

- *Rules-Based Engines* – Sustaining changing business environment and remaining competitive is one the biggest challenges faced by organizations today. Changes in competitive factors ultimately result in changes in business rules. Frequent changes to business rules increase the cost of maintenance, enhancement, and customization. This calls for flexibility in administration and maintenance of applications and real-time responsiveness to changes in business requirements. Rules-based engines reduce maintenance and enhancement costs by cleanly separating business rules from application code. A rules-based engine addresses functional and technical challenges of designing, developing, deploying, and managing business rules in a robust, scalable and high performance environment. North Dakota requires a rules-based engine in its MMIS and POS solutions.

5.4   PROJECT SCHEDULE

Considering the nature of this project and varying vendor approaches to tasks, there are various uncertainties that may cause significant differences in the target dates for implementation milestones.

In this section, DHS has developed a proposed schedule for the North Dakota Medicaid Systems Replacement Project's development and implementation activities. Vendors can use this schedule for reference, but are free to propose alternative schedules. A considerable amount of lead time has been provided for conversion design, which begins shortly after design in the ideal schedule, because DHS believes that conversion of existing data will be a very complex process. Similarly, test planning should begin before system design to allow sufficient

lead time for developing of a detailed test plan and detailed test cases. Again, system testing and acceptance testing will be complex activities.

*<u>Bidder's Note:</u> As part of this contract, the MMIS Contractor will be responsible for re-enrolling all providers with the North Dakota Medicaid program 6 months prior to the system's "Go Live" date.

Design and development of the DSS/DW lags behind the MMIS and POS design and development, because the design of the DSS/DW will be dependent on the design of the other two systems. See the figure below for the proposed project DDI schedule.

Figure 5: Proposed ND Medicaid Systems Replacement DDI Project Schedule

NORTH DAKOTA MMIS DDI SCHEDULE

Task	Start	End
DDI Phase of Contracts	12/30/05	4/24/08
MMIS and POS Development and Implementation		
Concept Verification and Validation	1/1/06	1/30/06
Requirements Verification and Validation	2/1/06	5/1/06
System Design Activities	3/1/06	9/30/06
System Development Activities	6/1/06	2/28/07
Data Conversion Activities -Design	6/1/06	6/30/07
Data Conversion Activities -Test	5/1/07	8/30/07
Data Conversion Activities - Execute	3/1/08	4/23/08
Structured System Test Activities	4/1/06	12/8/07
System Test - Design	4/1/06	6/30/07
System Test - Execution	7/1/07	10/15/07
User Acceptance Test - Design	7/1/06	9/30/07
User Acceptance Test - Execution	10/1/07	12/30/07
Operational Readiness Test Activities	1/1/08	4/23/08
Pilot Test Activities	1/1/08	2/28/08
System Implementation	4/1/08	4/24/08
DSS Development and Implementation		
Requirements Verification and Validation	5/1/06	7/31/06
DSS Design Activities	8/1/06	4/30/07
DSS Development Activities	12/1/06	8/31/07
DSS System Test Activities		
System Test	6/1/07	10/31/07
User Acceptance Test	11/1/07	3/1/08
DSS Data Loading - Production	2/1/08	3/31/08
DSS Implementation	4/1/08	4/30/08

6.0 GENERAL REQUIREMENTS

6.1 VENDOR QUALIFICATIONS

The bidder's (and subcontractor's) corporate background, corporate organization, and relevant corporate experience are significant factors in the evaluation process. The experience and reputation of the bidder in managing large projects of this nature and how the bidder interfaces with its clients on contract issues is also very important. Experience with Medicaid, large healthcare delivery systems, managed care operations, and recent technological advancements in healthcare IT will carry significant weight in the evaluation of submitted proposals.

6.1.1 MINIMUM BIDDER QUALIFICATIONS

DHS will consider bidders who meet the minimum qualifications identified below. Should DHS determine (at its sole discretion) that a bidder does not meet these minimum qualifications, DHS will disqualify the proposal from the evaluation and selection process.

The Bid Proposal must:

1.) Describe the bidder's experience in developing and operating systems on the hardware and software platforms proposed for North Dakota.

2.) State how many years experience the bidder has managing and staffing projects with complexity and scope comparable to that required by DHS for the North Dakota Medicaid Systems Replacement Project.

3.) For the MMIS contract, demonstrate bidder's experience in developing and implementing large claims processing systems, and must identify and describe at least one (1) system that meets this requirement.

4.) For the MMIS contract, demonstrate bidder's corporate and personnel experience in the CMS Certification process for an MMIS implementation, with special emphasis on successful Certifications of presently operating systems.

5.) For the POS contract, demonstrate bidder's experience in developing and implementing a Point-of-Sale system, and must identify and describe at least one (1) system that meets this requirement.

6.) For the DSS/DW contract, demonstrate bidder's experience in implementing a Decision Support System / Data Warehouse, and must identify and describe at least (1) system that meets this requirement.

7.) Identify key staff with experience in implementing a(n):

- MMIS - identify the staff person(s), their role(s) in implementing an MMIS, and the state(s) where it was implemented.

- POS - identify the staff person(s), their role(s) in implementing a POS, and the state(s) where it was implemented.

- DSS/DW - identify the staff person(s), their role(s) in implementing a DSS/DW, and the state(s) where it was implemented.

6.1.2   PROJECT SUMMARIES DEMONSTRATING PRIOR EXPERIENCE

Within Bid Proposals, bidders must complete one (1) page project summary tables that contain (at a minimum) information similar to those presented in the table below.

<u>*Bidder's Note:</u> Project summary tables do not have to be presented in the format shown, but should only be completed for all relevant projects that are within the last five (5) years.

Table 8: MMIS Contractor Project Summary Requirements

MMIS CONTRACTOR	
For each MMIS that the bidder has implemented (or is implementing), Project Summary tables should include:	• Title of the project • State name and name of sponsoring agency / department • Client contact information (i.e., name, role, phone #, e-mail) • Planned and actual DDI start / end dates (month / year) • Certification date (month / year) • Operations start / end dates (month / year) • Hardware platform • Primary language • Database information • Annual claim volume (specify claims versus lines) • Annual claim dollars • Other key transaction volumes • # of users • Contract value for the bidder's organization • Brief description of relevance to this contract
For other large non-MMIS claims management systems that the bidder has implemented (or is implementing), Project Summary tables should include:	• Title of the project • Name of client or State organization • Client contact information (i.e., name, role, phone #, e-mail) • Planned and actual DDI start / end dates (month / year) • Operations start / end dates (month / year) • Hardware platform • Primary language • Database information • Annual claim volume (specify claims versus lines) • Annual claim dollars • Other key transaction volumes • # of users • Contract value for the bidder's organization • Brief description of relevance to this contract

Table 9: POS Contractor Project Summary Requirements

POS CONTRACTOR	
For each large Point-of-Sale system that the bidder has implemented (or is implementing), Project Summary tables should include:	• Title of the project • Name of client or State organization • Client contact information (i.e., name, role, phone #, e-mail) • Planned and actual DDI start / end dates (month / year) • Operations start /end dates (month / year) • Hardware platform • Primary language • Database information • Annual transaction volumes • Annual transaction dollars • # of users • Contract value to bidder's organization • Brief description of relevance to this contract

Table 10: DSS/DW Contractor Project Summary Requirements

DSS / DW CONTRACTOR	
For each Decision Support System / Data Warehouse solution that the bidder has implemented for other Medicaid programs (or is implementing), Project Summary tables should include:	• Title of the project • Name of client or State organization • Client contact information (i.e., name, role, phone #, e-mail) • Planned and actual DDI start / end dates (month / year) • Operations start /end dates (month / year) • Hardware platform • Primary language • Database information • # of users • Contract value to bidder's organization • Brief description of relevance to this contract

The project summaries submitted in the Bid Proposal must also:

- Describe the bidder's role in each engagement described above and state the bidder's level of responsibility (e.g., prime contractor, subcontractor, etc.) for all phases of the project including requirements analysis, process design, construction, testing, and final implementation. Describe any pilot implementation phases.

- Clearly describe the scope and scale of those projects, including the bidder's performance in terms of schedule. Explain positive and negative variances from the schedule.

6.1.3   CORPORATE REFERENCE REQUIREMENTS

The proposal must:

1.) Include three (3) corporate customer letters of reference. At least two (2) of these references must be from projects comparable to the project being bid. For every reference, the proposal must also provide:

- Client or customer organization's full name

- Project name, dates of service

- Street address

- Client contact person who is directly familiar with the bidder organization's performance and who may be contacted during the proposal evaluation process (must be someone from outside the bidder's organization)

- Current telephone number of Client Contact

- E-mail address of Client Contact

- Brief description of project and its relevance to the North Dakota Medicaid Systems Replacement Project

- System transaction volumes for all transactions relevant to the bid

2.) Agree that references must be independent of the bidder's company/corporation (i.e., non-bidder owned, in whole or in part, or managed, in whole or in part), and include a statement that each reference meets this requirement.

3.) Agree that DHS reserves the right to contact all provided corporate references, as well as references from any other current or former client(s), and that these contacts may be considered by DHS in the scoring of Bid Proposals.

4.) Agree that DHS reserves the right to contact any other entity or person it wants to contact with regard to the bidder, including parties in addition to those recommended by the bidder. Further, agree that this contact may be used by DHS in scoring the bidder.

5.) Provide a statement that the bidder has notified each of its provided client references that they may be contacted by DHS and has assured that each reference will be reasonably available for a reference check during the evaluation period.

DHS reserves the right to conduct checks of bidder references, by telephone or other means, and evaluate the bidder based on these references. DHS considers references to be extremely important. It is the bidder's responsibility to ensure that every reference contact is available during the evaluation period.

For each subcontractor used on this project, an additional three (3) corporate letters of reference must be provided.

6.1.4   REQUIRED LICENSES

At the time specified by the deadline for submission of proposals, the bidder must have and keep current any professional licenses and permits required by Federal, State, and local laws for performance of this contract. Bidders who do not possess required licenses at the time Bid Proposals are due will be determined non-responsive.

6.2   STAFFING REQUIREMENTS

The State will require minimum standards for essential named staff for the North Dakota Medicaid Systems Replacement Project. North Dakota is only requiring a few "Key Personnel positions" to be named for each system component, consistent with the belief that the bidder should be in the best position to define the appropriate project staffing for the bidder's approach to the procurement requirements. The staffing requirements for the North Dakota Medicaid Systems Replacement Project are discussed below.

6.2.1   KEY PERSONNEL TO BE NAMED

General requirements for Key Personnel are as follows.

- The Contractor's Project Manager must be employed by the bidder when the proposal is submitted. The Project Manager cannot be an employee of a bidder's subcontractor.

- All other Key Personnel must be employed by or committed to join the bidder's organization (or its subcontractor, if relevant) by the beginning of the contract start date. If the identified Key Personnel is not an employee, a letter of commitment to join the organization must be submitted with the Bid Proposal.

- Key Personnel named in the Bid Proposal must be committed to the project from the start date identified in the procurement schedule.

Bidders are expected to propose sufficient staff with the requisite skills to meet all requirements in this RFP. The State has listed a limited number of key positions for which bidders must identify personnel and provide resumes. In addition, bidders must provide representative job descriptions for other positions identified in the bidder's organization for the North Dakota contract. The following personnel are defined as Key Personnel for this RFP:

- Project Manager

- Systems Development Manager

- Implementation Manager

- Training Manager (Implementation Activities)

Resumes for Key Personnel must be included in the Bid Proposal for the project, including resumes of Key Personnel from subcontractors. Resumes must show employment history for all relevant and related experience and all education and degrees, including: specific dates, names of employers for the past five (5) years, and educational institutions attended. For any

individual for whom a resume is submitted, the percent of time to be dedicated to the North Dakota Medicaid Systems Replacement Project must be indicated.

For each Key Person identified, the Bid Proposal must also include a minimum of three (3) professional references (from individuals outside the bidder's organization) that can attest to these persons' professional experience and performance within the last five (5) years. References need to be relevant to the assigned duties of the key person in relation to the project.

DHS reserves the right to check additional personnel references, at its option. The following charts illustrate the qualifications, start date, and any special requirements for Key Personnel who must be named for the MMIS, POS, and DSS/DW system components:

Table 11: Key Personnel Qualifications / Requirements

KEY PERSONNEL

Key Person	Qualifications	Start Date	Special Requirements
Project Manager	A minimum of three (3) years experience in managing or in a key management position for a large-scale healthcare IT development project; and - Previous experience with a system similar to the solution being bid, or with major components of the operational system. - Previous responsibility for managing subcontractor resources, if subcontractors are included as part of this proposal. - PMI management certification is preferred.	Contract signing date	May not serve in any other position. Must be 100 percent dedicated to the North Dakota Medicaid Systems Replacement Project.
Systems Development Manager	A minimum of three (3) years of experience in the design, development, and implementation of a large-scale automated application similar to the proposed system; and - Previous experience with a system similar to the solution being bid - Knowledge of HIPAA regulations, including Transactions and Code Sets, Privacy and Security, and NPI. - Knowledge of the MITA architectural framework.	Contract signing date	Must be 100 percent dedicated to North Dakota Medicaid Systems Replacement Project until start of operations phase.
Implementation Manager	A minimum of three (3) years of experience in managing an design, development, and implementation effort similar to the project being bid; and - Previous experience in the conversion effort on an MMIS, POS, DSS/DW, or other large-scale system implementation project. - Previous responsibility for system testing of all levels of a large-scale system installation, including: unit, system, integration, parallel and acceptance testing. - Knowledge of HIPAA regulations, including Transactions and Code Sets, Privacy and Security, and NPI. - Knowledge of the MITA architectural framework.	Approximately eight months prior to start of operations phase.	May not serve in any other capacity
Training Manager	A minimum of three (3) years experience providing training to staff (operations, applications and support) for an MMIS, POS, DSS/DW, or other large-scale system implementation project.	Approximately six months prior to start of operations phase	

6.2.2   DHS APPROVAL OF KEY PERSONNEL

DHS reserves the right of prior approval for all named Key Personnel in the bidder's Bid
Proposal. DHS also reserves the right of prior approval for any replacement of Key Personnel.
DHS reserves the right to interview any and all candidates for named key positions prior to
approving the personnel.

6.2.3   CHANGES TO CONTRACTOR'S KEY PERSONNEL

The Contractor (as well as its subcontractors) may not replace or alter the number of,
distribution of, or individuals named as Key Personnel in its bid proposal without the prior written
approval of the DHS Project Directors, which shall not be unreasonably withheld. Replacement
staff will have comparable training, experience and ability to the person originally offered for the
position. If the DHS Project Directors give written approval of the termination, transfer, or
reassignment of Key Personnel, such personnel will remain assigned to the performance of
duties under this contract until replacement personnel approved by the DHS Project Directors
are in place performing the Key Personnel functions. The DHS Project Directors may waive this
requirement upon presentation of good cause by the Contractor.

The Contractor will provide the DHS Project Directors with fifteen (15) business days notice
prior to any proposed transfer or replacement of any Contractor's Key Personnel. At the time of
providing such notice, the Contractor will also provide the DHS Project Directors with the
resume(s) and references of the proposed replacement Key Personnel. The DHS Project
Directors will accept or reject (specifying the reasons therefore) the proposed replacement Key
Personnel within ten (10) business days of receipt of notice. Upon request, the DHS Project
Directors will be afforded an opportunity to meet the proposed replacement Key Personnel in
North Dakota within the ten (10) business day period. The DHS Project Directors will not reject
proposed replacement Key Personnel without reasonable cause. The DHS Project Directors
may waive the fifteen (15) business day notice requirement when replacement is due to the
death or resignation of a Key Personnel employee.

6.2.4   SUPPORTING STAFF

DHS has not established minimum numbers for the different types of Contractor-supplied
support staff necessary to design, develop, and implement the requested systems solutions. It
is assumed that the bidder is most familiar with the staffing they will require to implement a
solution that meets the requirements of this RFP. In its response to General Requirements, the
bidder must complete a table similar to the one below, which will identify the types, quantities,
and responsibilities of Contractor staff supporting the aforementioned Key Personnel.

Table 12: Sample Contractor-supplied Supporting Staff Table

CONTRACTOR STAFF TYPE	#	DESCRIPTION OF ROLES / RESPONSIBILITIES / ACTIVITIES

6.2.5   STATE RESOURCE PLANNING

Bidders are also expected to document their assumptions regarding State staff involvement. The tables below are samples of the type of information that DHS expects in Bid Proposals as documentation of the Contractor's required State resource plan. Bid Proposal responses to this requirement need not look exactly like the tables shown.

Table 13: Sample State-supplied Supporting Staff Table

STATE STAFF TYPE	#	DESCRIPTION OF ROLES / RESPONSIBILITIES / ACTIVITIES

Table 14: Sample State Staff DDI Involvement Table

	STATE STAFF TYPE			
DDI ACTIVITY	# OF STAFF TYPE 1	# OF STAFF TYPE 2	# OF STAFF TYPE 3	ETC.
Project Management Activities				
Planning Activities				
Concept V&V Activities				
Requirements V&V Activities				
System Design Activities				
Etc.				

Other requirements related to State resource planning are as follows:

1.   The bidder must specifically identify how many State staff will be required for testing efforts, including an anticipated number of hours per staff member on such tasks.

2.   In the event that the bidder's required State support level is more than what DHS can allocate to the project, what would be the bidder's plan for making up the difference?

3.   The bidder must document any other staffing assumptions that have factored into their proposed Technical and Cost Proposals. Note that no cost-specific information should be discussed in the Technical Proposal.

6.2.6   RIGHT OF TERMINATION OF PERSONNEL

The State reserves the right to request that any Contractor or Subcontractor staff associated with this project be replaced at the sole discretion and as deemed necessary by the State. The Contractor may be required to relieve any of the Contractor's personnel from any further work under this contract if in the State's opinion:

1.) The individual does not perform at the applicable skill level specified in the RFP, the Contractor's proposal, and the approved initial project implementation work plan,

2.) The individual does not deliver work which conforms to the performance standards stated in the RFP, the Contractor's proposal, and the approved Work Plan, or

3.) Personality conflicts between Contractor's staff and State personnel hinder effective progress on the work of the project or unit to which the individual is assigned.

The DHS Project Directors must provide the Contractor with written notice of a request for re-assignment of Contractor's personnel and allow Contractor thirty (30) days to replace the personnel.

6.2.7   SPECIAL STAFFING NEEDS

6.2.7.1   JOB ROTATION

The Contractor will be required to develop and maintain a plan for job rotation and cross-training of staff to ensure that all functions can be adequately performed during the absence of staff for vacation and other absences.

6.2.7.2   COVERAGE DURING VACATIONS FOR SENSITIVE POSITIONS

The Contractor will be required to designate staff that is trained and able to perform the functions of sensitive positions when the primary staff member is absent on consecutive days of vacation.

6.3   FACILITY REQUIREMENTS

6.3.1   LOCATION OF WORK

6.3.1.1   DDI PHASE / START-UP ACTIVITIES

DHS requires that the majority of the work during the Design, Development, and Implementation Phase be performed locally in Bismarck, North Dakota in a facility secured by the State. Any deviation from this requirement must be submitted to DHS for approval.

In their Cost Proposal, the bidder must factor in any transportation, lodging, and per diem costs that may be required for any North Dakota site visits by non-local staff. Travel of local staff to locations other than the cities of Bismarck, North Dakota or Mandan, North Dakota will not be required.

The following DDI contract functions must be performed at the local Bismarck facility:

- Contract administration
- Joint application design (JAD) sessions
- Demonstrations of design prototypes
- Deliverable walkthroughs
- Conversion mapping
- Takeover task activities
- System testing task walkthroughs
- User Acceptance Test support
- Implementation planning
- Training
- Transition management support

The State will be responsible for securing a fully-equipped office space for its operations in Bismarck, North Dakota while performing DDI activities.

The Contractor shall be responsible for its portion of facility-related costs, including, but not limited to:
- Hardware and software acquisition and maintenance
- Long distance telephone service
- Office equipment
- Supplies
- Security
- Storage
- Transportation to project-related meetings in North Dakota
- Shredding of confidential documents

If any DDI activities are approved by the State to be performed off-site, then the Contractor must provide toll-free communications with DHS staff to conduct DDI business operations.

*<u>Bidder's Note</u>: If any contract activities are proposed that utilize offshore personnel (including operational responsibilities for the DSS/DW Contractor), the bidder must fully disclose the nature of such activities in its Bid Proposal. Offshore activities are subject to prior approval by DHS.

6.3.1.2   KNOWLEDGE TRANSFER / TRAINING PERIOD

After implementation, Contractors will be expected to support the State in an on-site "Knowledge Transfer" role for up to six (6) months. MMIS and POS Contractors should expect that relevant Key Personnel and an appropriate number of supporting staff will remain on-site for the full six (6) months.

Upon completion of DSS/DW implementation activities, the DSS/DW Contractor will begin to transition its staffing to their off-site operations phase facility. DSS/DW Knowledge Transfer responsibilities may not be required for the full six (6) months. As such, DHS will plan on reimbursing the DSS/DW Contractor on a month-by-month basis (as needed) for Knowledge Transfer / Training activities.

6.3.1.3   OPERATIONS PHASE ACTIVITIES

At the end of DDI, the DSS/DW Contractor would be off-site. Occasional travel to Bismarck, North Dakota may be required for contract management and systems maintenance purposes.

6.3.2   STATE FURNISHED PROPERTY / EQUIPMENT / SERVICES

The State of North Dakota will provide office space for Contractor staff during the DDI Phase of the North Dakota Medicaid Systems Replacement Project, as well as during the Knowledge Transfer / Training activities. The State will also provide conference rooms that are available for meetings between/among Contractor personnel, State staff, providers, and other stakeholders.

At no cost to the vendor, DHS and ITD will provide the following:

- Office space for all North Dakota MMIS Replacement Project Contractors
- Workspaces and cubicles
- Network infrastructure and network connections
- Telephones
- Fax machines, available on a charge-back basis
- Photocopiers and paper, available on a charge-back basis
- Larger network printer(s) for large jobs, available on a charge-back basis
- Access to the State's enterprise server

*Bidder's Note: In Technical Proposals, bidders must define a network connectivity plan, which identifies the bidder's strategy for connecting to the State's network from off-site data centers and/or development sites. The network connectivity plan will be finalized during contract negotiations and project Start-up Activities.

Within the General Requirements section of the Technical Proposal, the bidder will provide the following information:

- Approximate square footage that is necessary to conduct each individual business function required for the RFP component that is under consideration

- Anticipated needs for the following:
  - Cubicles
  - Workspaces
  - Telephones

- Approximate number of computers that need to be connected to the network

- Estimated total number of staff, including Key Personnel

6.3.3 CONTRACTOR FURNISHED PROPERTY / EQUIPMENT / SERVICES

The Contractor must provide any additional equipment and software necessary during the Design, Development and Implementation Phase for its staff to successfully fulfill their obligations of designing, developing, testing, and implementing the North Dakota MMIS, POS, and DSS/DW. Such equipment includes:

- Chairs
- Personal computers
- Office supplies
- Small network printers for routine printing;

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7.0 SYSTEM REQUIREMENTS

7.1 GENERAL SYSTEM REQUIREMENTS

7.1.1 OVERVIEW

The technical requirements and preferences within this Section refer to the proposed platforms and other hardware required to support the information technology structures for the North Dakota replacement MMIS. Because of the varied nature of POS and DSS/DW vendor solutions available in the marketplace, DHS has not set specific requirements for POS and DSS/DW in all areas. However, DHS expects that POS and DSS/DW bidders will offer solution(s) that conform and adhere to as many of these standards and requirements as possible.

The solutions for MMIS and POS will be "turnkey systems" whereby the respective Contractors will design, develop, implement, and install the replacement MMIS and POS in the State's data center and "turn over" the replacement system to the State. The State will own the implemented MMIS and POS, will have the ongoing responsibility for the operation and routine maintenance of the replacement MMIS and POS after the one (1) year System Warranty period has expired, and will provide any application programming support for ongoing changes and enhancements.

The State of North Dakota is considering the migration of all applications off of the mainframe environment on to a multi-tier client/server environment within three (3) years. ITD is responsible for developing statewide technology standards. To accomplish this in the past, ITD has facilitated quarterly meeting with the standards committee composed of agency representatives.

As of June 2002, standards and policies began development under the governance structure for Enterprise Architecture (EA), which defines the team concept. The structure provides a proactive model to manage and govern technology efforts in the State of North Dakota. This RFP was developed incorporating the EA standards. The EA standards continue to evolve to meet the capabilities of new technologies. The current technology standards for EA are accessible via the Web. The link to the current technology standards is:

http://www.state.nd.us/ea/standards/

The link to proposed technology standards is:

http://www.state.nd.us/ea/standards/recommendations/

In responding to this section of the RFP, all bidders are to respond to each requirement of their proposed solution by acknowledging the requirements, describing how their solution meets or exceeds the requirements, and (where appropriate) describe the solution's benefits to North Dakota.

The Department will supply the necessary platforms. The Contractor will supply information technology (IT) support for the system documentation, telecommunications, and other components required to implement a completed system into the State's data center. After implementation into the State's data center, the Contractor will train State staff to operate the replacement MMIS. Sufficient dedication of computer resources and IT to support the development of the replacement MMIS is essential.

After turnkey, State staff will be responsible for all aspects of operating the replacement MMIS and POS – facilities, equipment, hardware, and infrastructure – as well as running the system(s), maintaining the system hardware and software, and performing operations tasks.

Requirements:

The Bidder Must:

1. Describe their approach to the transition of the replacement MMIS and POS to the Department and into the State's data center. This description should include unique or innovative features and describe the advantages/benefits to the Department.

2. Develop a detailed work plan that includes all tasks necessary to transition the replacement MMIS or POS to the State for the turnkey option. This plan must include, at a minimum, all topics covered in this section.

7.1.1.1 GENERAL TECHNICAL REQUIREMENTS

The general technical requirements apply to the replacement MMIS functionality to be designed, developed and implemented at the State's data center. The technical characteristics of the new system are required to be consistent with the State's emerging enterprise architecture principles as briefly outlined below.

ITD has developed an agency-wide enterprise architecture that will include policies, principles, reference models and standards that will guide agency decisions and investments. The enterprise architecture encourages:

1. Component-based design around natural clusters of business functionality and data which gives the agency maximum flexibility to upgrade or replace components in the future or expose components for use by other parts of the Department or the State.

2. The ability to support interoperability and integration across the agency's portfolio of systems that may require integration with agency level reference systems.

3. The ability to meet future MITA or other external architecture requirements.

Requirements:

The Bidder Must:

1. Describe the approach to systems architecture describing and illustrating proposed applications and their interactions and data exchanges, network connectivity between

major hardware components, connectivity to the State network, connectivity to the provider/health plan community and the applications available to them.

2. Disclose the current technical environment of the system being transferred / installed and describe what technical environment the system will be migrated to in order to comply with the RFP's technical requirements.

3. Provide a logical data model of the database proposed to support the system. If no logical data model is available, a physical model of the implementation proposed as a transfer system can be provided. Any industry standard representation of the model, such as an ERD with a data dictionary, can be provided as long as it is readable without proprietary or specialized applications. This section can be marked as confidential or proprietary information and the State will provide complete confidentiality for it.

4. The vendor must propose an industry standard, non-proprietary tool to provide the metadata layer. Proprietary solutions will not be accepted as adequate for this requirement.

7.1.1.2   STANDARDS

The technical standards proposed herein are aligned with MITA and the successful vendor's contact, will continue to operate under such standards. The State currently operates its computer system in compliance with many technology and operational standards. These standards originate from internal development, industry best practices and governmental mandates. All applications provided by the successful Vendor must operate in compliance with these standards and practices.

The following set of tables depicts (from a technical perspective) the technical requirements for the replacement MMIS; the Department's preferred solution, and the technical items North Dakota currently supports or plans to support.

Table 15: Technical Requirements, Preferred Solutions, and Current Level of Support (Part 1)

	RDBMS	Application Server(s)	Web Server(s)	Operating System(s)
The Replacement MMIS requires:	Industry standard relational database technology and table-driven design for the persistence tier. Compliance with the North Dakota's Enterprise Architecture Proposed products supported on multiple hardware platforms and operating systems.	Compliance with the North Dakota's Enterprise Architecture Proposed products supported on multiple hardware platforms and operating systems.	Compliance with the North Dakota's Enterprise Architecture Proposed products supported on multiple hardware platforms and operating systems.	Compliance with the North Dakota's Enterprise Architecture

	RDBMS	Application Server(s)	Web Server(s)	Operating System(s)
The preferred solution is:	Oracle MS SQL Server	Websphere	IIS Apache	Windows XP Windows 2000(Server) Windows 2003(Server) Solaris(Server) Linux(Server)
North Dakota currently supports or plans to support in near future:	Oracle MS SQL Server DB2 UDB	WebSphere on Linux Weblogic	IIS Apache	Windows XP Windows 2000 (Server) Windows 2003 (Server) Solaris(Server) Linux (Server) AIX (Server)

Table 16: Technical Requirements, Preferred Solutions, and Current Level of Support (Part 2)

	Server Hardware Platform(s)	Desktop Hardware Platform(s)
The Replacement MMIS requires:	Compliance with the North Dakota's Enterprise Architecture	Compliance with the North Dakota's Enterprise Architecture
The preferred solution is:	Intel Sun Solaris IBM AIX	Intel
North Dakota currently supports or plans to support in near future:	Intel Sun Solaris IBM AIX	Intel

Table 17: Technical Requirements, Preferred Solutions, and Current Level of Support (Part 3)

	External User Interface	Internal User Interface	Component Architecture
The Replacement MMIS requires:	Web browser access. Isolating the presentation layer from content and business logic. Compliance with the North Dakota's Enterprise Architecture, Intuitive and user friendly screens, consistent look and feel within applications	Web browser access. Isolating the presentation layer from content and business logic. Compliance with the North Dakota's Enterprise Architecture, including ADA Intuitive and user friendly screens, consistent look and feel within applications Asking the vendor to specify what functions require Windows-based PC Rich Clients	Web services support. Open standards based component architecture (J2EE, .NET). Open standards based interfaces. Compliance with the North Dakota's Enterprise Architecture
The preferred solution is:	Web Browser Hypertext Markup Language (HTML)	Web Browser HTML Rich Client	J2EE
North Dakota currently supports or plans to support in near future:	Web Browser HTML	Web Browser HTML Rich Client	J2EE, .NET, N-tier client-server

Table 18: Technical Requirements, Preferred Solutions, and Current Level of Support (Part 4)

	Messaging	**Testing**	**Electronic Document Management**	**Workflow Management**
The Replacement MMIS requires:	Compliance with the North Dakota's Enterprise Architecture	The use of automated testing tools Load Testing Functional Testing	The use of an electronic document management system	The use of a Workflow Management System
The preferred solution is:	Websphere MQ	Segue Software Mercury Interactive Loadrunner	FileNet P8 Content Manager	FileNet P8 BPM
North Dakota currently supports or plans to support in near future:	Websphere MQ SeeBeyond IQ ICAN 5.0	Segue Software Mercury Interactive Loadrunner	FileNet P8 Content Manager	FileNet P8 BPM

Requirements:

The Bidder Must:

1. Provide a high-level description of their proposed approach to compliance with State Enterprise Architecture, other State and industry technology standards. Include unique or innovative features and advantages/benefits to the Department.

2. Provide the Department with an inventory of all hardware and software that will be placed within the State government infrastructure.

3. Support current technologies for data interchange [e.g., eXtensible Markup Language (XML) and Web services].

4. Ensure that all components installed on the State's desktop are compatible with Department currently supported versions of the Microsoft Operating System, Microsoft Office Suite and Internet Explorer. Current versions supported include: NT, 2000, XP Professional, MS Office 2003, and Microsoft IE 6.0

5. Ensure that components developed for use by external users (providers) are Web / browser-based and support Microsoft IE 5.0 and newer.

6. Ensure that all equipment and network hardware and software required to interface with the State systems meet the State network and security standards. The security standards are available upon request.

7. Ensure that Web applications provided to the State satisfy the Priority 2 Checkpoints from the Web Content Accessibility Guidelines 1.0 developed by the World Wide Web

Consortium (W3C), as detailed at: http://www.w3.org/TR/WCAG10/full-checklist.html and http://www.state.nd.us/ea/standards/standards/approved/egt004-04.1%20accessibility.rtf.

8. Ensure that client desktop software updates work with the then current version of the State's desktop operating system (MS 2000, NT, XP Professional) and Internet browser (IE 6.0) prior to release.

9. Ensure that client desktop software work with new desktop operating system patches and upgrades based upon patch management policies. The security standards are available upon request.

7.1.1.3   TECHNICAL ARCHITECTURE VISION

The Department has formulated a strategic vision as an early adopter of the Medicaid Information Technology Architecture (MITA) that will transform the architecture and infrastructure of its existing information systems from procedurally programmed, monolithic applications into enterprise-wide, services-oriented components. The focus of MITA is a set of loosely coupled business process support applications. They will rely on shared services governed by the Department's Services-Oriented Architecture (SOA) – an architectural style that emphasizes discrete functions linked through standard and modular component container technologies.

At the core of this MITA model are business services rather than a collection of "agency applications." Since these business services are decoupled from one another, they can be deployed in alternative configurations as necessary, to meet business needs. Furthermore, as business requirements evolve, so can the business services; new services can be rapidly assembled instead of being reinvented. Even though the business services carry out disparate business functions, they share a common structure and semantics defined by the service-oriented architecture. While the service-oriented architecture is conceptually unified, it is not monolithic; instead, it is a collection of coarse-grained, loosely coupled business services.

The Department envisions integration architecture based on a common set of industry standards and tools that allow applications to: (a) coordinate the business logic they employ; and (b) share data using:

1. Utilizing Web Services and Web-enabled Applications through the use of open standards-based interfaces [*e.g.,* J2EE - Java 2 Platform Enterprise Edition, Simple Object Access Protocol (SOAP)].

2. An Enterprise Service Bus (ESB) or broker to handle inter-communication and data transport.

3. Standard toolsets for data transformation, adding connector logic to existing applications, and orchestrating process workflow.

The Department is planning to adopt the Enterprise Service Bus (ESB) or equivalent model as its messaging architecture. ESB provides messaging and additional capabilities including:

1. Content-based routing (dynamic routing based on the contents of a message).

2. Lightweight connectors allowing a small process to run at end-point with access to the message bus.

3. High scalability and reliability due to lack of a central broker – messages carry routing information with them, helping to create point-to-point, peer-to-peer connectivity.

The State desires that its investments in information technology result in systems that are interoperable to meet the business requirements of its agencies and to effectively serve its constituencies.

Requirements:

The Bidder Must:

1. Describe their approach to MITA as it relates to the proposed system for the time period of 2005 to 2008. The description must include how you intend on moving your proposed solution towards the MITA framework during this period.

2. Identify each MITA component and explain how each component is used and/or reused during the claims adjudication process (from claims receipt through claims payment).

3. Adhere to component-based architecture such as J2EE and .NET that supports Web services and open standards-based interfaces. J2EE is the preferred component architecture direction for the Department.

4. Adhere to the standards and policies of the North Dakota Enterprise Architecture that defines the team concept. The current technology standards for EA are accessible via the Web.   The link is: http://www.state.nd.us/ea/standards/.

   North Dakota maintains proposed standards at:
   http://www.state.nd.us/ea/standards/recommendations/.

The Solution Must:

1. To maximize future portability of the replacement systems solutions, support products that are preferably available on multiple vendor operating systems and hardware platforms for the following tiers of the system:
   a. Database.
   b. Application server.
   c. Web server.

2. Employ an industry standard relational database technology and table-driven design.

3. Provide a "configuration-based" system that allows end users with the appropriate permissions and privileges to make effective-dated business rule and configuration changes without relying on programming solutions.

4. Must support SOAP secure Web services.

5. Support and employ standards-based interfaces including X12 EDI and/or ebXML formats. Where possible, ebXML should be the protocol of choice for all data exchanges and reference table updates with a standard HIPAA X12 EDI transaction payload.

Identify each technical component, platform, and/or software used in support of this requirement.

7.1.1.4   OPERATING SYSTEMS AND PLATFORM SYSTEMS

Operating systems and platforms will support a highly networked, workstation based, distributed databases architecture. Existing platforms in this architecture include the Information Technology Department's enterprise server, which currently runs network applications and databases as well as legacy systems. The State standards reflect the industry trend toward open systems and advance the implementation of a consistent end-user interface to a variety of distributed computing services. Operating systems and platforms will support a wide range of commercially available software and development tools and the system platforms will allow for application migration to other platforms as they grow. Support costs will be reduced through standardization within agencies and across the enterprise. Purchasing policies will support the efficient and timely purchase of products that meet the standards.

Requirements:

The Bidder Must:

1. Ensure that there are no mainframe components in the solution as North Dakota is considering the migration of all applications off of mainframes within three (3) years.

2. Describe the approach to installation of hardware into the State's data center and transition of the hardware to the State. This description should include unique or innovative features and describe the advantages/benefits to the Department.

3. Work with ITD staff to utilize the existing hardware structure within ITD. The solution must integrate within the existing structure. Please refer to Attachment I for a list of the current hardware within the ITD.

4. Describe all necessary hardware to support the server functions on the replacement MMIS, including but not limited to: servers and storage.

5. Assist ITD in the installation of the development, testing, and training servers at the ITD data center as soon as they can be obtained. The Contractor shall accommodate, to the extent possible, the State's preference that the development, testing, and training servers be located at ITD in order to facilitate the transition to production.

6. Describe your redundancy plan for application support, including the capability of deployment to dual data centers.

7. Collaborate with ITD to ensure that the system hardware and network components are configured with sufficient processing power, storage, and network bandwidth to enable design, development and testing (including performance testing) of the replacement MMIS.

8. Utilize the *de facto* desktop standard of an Intel platform running some variety of Windows. Windows 2000 is the most common although significant installations of Windows XP, Windows NT 4.0 and Windows 98 exist.

9. Integrate the replacement MMIS utilizing one of the following appropriate servers:

    a. Windows servers with Windows 2000 Server being the preferred OS; Windows 2003 will be deployed gradually over time

    b. Intel RedHat Linux servers

    c. Sun Solaris servers

10. Describe all necessary operating system components to support the server functions for the replacement system, including but not limited to: servers and storage.

11. Obtain, for development activities without additional costs, all operating system components licenses obtained to support the server functions on the replacement system including but not limited to: servers and storage. The State will be responsible for obtaining the required licenses for the operational period.

12. Describe all necessary application components to support the server functions for the replacement system.

13. Describe all necessary operating system and application components to support the *client* functions on the replacement system.

7.1.1.5   SECURITY

The State requires that all computer applications operate in a secure manner by complying with security standards and regulations including the HIPAA Security and the Information Technology Security Policy State's security standards. The security standards are available upon request. The requirements in this section emphasize some of the items in those standards and also describe various capabilities to be provided in terms of security in the replacement systems.

Requirements:

The Bidder Must:

1. Provide a high-level description of their proposed Security offering. This description should include unique or innovative features and describe the advantages/benefits to the Department. This description should also describe any and all internal application security.

2. Allow and cooperate with the State of North Dakota's periodic review to ensure that security features are continuously implemented and effective.

The Solution Must:

1. Utilize or integrate user accounts authenticated in Active directory or a LDAP Version 3 compliant product. Additional security may reside within the bidder's system applications. The security standards are available upon request.

2. Define levels of security (read only, read and write, etc.).

3. Define security at the data element/field, individual, user group or user role level.

4. Assign a user to one or more roles or groups.

5. Control access to system resources based upon security rights.

6. Control performance of system functions based upon security rights.

7. Comply with all standards and requirements as specified in the State's security standards. The security standards are available upon request.

8. Automatically log-off user if inactivity exceeds defined time-out period.

9. Assign to each user a unique user ID and password.

10. Provide protection against viruses, worms or any other attack from external agents.

7.1.1.6   ERROR HANDLING

Responsible oversight and care of the system requires that all occurrences of errors be logged for review and that critical errors are accompanied by appropriate alerts. Authorized users such as System Administrators, Database Administrators or Programmer/Analysts need to be able to query and review the error log and configure the alerts.

Requirements:

The Bidder Must:

1. Provide a high-level description of their proposed Error Handling offering. This description should include unique or innovative features and describe the advantages/benefits to the Department.

The Solution Must:

1. Ensure all errors are written to an error log.

2. Allow for an administrator to view, filter, sort and search the error log.

3. Allow for an administrator to archive error log entries based upon user-defined criteria.

4. Allow for an administrator to define an alert message to be executed upon the occurrence of an error.

7.1.1.7   DATABASES

The State requires the benefits inherent with a relational database management system (RDBMS). The accessibility, flexibility and maintainability achieved through normalized data structures are essential to achieving the business objectives outlined in this RFP. All components of the replacement systems must be based on a relational database management system.

Requirements:

The Bidder Must:

1. Provide a high-level description of their proposed database offering. This description should include unique or innovative features and describe the advantages/benefits to the Department.

The Solution Must:

1. Use a relational database management system (RDBMS) as defined in the North Dakota ITD standards.

2. Maintain referential integrity throughout the RDBMS.

3. Have the ability to scale to a large number of users.

4. Provide data integrity; meaning the data in the database is consistent and accurate.

5. Provide support for industry standards [e.g., American National Standards Institute Structured Query Language - 92 (ANSI SQL-92), ODBC, Java Database Connectivity (JDBC) and XML].

6. Provide for security of the data.

7. Provide built-in audit capabilities.

8. Provide point in time recovery.

9. Provide backup and recovery utilities.

10. Provide logging for backup, recovery, and auditing.

11. Describe the usage of binary or character large objects (e.g., BLOBS, CLOBS, etc.) within the RDBMS and your solution.

12. Provide the basic properties of a database transaction: (ACID) Atomicity, Consistency, Isolation, and Durability.
    a. Atomicity – The entire sequence of actions must be either completed or aborted. The transaction cannot be partially successful.
    b. Consistency – The transaction takes the resources from one consistent state to another.
    c. Isolation – A transaction's effect is not visible to other transactions until the transaction is committed.
    d. Durability – Changes made by the committed transaction are permanent and must survive system failure.

7.1.1.8 BACK-UP AND RECOVERY

The State requires the ability to create back-up copies of the systems and to restore and use those back-up copies for the basic protection against system problems and data loss. The successful Vendor must provide a comprehensive and easily manageable back-up and recovery process that is responsive to the State's needs.

Requirements:

The Bidder Must:

1. Provide a high-level description of their proposed Back-up and Recovery offering. This description should include unique or innovative features and describe the advantages/benefits to the Department.

2. Must execute system recovery processes according to State escalation rules and decision points.

3. Provide procedures for the regular scheduled back-ups of data.

4. Describe the back-up and recovery process during the development at any off-site development site.

The Solution Must:

1. Provide point-in-time recovery of data to the last completed transaction.

2. Allow for continued use of the system during the back-up of data residing within databases or on files.

3. Provide a complete back-up and recovery process for all database tables and system files.

4. Create on request back-ups of data residing within databases or on files.

5. Have the ability to execute system recovery processes according to State escalation rules and decision points.

6. Be tested during the transition to validate recoverability.

7.1.1.9   SYSTEM INTEGRATION

User functionality and data accessibility within the systems must be integrated and standardized across all components of the system and in all user interface characteristics. The system must not contain constraints that create artificial barriers between subcomponents of functionality or various kinds of data (e.g., recipients, claims, providers, reference files, benefit plans, etc.).

The system must be able to maintain a single identifier for each recipient regardless of program, eligibility or services. Likewise, a single provider identifier (MMIS ID) must be maintained regardless of benefit plan or services.

The Department is moving toward Common Eligibility (through the State's VISION system) that will provide a single source of recipient identification information across the various State agencies. These data hubs will have the ability to lookup a master record to see if it already exists in the data hub using information provided real-time from source applications or data files.

Components of the successful Vendor's overall solution that are provided through third party business partners must be interfaced or integrated such that user terminology and data definitions are constant across the system boundaries. Data exchanges between components must be conducted real-time so that data is always in synchronicity across all systems.

Requirements:

The Bidder Must:

1. Provide a high-level description of their proposed System Integration offering. This description should include unique or innovative features and describe the advantages/benefits to the Department.

The Solution Must:

1. Maintain a common "look and feel" between different system applications resulting in the user experiencing what appears to be a seamless system, despite navigation between applications.

2. Provide for the access to all on-line claim/encounter information regardless of the business area or subsystem of the MMIS where the information is stored.

3. Provide for the access of recipient information that is currently stored in separate systems (i.e., VISION, TECS, and the "old" MMIS) in a real-time environment. Please refer to the System Requirements for additional information on the recipient systems and the Interface section of this RFP.

4. Maintain an integrated repository of provider information, including a single unique identifier, for all providers where payments are made from the replacement MMIS.

5. Maintain an integrated claim payment system to provide users with access to all payments made from the replacement MMIS in a manner that is seamless to that user.

7.1.1.10 TEST ENVIRONMENT AND INTEGRATED TEST FACILITY

The Department requires multiple separate test environments designed to ensure computer applications meet their specifications. Separate test regions (e.g., unit, system, integration, user acceptance, and training), along with test data and appropriate copies of the logic modules that make up the system, must be established. Version control procedures and update schedules must be used to facilitate tests, track defects and facilitate regression test analysis.

Test Environments

The Department desires the following test environments:

1. Unit Test Environment: An environment that allows the programmer to test a single component (i.e., program) as a standalone entity. Unit testing ensures that a single component is resilient, will function correctly on a standalone basis, and meets the technical specifications for that component (e.g., the modified component can accept the specified inputs and produce expected outputs). The Unit Test Environment may reside within the vendor's development environment.

2. Integration Test Environment: An environment that allows the software engineer to test integrated components as a part of the system/subsystem in which they function. Integration testing ensures that sets of programs function as designed. The integrated

system may involve systems/subsystems interfaced together. The testing will ensure interfaces are exchanging data correctly. The Integration Test Environment will reside on the State's MMIS environment.

Integrated Test Facility (ITF)

The Integrated Test Facility (ITF) consists of the environments outlined below. Software will be promoted from the development environment to the ITF utilizing the Project's configuration management process and only after State signoff of unit and integration tests. These promotion and authorization steps will be documented as a part of the configuration management procedures. The ITF environments must include the following:

1. System Testing Environment: After software builds are completed and processed through the unit and integration test environments, they will be promoted to the System Testing environment. System testing exercises end to end test scenarios to test the working of the system as a whole. In the System Testing Environment, the software will be verified against the requirements by a team independent from the software developers.

2. User Acceptance Test (UAT): An environment that allows the business users to validate that the delivered software meets the true business needs of the State. Scenarios will be defined to ensure that requirements are thoroughly tested by the user. When used for impact analysis, this environment will allow business users to test actual or potential changes to business rules and procedures. This environment would allow the business to perform "what if" testing to assess the impact of a proposed business rule change resulting from policy/legislation changes.

3. Training Environment: A demo environment that allows the Contractor and/or Department to provide hands on training to users. This environment would allow the Department to maintain unique data for use in training and conduct training without interference with other test and production environments.

The Department will define and implement the following procedures to facilitate associated activities across the entire project:

1. Promotion / Demotion Procedures: Procedures for promoting software builds from one test level to the next (e.g., from unit to system testing).

2. Configuration Management Procedures: Configuration Management control procedures will be in place and documented to ensure a common and consistent method of identifying and tracking all changes, as well as the software builds that move through the testing process. This will include formal definitions of configuration items (CI), revision and versioning of the CIs, definitions of baselines, and milestones for baseline promotion.

3. Defect Tracking: Defect tracking will be defined and in place that allows the tracking of a specific defect from identification through correction including all testing performed to ensure the correct fix is in place.

These processes will be defined by the State, and finalized during the Start-up phase of the project. During the Start-up phase, the successful bidder(s) will be expected to provide their

experience with comparable procedures in the form of "best practices" recommendations. The State will evaluate their recommendations and implement those that will best serve the Project as a whole.

Requirements:

The Bidder Must:

1. Provide a high-level description of their proposed Test Environments offering. This description should include unique or innovative features and describe the advantages/benefits to the Department.

2. Provide a high-level description of their proposed Integrated Test Facility offering. This description should include unique or innovative features and describe the advantages/benefits to the Department.

3. Utilize automated testing tools, especially in System test. The bidder is expected to provide development staff that is trained on the automated testing tools used by the bidder. The bidder is expected to provide training to State staff in the utilization of these automated testing tools.

4. Develop scripts that are to be used with the automated testing tools. These scripts must be built so there are checkpoints that have built-in verification of test results.

5. Develop and provide the entire test bed for use in Systems testing.

6. Develop and provide the entire test bed for use in User Acceptance Testing.

The Solution Must:

1. Automate the system test execution to the greatest degree possible.

2. Provide the ability to systematically verify the results.

3. Provide the ability to trace through the testing results to identify the outcome of any given edit/audit.

4. Provide for the modification of the library of test cases, as defined by changes to the user requirements.

5. Create an ITF that is as much like the planned production environment as possible, including all hardware, operating software and utilities, and application software as promoted through the configuration management process.

6. Engineer test data to test specific requirements including claim edits

7. Have the ability to execute impact analysis testing of any proposed system change.

8. Have the ability to create what-if scenarios and compare results between scenarios in a test environment.

9. Be able to perform regression testing in System, Integration, and Acceptance Test environments.

10. Comply with the Project's change management process to ensure that all requirements changes are incorporated into development test efforts.

11. Comply with the Project's configuration management process and tools.

12. Conduct load testing of any Web application prior to production deployment. A successful load test includes acceptable user interface response times and satisfactory central processing unit (CPU) and memory utilization on server platforms during the test.

13. Have the ability to modify data (provider, health plan, recipient or claim) in a test environment, as needed for testing, in compliance with Federal guidelines.

14. Maintain traceability of all development test objects to the specified requirements as maintained throughout the life of the North Dakota Medicaid Systems Replacement Project.

15. Have the ability to manage test cases/packets to support reuse of those test cases.

16. Provide a systematic update process for maintaining key fields such as dates on test case data, and make that update available to the Project

17. Have the ability to test claims processing throughout the lifecycle of the claim, from entry through payment and reporting.

18. Have the ability to accelerate time-dependent test cycles.

The successful vendor must turn over to the State:

1. All documentation for the library of test cases.

2. All utilities to assist in identifying selected claim samples to use for testing (i.e., identify claims that currently test true for a specified edit).

3. All impact analysis testing procedure and tools.

4. All what-if scenarios.

5. All regression test case packets that support regression test methods.

6. All documentation on the a testing approval process that assures that all areas are notified of changes, regardless of whether that change is determined to impact their area or not.

7. All test cases/packets that support reuse of those test cases.

8. All documentation on the execution of testing claims processing throughout the lifecycle of the claim, from entry through payment and reporting.

9. All copies of data (e.g., claims) from the production history environment used to establish appropriate history for the test environment.

10. All copies of production data (e.g., provider, health plan, recipient or claim) that has been used in a test environment.

11. All test scripts.

7.1.1.11   NETWORK SERVICES

Communication between agencies and with external customers requires a single, secure, integrated wide area network that is reliable, widely available and allows for flexible growth. The network architecture will be based on common, open, non-proprietary protocols and on industry and product based standards. Network capacity will provide sufficient bandwidth for future expansion and multiple data formats, including voice and video. Commercial services will be used when appropriate and economically justified. Remote access will be available to State agencies with mobile employees or distant offices. Political subdivisions will be provided the opportunity to connect with State agencies and resources.

ITD provides both local and wide area network services for State Government. All Local Area Network (LAN) segments are switched 100-megabit Ethernet networks. The Fargo and Bismarck metropolitan area networks are gigabit fiber based while the majority of Wide Area Network (WAN) connectivity is obtained via Asynchronous Transfer Mode (ATM) T1s. The core of the WAN consists of a SONET ring. End User support is provided through a central help desk; this service is available 24x7x365.

The State anticipates that the successful Contractor will integrate the required hardware components within the State data center. This Vendor-supplied hardware will need to connect to the State's network. The State expects the successful Vendor to place a network device inside the State data center's "Vendor DMZ" to support the development process. The preference is to utilize a Virtual Private Network (VPN) gateway. The successful Vendor must provide network connectivity from the Vendor-supplied hardware to the Vendor network device within the State's data center. The successful Vendor will be responsible for all connectivity components and services required to connect the modern MMIS to the State network.

Requirements:

The Bidder Must:

1. Provide a high-level description of their proposed Network Connectivity offering for the development process. This description should include unique or innovative features and describe the advantages/benefits to the Department.

2. Work with ITD in the connection of VPN to obtain all necessary hardware to support Network Connectivity for the replacement MMIS.

3. Maintain sufficient redundancy of hardware at the development site in order to ensure minimal system downtime.

4. Collaborate with ITD to ensure that the system hardware and network components are configured with sufficient processing power, storage, and network bandwidth to enable design, development and testing (including performance testing) of the replacement MMIS.

The Solution Must:

1. Utilize Transmission Control Protocol/Internet Protocol (TCP/IP) as the standard communications protocol used for inter-LAN [network] communications (N001-95).

2. Support Ethernet as the standard topologies (N003-96).

3. Support Windows NT as the network operating systems.

4. Utilize fixed TCP port numbers for vendor applications.

5. Secure the connection to authorized traffic only.

6. Ensure the compatibility of application and connectivity with the State's network, securing the traffic traversing the DIS Vendor DMZ to only authorized IP addresses and TCP port numbers.

7. Ensure that all IP addresses assigned for this connection and applications are not advertised or reachable from the public Internet.

7.1.1.12   INTERNET DEVELOPMENT

The implementation of best practices for development of accessible, consistent, and user-friendly websites provide quick, simple access to government information and services, thereby reducing costs and streamlining government by providing greater access to information and more convenient government services.

Requirements:

The Bidder Must:

1. Provide a high-level description of their proposed Internet Development offering. This description should include unique or innovative features and describe the advantages/benefits to the Department.

The Solution Must:

1. Conform to North Dakota's Web development standards, as detailed at: http://www.state.nd.us/ea/standards/standards/approved/egt003-04-2-webdev.rtf

2. Ensure that Web applications provided to the State must satisfy the Priority 2 Checkpoints from the Web Content Accessibility Guidelines 1.0 developed by the World Wide Web Consortium (W3C), as detailed at: http://www.w3.org/TR/WCAG10/full-checklist.html and http://www.state.nd.us/ea/standards/standards/approved/egt004-04.1%20accessibility.rtf.

3. Display the "State Banner" on all Web pages for all entities.

4. Not reproduce or modify the Great Seal of North Dakota for commercial use. The Great Seal of North Dakota is reserved for the official use of the State of North Dakota (NDCC 54-02-01).

5. Provide a homepage, which contains the following contact information: e-mail address and/or telephone number.

6. Contain a privacy statement on entity home pages and any other page where personally identifiable information is collected. (Privacy Policy - DP004-00)

7. Display a disclaimer on entity home pages. (Privacy Policy - DP004-00)

8. Contain images in Graphic Interchange Format (GIF) or Joint Photographic Experts Group (JPEG) format.

9. Not store or retain Credit Card information.

10. Encrypt personal information and passwords. (Encryption Policy – S006-02)

11. Ensure that each page has a <TITLE> tag plus description, keywords, resource type and content META tags. (May not be required of pages generated dynamically unless page can be accessed directly.)
    Example:
        <TITLE>Tax Form</TITLE>
        <META NAME ="description" CONTENT="This page provides information about tax forms.">
        <META NAME ="keywords" CONTENT="Tax, Forms, Payment, Refund">
        <META NAME="resource-type" CONTENT="document">
        <META NAME="Content-language" CONTENT="en-us">

7.1.1.13 SYSTEM PERFORMANCE AND SIZING

This section describes requirements related to the replacement systems' on-line and batch system performance, response times, and sizing from a system architecture standpoint.

Requirements:

The Bidder Must:

1. Provide a high-level description that demonstrates that the solution is sized appropriately and how system performance is attained and maintained. This description should include unique or innovative features and describe the advantages/benefits to the Department.

The Solution Must:

1. Ensure that performance is not degraded when executing on-line analysis, reporting, or other functions during normal system operations.

2. Meet real-time transaction time target of 2.0 seconds or less, measured from the time the switch receives a transaction request to the instant a transaction response is sent back from the switch. An example of a real-time transaction is eligibility inquiry.

3. Meet on-line response time targets for different categories of access to the replacement system, including but not limited to on-line Department User access and on-line self-service access for recipients and other stakeholders, as defined:

    a. For complex transactions, transactions processed on-line will complete within 4.0 seconds or less. Response time will be measured as the interval from the time a User request is received by the Web server to the time a response is sent from the Web server, during normal business hours. During Requirements Validation and Design, the Department will work with the Contractors to define what transactions qualify as "complex transactions".

    b. For simple transactions, transactions processed on-line will complete within 2.0 seconds or less. Response time will be measured as the interval from the time a User request is received by the Web server to the time a response is sent from the Web server, during normal business hours. During Requirements Validation and Design, the Department will work with the Contractors to define what transactions qualify as "simple transactions".

4. Meet the batch cycle window requirements defined and approved by the Department during Requirements Validation and Design. The batch cycle includes but is not limited to:
    a. MMIS and POS batch processing.
    b. Data Warehouse feed schedule.
    c. Backup, restore, and other routine maintenance procedures.

5. Be WAN-friendly, i.e., the transaction response times will not be adversely affected by connecting through a WAN.

6. Support the production volumes at the time of replacement system Go Live, and be scalable, with a minimal design system impact, to accommodate future growth.

7. Perform on-line and batch response time benchmark tests. The benchmark test scripts must include various transaction types in proportions consistent with State transaction statistics and data volumes consistent with expected Go Live and future production volumes. As part of the benchmark test, simulate the following, at a minimum:
    a. Simple transactions.
    b. Complex transactions.
    c. On-line analysis and queries against audit trail.
    d. Batch cycle.

7.1.1.14 DEVELOPMENT STANDARDS

Requirements:

The Bidder Must:

1. Provide a high-level description of their proposed Development Process and Standards offering. This description should include unique or innovative features and describe the advantages/benefits to the Department.

2. Adhere to the overarching information technology policies and guidelines set forth in the State's Enterprise Architecture available for download at: http://www.state.nd.us/ea/standards/

3. Not use any proprietary tools or utilities in the development of the system, unless expressly approved by DHS.

4. Provide a system that does not require any proprietary tools or utilities for ongoing maintenance of the system.

The Solution Must:

1. Provide on-line screens using consistent format and navigational rules to ensure a consistent "look and feel".

2. Comply with both State and W3C Web accessibility standards.

7.1.1.15 DOCUMENTATION STANDARDS

Requirements:

The Bidder Must:

1. Provide a high-level description of their proposed Document Standards offering. This description should include unique or innovative features and describe the advantages/benefits to the Department.

2. Maintain documentation by performing timely and accurate updates throughout the duration of the Contract. All documentation must be completely accurate and up-to-date upon final acceptance of the replacement system.

3. Maintain all documentation, along with all other project deliverables within a Department-approved document management system.

4. Provide all documentation in both hardcopy (double-sided, 3-hole-paper format) and electronic media.

5. Generate all documentation using tools that are currently under license by the Department, or tools that are provided by the Contractor at time of system turnover.

6. Provide operations and business logs and forms required by the Contract and/or the Federal certification regulations.

The Solution Must:

1. Ensure that data elements used in the system are well defined and documented, normalized to the extent possible, and consistent throughout all components of the replacement system.

2. Ensure that all transferred and newly developed source code is organized in a modular manner, well defined and documented, and meets commonly accepted standards.

7.1.1.16 VERSION CONTROL

Requirements:

The Bidder Must:

1. Provide a high-level description of their proposed Version Control offering. This description should include unique or innovative features and describe the advantages/benefits to the Department. The vendor will perform this version control through the Implementation Phase.

2. Provide all source code in ANSI text format so that the code can be loaded into Rational Clear Case. This is performed after User Acceptance Testing.

The Solution Must:

1. Enable the Contractor and State to:
   a. Maintain versions of all changes made;
   b. Record the changes;
   c. Record date and time stamps of when the changes were recorded;
   d. Record who made the changes; and
   e. Provide the capability to restore previous versions.

2. Provide the ability to load all code from the Vendor's code management system into Rational Clear Case.

7.1.1.17 CHANGE CONTROL PROCESS

This section focuses on requirements related to the replacement system change control process. Change Control is the formal process for identifying the impact of any change or correction that modifies scope, deliverables, timeframes, or resource allocations, and determining the disposition of the requested change or correction. Design and development-related scope changes that are approved through the Change Service Request process are examples of project elements that are ultimately managed by the Change Control process. In practice, the change control process generally applies at two stages of the system development lifecycle:

1. After the completion of the Detailed System Design milestone.

2. After the production release scope has been defined at the completion of the SAT milestone, and sign-off for implementation has been granted.

Design flaws must go through the Change Control process. The Department will not assume financial costs for corrections due to design flaws.

Requirements:

The Bidder Must:

1. Provide a high-level description of their change control process. This description should include unique or innovative features and describe the advantages/benefits to the Department.

2. Implement and follow a Department-approved change control process.

3. Incorporate a formal Change Order process that:
   a. Provides a clear scope of what is included and excluded from each change order request;
   b. Delineates the system downtime required to implement the change(s), if any;
   c. Requires the successful completion of regression testing prior to the implementation of the change;
   d. Incorporates multiple levels of priority for change orders (e.g., critical, must-have, desired, etc.). The change order process could be initiated by events including but not limited to:
      i. Certification requirements;
      ii. Application defects and technical problems;
      iii. Changes introduced by third party vendor;
      iv. Changes in business processes; and
      v. New business requirements.

4. Support the change control process by estimating impacts, investigating solutions, identifying alternatives, and inputting appropriate information into project tracking tools, participating in the decision-making process, and implementing the agreed-upon solution.

5. Provide and maintain a fully documented and automated tracking system for software Change Order requests.

The Solution Must:

1. Enable the Department to control and monitor applicable Change Service Requests.

2. Include the following features in the automated change request system:
   a. Provide for Department review and approval for all system changes.
   b. A process for reporting the status of all change requests;
   c. The ability for the Department to set and change priorities on individual change requests;
   d. A method for the Department to determine the estimated and actual hours allocated to each change request, and the personnel assigned to each request; and
   e. A method to schedule a completion date provided by Department for each change request.

7.1.1.18 SYSTEM MAINTENANCE

During the System Warranty period, System Maintenance activities for the replacement systems will fall into four (4) categories:

- Correction of application defects: An application defect is an application malfunction, or deviance in the function of the application from its design. Accordingly, no requirements or design changes are involved in the correction of application defects. The Contractor must take corrective action and ensure that the application performs as designed;

- Software upgrades: Installing new releases, patches and upgrades to system and application software, including the process of evaluating the impact on current modification;

- Routine maintenance: All normal operations and procedures required for the ordinary operation of the replacement system and related functions, and operational tasks. The routine maintenance tasks include, but are not limited to:
  - o Purging, archiving, backing up and restoring required data;
  - o Monitoring and providing adequate space allocations for the systems data volume; and
  - o Monitoring and tuning the replacement system to maintain system performance.

- Federal and State legislative changes: During the course of post-DDI maintenance activities, some Federal and/or State legislative changes may occur that will necessitate system modifications. Contractor hours necessary to address these changes will be reimbursed at the hourly CSR rate that has been priced separately by the bidder for out-of-scope system modifications. For additional information on the CSR rate, see Section 10 of this RFP.

Application Defects:

The definition of priority (urgent, high, medium, and low) for application defects is as follows:

- Urgent: issue/problem has caused, or has potential to cause, the entire system to go down or to become unavailable;

- High: issue/problem directly affects the public, or a large number of Users are prevented from using the system. High-priority problems include those that render a site unable to function, make key functions of the system inoperable, significantly slow processing of data, severely impact multiple Users, lead to Federal penalties, misdirect payments, or severely corrupt data;

- Medium: all other issues/problems. Medium- and low-priority problems include those errors that slow the processing of data by a small degree, render minor and non-critical functions of the system inoperable or unstable, and other problems that prevent Users or administrators from performing some of their tasks; and

- Low: all service requests, and other problems that prevent a User from performing some tasks, but in situations where a workaround is available;

Technical problems and inquiries that cannot be resolved immediately upon receipt by the Department will be classified into simple, medium and high complexity. These are defined as follows:

- <u>Simple:</u> the problem is a known issue, or an immediate solution is available;

- <u>Medium:</u> the problem appears to be a bug/defect or data problem; and

- <u>High:</u> the problem is hard to trace and is likely to need extensive troubleshooting.

<u>Requirements:</u>

The Bidder Must:

1. Provide a high-level description of their maintenance process. This description should include unique or innovative features and describe the advantages/benefits to the Department.

2. Utilize the approved change control process for all maintenance activities.

3. Review and diagnose all medium- and low-priority problems within four (4) hours of receipt of the problem report.

4. Submit a written report of the analysis to the Department's Project Manager upon completion of the analysis and diagnosis that identifies the proposed resolution, if it can be identified at that time, and the anticipated completion date/time.

5. Upon Department approval, begin working to implement or define a proper solution for all urgent and high-priority problems immediately and, if requested by the Department's Project Manager, provide on-site assistance and dedicate all available resources to resolving the problem.

6. Once the resolution is defined (if not defined with initial diagnosis), confer with Department to confirm approval of resolution.

7. Correct system fatal errors and abends (abnormal end), and the software defects causing such problems. On-line fatal errors and abends must be corrected within 24 hours from the time that the problem occurs unless the Department Project Manager has approved additional time for corrective action. Batch abends that are critical for processing must be fixed and the batch cycles must be completed before the time the system is scheduled to be available on-line.

8. Resolve all other technical issues and application defects within timeframes specified in the following table:

Table 19: Technical Issue Resolution Timeframes

Complexity	Priority		
	Low	Medium	High
Simple	3 Business Days	1 Business Day	1 Business Day
Medium	7 Business Days	3 Business Days	1 Business Day
High	10 Business Days	4 Business Days	2 Business Days

9. Whenever an operational problem results in inaccuracy, data corruption, delay or interruption in on-line availability, or delays in claims adjudication, notices, reports or other output, immediately notify the Department's Project Manager or his/her designee. This notification must include distributing information to subject matter experts, and to Department staff via a production status report (delivered at an interval designated by the State). The notification must include a description of the problem, the expected impact on operational functions, a corrective action plan, and expected time of problem resolution.

10. Upon correction of the problem, notify the above-mentioned staff that the problem is resolved.

7.1.1.19 SOFTWARE UPGRADE PROCESS

This section focuses on requirements related to the replacement systems' software release management and upgrade process. This includes updated to the vendors software as well as update of a third-party component within the system or other firmware.

Requirements:

The Bidder Must:

1. Provide a high-level description of their Software Upgrade process. This description should include unique or innovative features and describe the advantages/benefits to the Department.

2. Provide a comprehensive software release management and upgrade strategy that encompasses all required third-party software products.

3. Provide a comprehensive software release management and upgrade strategy that encompasses all required application software.

7.1.1.20 TRAINING

After turnover of the replacement systems, the State will own the systems.. However, State staff will only be responsible for the ongoing operation and maintenance of the MMIS and POS.

Requirements:

The Bidder Must:

1. Describe the approach to training. This description should include unique or innovative features and describe the advantages/benefits to the Department.

2. Bidders must describe in detail their approach to training the State's operations staff in the execution of the replacement system; this includes, but is not limited to:
   a. Daily job cycles and programs
   b. Weekly job cycles and programs
   c. Monthly job cycles and programs
   d. Quarterly job cycles and programs
   e. Semi-annual job cycles and programs
   f. Annual job cycles and programs
   g. On-request job cycles and programs
   h. Application back up
   i. Application restores
   j. Data and database back up
   k. Data and database restore
   l. Data Warehouse extract
   m. System Start/Restart procedures
   n. Configuration Management
   o. Version Change Control
   p. Utilities and tools
   q. All operations procedures not included in the above list

3. Develop a detailed turnover training work plan that incorporates, at a minimum, all topics listed in the approach to training. This work plan that includes all tasks necessary to train State staff in the technical components of the replacement DSS/DW to the State or a successive contractor.

4. Describe in detail a staffing plan that depicts the number of State operations staff, the types of State operations staff, and when the State operations staff is needed to ensure complete understanding of the execution of all replacement system components. This is to include the number of State operations staff needed to support the ongoing operations.

5. Describe in detail their approach to training the computer network staff in the handling of the network components of the replacement system.

6. Describe in detail a staffing plan that depicts the number of State network staff, the types of State network staff, and the when this State network staff is needed to ensure complete understanding of the execution of all replacement system components. This is to include the number of State network staff needed to support the on-going network operations.

7. Describe in detail their approach to training the application support staff (programmer/analysts) in the application components of the replacement system; this includes, but is not limited to:
   a. Daily job cycles and programs
   b. Weekly job cycles and programs
   c. Monthly job cycles and programs

    d.   Quarterly job cycles and programs
    e.   Semi-annual job cycles and programs
    f.   Annual job cycles and programs
    g.   On-request job cycles and programs
    h.   Application back up
    i.   Application restores
    j.   Data and database back up
    k.   Data and database restore
    l.   Data Warehouse extract
    m. System Start/Restart procedures
    n.   Configuration Management
    o.   Version Change Control
    p.   Utilities and tools
    q.   Programming languages
    r.   All operations procedures not included in the above list

8. Describe in detail a staffing plan that depicts the number of State application support staff, the types of State application support staff, and the when this State application support staff is needed to ensure complete understanding of the execution of all replacement system components. This is to include the number of State application support staff needed to support the replacement system applications.

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7.2 MMIS REPLACEMENT SYSTEM REQUIREMENTS

The State of North Dakota has begun the transition from a mainframe legacy system to an agency-wide enterprise architecture that is component-based, focusing on business functionality. This architecture will provide flexibility and interoperability, as well as reducing the time and cost associated with future system enhancements. This transition is consistent with the MITA principles of flexibility and adaptability, and as such, the Department has made the decision to become an early adapter of the MITA architecture. The requirements of the replacement MMIS listed below are aligned with the business functional areas that are core to the programs offered by the Department of Human Services.

The functional requirements, inputs and outputs for each of the following business areas of the replacement MMIS are listed below:

- Provider Services
- Recipient Services
- Data Management
- Prior Authorization
- Claims
- Administrative Reporting
- Utilization Management
- Financial Management
- Managed Care
- Call Management
- Workflow Management
- Document Receipt and Control

7.2.1 PROVIDER SERVICES

States across the nation are challenged with decreased funding for Medicaid and other health programs, making it difficult to attract and retain providers for these services. Factors such as distance and weather can create unique challenges for a rural state like North Dakota to offer support to providers in a face-to-face setting. In an effort to enhance provider services, the Department intends to increase utilization of the Web and other automated processes to support and assist providers. Enrollment, training, correspondence, and general program information are all areas that can be addressed electronically. The replacement MMIS must accommodate these goals, as well as new functions, such as the implementation of the National Provider Identifier.

The functional requirements, interfaces, inputs and outputs for Provider Services are listed below:

7.2.1.1   FUNCTIONAL REQUIREMENTS

Functional Requirements for the Provider Services function include, but are not limited to:

1. The system must provide on-line access to the provider master file with inquiry. Search
    criteria include:
    a.) Provider number
    b.) Provider name
    c.) License number
    d.) Group number and name
    e.) Tax Identification Number (TIN); i.e., SSN or Federal Employer Identification Number
    (FEIN)
    f.) Provider type
    g.) Program participation
    h.) Drug Enforcement Agency (DEA) number
    i.) UPIN
    j.) NPI
    k.) NCPDP number
    l.) Medicare number
    m.) Provider specialty
    n.) Business name
    o.) Provider service types
    p.) Other key field as determined by DHS

2. The system must unduplicate records when a provider is found to have more than one
    provider record in the system. The system consolidates the provider data and the claims
    payment history data into one consolidated record.

3. The system must display an OCR Image of completed Provider Application Form.

4. The system must accept electronic, on-line provider applications for enrollments and allow
    for on-line updates.

5. The system must update and maintain as appropriate automated financial data accessible
    to on-line inquiry, including Calendar current year and prior year to date:
    a.) Amount billed for paid claims
    b.) Amount paid
    c.) Amount allowed
    d.) Amount returned/recovered
    e.) Number of claims paid
    f.) Number of claims rejected/denied

6. The system must update and maintain as appropriate automated financial data accessible
    to on-line inquiry, including State fiscal year to date:
    a.) Amount billed for paid claims
    b.) Amount paid
    c.) Amount allowed
    d.) Amount returned/recovered
    e.) Number of claims paid

f.) Number of claims rejected/denied
g.) Current number of claims pended and billed amount for those claims

7. The system must update and maintain as appropriate automated financial data accessible to on-line inquiry, including current negative balance amount:
    a.) Dollar limit and/or percentage of negative balance to be recovered on next checkwrite
    b.) Recovery period (i.e., scheduled from and through dates for recovery)
    c.) Amount of last recovery
    d.) History of collections (i.e., amount collected and payment date for each payment cycle in which funds were recovered)
    e.) Source of recovery [e.g., Internal Revenue Service (IRS), claim overpayment, etc.]
    f.) Total amount due
    g.) Current outstanding balance
    h.) The claims to which the recovery was applied

8. The system must update and maintain as appropriate automated financial data accessible to on-line inquiry, including current and prior year 1099 amounts reported.

9. The system must identify providers whose licenses, certifications and permits are about to expire. The expiration thresholds must be user-definable, for example: ninety (90) days prior to the end date of the current certification, licensing, or permit period. The system must be able to generate letters to providers 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 is not provided. If the information is not provided within sixty (60) days after expiration, deny the claims.

10. Provider license and certification records must be available on-line and accessible to update by users with the proper authority. This should include external users, such as Children and Family Services (CFS) staff entering certification to provide wraparound services.

11. The system must link providers to other entities, such as Groups, MCOs, Chains, Network, Ownership, Partnership, etc.

12. The system must track the number of recipients assigned to a Primary Care Provider.

13. The system must track provider activity by:
    a.) Year to Date (YTD) dollars paid (Federal Fiscal Year, State Fiscal Year, and Calendar Year)
    b.) Payment History
    c.) Number of recipients
    d.) Number of claims
    e.) Number of units

14. The system must generate information requests, correspondence, or notification based on the status of the application for enrollment or program specific criteria.

15. The system must allow providers to be flagged in the system for manual claims review, based on different criteria, such as specific procedures performed or dates of service.

16. The system must maintain date-sensitive demographic information as well as provider type and specialty for all provider types. The system must support multiple provider service types, multiple specialties, and multiple office locations for a single provider record.

17. The system must maintain the status of the provider as an electronic biller and/or EFT provider, and whether provider chooses paper or electronic remittance advice (RA).

18. The system must maintain current and historical multiple addresses for a provider, including:
    a.) Pay-to
    b.) Mail-to
    c.) Service location(s)
    d.) Publication distribution addresses and media
    e.) Other addresses

    Address type values must be maintainable by users without programming.

19. The system must maintain multiple telephone numbers and e-mail addresses for a provider, including business phone, FAX number, and e-mail address for each location.

20. The system must maintain a history of TINs that have been associated with provider numbers.

21. The system must produce 1099 forms and revised 1099 forms based on TIN. The system retains the original 1099 values when revised 1099s have been produced.

22. The system must maintain a history of all Provider IDs used by a provider at various times. If multiple provider numbers exist for a single provider in history, the system must display all of the provider numbers for the provider when a cross-reference is requested. This includes all IDs inactivated in unduplicating a provider.

23. The system must allow border state providers (i.e., providers that fall within a 50 mile radius of the North Dakota state border) to be treated as in-state providers. Out-of-state providers that are "flagged" as in-state providers therefore follow the same guidelines as in-state providers.

    *<u>Bidder's Note</u>: The bidder must address how their system's database will identify that all in-state ZIP Codes are in-state and specific out-of-state ZIP Codes are also "in-state".

24. The system must include an indicator on the main provider display screen to identify whether the provider is related to other entities, and if so, the type(s) of entity (e.g., group, clinic, managed care organization, etc.), associated dates, and cancellation codes.

25. The system must maintain a history of date-sensitive rate information for providers who have provider-specific rates or rate components. The system must support on-line access to 7 years of provider rates, historical provider information and effective dates.

26. The system must set multiple status codes, including:
    - Active
    - Inactive (need multiple status codes to indicate reason for inactivity)
    - Suspended (temporary with end date); need multiple status codes to indicate reason for suspension (e.g., under investigation, etc.)
    - Terminated / Disenrolled

    Status code values must be maintainable by users without additional programming. Status codes must also be able to be associated with a related reason code to indicate the reason for status such as termination (e.g., deceased, voluntary, etc.).

27. The system's Provider File must support free-form comments when required to explain standard provider data.

28. The system's Provider File must integrate with Microsoft Office's mail merge function for correspondence, labels, etc.

29. The system's Provider File must have an indicator to designate whether a provider wants to receive provider manuals, bulletins, memos, etc. by mail, e-mail, or Web download.

30. The system must provide tools to support user-friendly on-line access and query support to provider data.

31. The system must cross-reference or relate individual Provider IDs to:
    a.) National Provider Identifier (NPI)
    b.) UPIN
    c.) License numbers
    d.) DEA numbers
    e.) Medicare ID

32. The system must provide the capability to update rate changes on-line.

33. The system must edit all rate change transactions for validity. Rate changes are subject to on-line audit trails.

34. The system must include date spans (i.e., from and through dates) for all affiliations.

35. Provider participation for each MMIS-supported State program will have start and end dates uniquely identified.

36. The system must maintain date-sensitive, historical provider license, certification, and permit status information, including type of license/certification/permit and associated license / certification / permit numbers.

37. The system must cross-reference individual physicians and other providers to FQHCs, rural health clinics, and other institutional or clinic-based locations.

38. The system must allow "two-way" cross-reference, meaning that inquiries and linkages for editing and reporting can be made between the individual and the associated entities, and the entities and the individual.

39. The system must automatically cross-reference license and sanction information with other State agencies, other licensing or accreditation agencies, and the federal Office of Inspector General sanction list to prevent enrollment and certification of any provider with outstanding sanctions.

40. The system must update (and maintain as appropriate) automated financial data accessible to on-line inquiry, including
    a.) Month-to-date payments
    b.) Amount paid
    c.) Amount allowed
    d.) Number and billed amount of pended claims
    e.) Number and billed amount of denied claims

41. The system must maintain current and accurate, date-sensitive information on providers' eligibility to render specific services, at specific locations, to specified categories of eligibles.

42. The system must maintain contact person information for each provider office or location.

43. The system must assign and maintain a unique identifier for each provider that meets the requirements of the finalized HIPAA National Provider Identification (NPI) standards. The system also can assign provider identification numbers to providers who are not currently participating in the Medicaid program.

44. The system must enroll individual pharmacists and link the pharmacist to the pharmacy.

45. The system must store information from provider applications with a code indicating the status of the application.

46. The system must accept and process North Dakota Provider Enrollment Application Forms received via Web Portal data entry.

47. The system must maintain current and accurate, date-sensitive information on providers' eligibility to render specific services, at specific locations, to specified categories of eligibles.

48. The system must capture the Health Care Identifier/DEA (HCIdea) number in the provider file.

49. The MMIS and POS must both capture the UPIN for prescribing physicians and pharmacists who are authorized by law to prescribe until the implementation of NPI, at which time the MMIS and POS will capture the NPI numbers for these physicians and pharmacists with no additional cost to the Department.

50. The Provider File must have every provider's address in the system (including non-Medicaid providers), for the purposes of Retro-DUR. The system must be able to capture

DEA numbers and inter-relationships between providers, such as participation in groups, clinic participation, and similar relationships. Provider Relationship types must be user maintainable and able to be changed without coding changes.

51. The system must enroll individual pharmacists, specifically for prescription tracking and various reporting needs. Edits would be needed to allow items such as Coordinated Service Program PCPs for recipients.

52. System must allow providers to have more than one specialty, without the need for multiple provider numbers. Providers may have only one active provider number.

53. The system must have a process to allow the State to disenroll providers based on criteria established by the State.

54. The system must provide a Web Search functionality for recipients to search for certain providers located in their area by specialty, location, services offered, distance, etc.).

55. The system must update (and maintain as appropriate) automated financial data accessible to on-line inquiry, including the date and amount of previous cost settlements and the time period associated with the settlement.

56. The system must update (and maintain the history as appropriate) automated financial data accessible to on-line inquiry, including: reimbursement rate (including per diem), percent of charges, case management fee, per capita rate, payment rate for specific procedure/revenue code, prescription dispensing fee, and others.

57. The system must update (and maintain as appropriate) automated financial data accessible to on-line inquiry, including the overall payment percentage to be applied to allowed amounts to this provider.

7.2.1.2 INTERFACES

The Interfaces for Provider Services are:

1. State Board of Examiners website for Verification of Licensure.

2. U.S. Department of Health and Human Services (HHS) Office of Inspector General website for Verification of Excluded Party Listing.

3. Manual interface with Department of Transportation for verification of Driver's Licenses for transportation providers.

4. The system must support an automated interface with the DEA.

5. The system must support an automated interface with National Practitioners Data Bank.

6. The system must support an interface with CMS Clinical Laboratory Improvement Amendments (CLIA) database for information regarding laboratory certifications (OSCAR).

7. The system must support an electronic interface with CMS for the Medicare sanction/reinstatement report.

8. Provider File information sent to Data Warehouse.

9. The system must interface with the National Plan and Provider Enumeration System (NPPES) upon the implementation of the NPI rule.

10. Interfaces with Lotus Notes in the Division of Developmental Disabilities to provide MMIS Provider IDs to ASSIST provider records.

11. Interfaces with other entities as needed.

7.2.1.3   INPUTS

Inputs for Provider Services include, but are not limited to:

1. Provider applications, both paper and electronic.

2. Provider rates.

7.2.1.4   OUTPUTS

Outputs for Provider Services include, but are not limited to:

1. System generated reports.

2. Provider mailing labels.

3. Provider Directory supplied to the MCOs for panel development.

4. Data extracts for the DSS.

5. All information necessary for claims processing.

6. Other distribution lists using e-mail addresses.

7.2.2   RECIPIENT SERVICES

The State of North Dakota has already demonstrated the move toward component-based architecture with the use of the VISION system for recipient eligibility, rather than maintaining a traditional Recipient subsystem within the MMIS. It is the Department's goal to continue to use VISION for the majority of recipient eligibility, and a successful vendor must be willing to adapt to this way of doing business, rather than proposing a "one size fits all" Recipient subsystem. The use of a metadata layer and shared tables, as described in Section 5, are integral pieces of the desired functionality and must be included in a successful proposal.

The functional requirements, interfaces, inputs and outputs below address the following areas within Recipient Services:

- Eligibility
- Third Party Liability
- Waivers and Special Programs
- EPSDT
- Recipient Liability / Co-payment

7.2.2.1   ELIGIBILITY

7.2.2.1.1   Functional Requirements

The Functional Requirements for the Eligibility function are:

1. System maintains a MMIS ID Master File (i.e., MMIS ID index) and associated tables that represent the MMIS ID, recipient identifying information, and IDs from each program in which the recipient participates. Data to be maintained will include, but not be limited to:
   - Medicaid ID
   - Other program-specific IDs
   - MMIS ID
   - First Name
   - Middle Name
   - Last Name
   - Date of Birth
   - Gender
   - Social Security Number
   - Address(es), including county of residence and legal county
   - Program Participation data
   - Eligibility Source
   - Eligibility Type
   - Begin Date
   - End Date
   - Status

2. The MMIS System must assign a unique MMIS ID number. All recipients entered into the Eligibility Reference File will be assigned a unique MMIS ID.

3. The system must support Web-based and on-line searches for recipients based on criteria such as: MMIS IDs, Medicaid IDs, other program-specific ID, name, date of birth, gender, Social Security Number, county of residence, legal county, and program. The system must display a list of recipients matching the search criteria and allow the user to drill-down for more detail on one and return to the list without re-initiating the search. The detailed screens must include demographics, address, eligibility history, and case composition.

4. The system must display family and case data for recipients that exist on the VISION / TECS system. The system must be able to perform duplicate checks, including checks against Medicaid eligibility information held in VISION / TECS and the MMIS recipient files.

5. For each recipient added to the Eligibility Reference File, the system performs a duplicate check using the name, date of birth, gender and Social Security Number (SSN). For records added through the automated interfaces, duplicate records that match one name, DOB, gender and SSN will be suspended until users can review the records. The system provides a window to display the added records and the suspected duplicate records and allow the user to create a new record or update an existing record. For manually entered records, the system will display an error message for duplicate or near duplicate records, allow the user to view the suspected duplicate record, and allow the user to add the record or update an existing record. No IDs will be assigned until these issues are resolved.

6. The system's Eligibility File must maintain multiple eligibility records for the same period for any recipient, and identify the primary eligibility at any given time in accordance with an eligibility hierarchy. The updating and ending of records may be performed by external systems and the eligibility file maintains the results of those determinations without changing them.

7. The system's Eligibility File will support inquiry into a recipient's eligibility for any purpose within MMIS, including claims and encounter processing, provider support inquiry, and recipient support inquiry. The system will query the Master MMIS ID index to determine which systems contain eligibility information about the recipient.   VISION / TECS include eligibility data; the system will view/read VISION / TECS records to obtain current eligibility records and complete demographic and address records. If no record is found on the Eligibility Reference File, the system will search VISION / TECS based on name, DOB, gender and SSN to determine whether the record has been added to VISION / TECS. If a VISION / TECS record is found, the system will update the MMIS reference file with VISION / TECS data and retrieve the data required from that system.

8. The system will maintain a complete cross-reference from Medicaid IDs to any IDs used in other systems, as linked through the MMIS ID.

9. When the system receives begin dates or termination dates of MMIS eligibility for recipients with eligibility in other systems, the staff assigned to those recipients in the other systems receive notification of the change(s).

10. When duplicate recipient records are identified, the system must (upon manual review and approval) unduplicate the records without loss of information and consolidate the recipient data and the claims payment history data into one consolidated record.

11. The system's Recipient Files must identify staff assigned to recipients in every program for which the MMIS Eligibility Reference File has eligibility records. That may be through direct reads of the systems, through accepting batch files, or on-line entry and updating through MMIS windows.

12. The system will accept eligibility terminations for each type of eligibility as end dates and process the data for the Eligibility Reference File. VISION end date transactions will be received on a basis to be determined during Detailed Requirements Definition. Any discrepancies in transactions, such as an end date for an eligibility that does not exist or has been terminated, will be suspended for action by MMIS staff. The system will provide a window to display discrepancies and resolve them on-line.

13. The system must contain the functionality to pull the necessary data to produce the thermal identification cards.

14. The system must return the 271 Response to the Sender of the 270. For example, if an MMIS user sends a 270 transaction to inquire about benefits for a person applying for Medicaid, the 271 Response must be sent to the user that initiated the 270.

15. The system must provide access through a Web portal to recipient data including (but not limited to) demographics, eligibility, and enrollment.

16. The system must provide users with the capability to choose whether the end date of eligibility should automatically be put as an "end date" on any related files. The system also must provide the ability for DHS to determine for which files this will occur (if any).

    *Bidder's Note: Currently, the consensus is that screenings for HCBS services should not be affected by the end date, as the individual may be reinstated for Medicaid eligibility before the screening is normally scheduled to end. These screenings are in effect for one year, even if they aren't using Medicaid HCBS for a given month. However, there are different purposes for screenings, authorizations, etc. Some of these differences may require use of the automatic closing, if eligibility has ended.

17. The system must produce a notification or report to alert HCBS programs of required action (if any) for instances when eligibility for Medicaid has ended but the recipient still qualifies for other HCBS programs.

18. The MMIS system will read eligibility records using a metadata or API program that can read both external system files and the MMIS Recipient Eligibility file. The eligibility type in the MMIS ID index will indicate where eligibility is stored for each type of eligibility. See Section 5.2.1.2 and Attachment K for a more detailed discussion.

19. System must produce Recipient Explanation of Medical Benefits (REOMB) letters.

20. The System must provide access to external staff to update recipient records that they own. Ownership must be determined by rules based on the program for which a recipient qualifies.   Where multiple programs may own the same data, ownership must be based on a priority hierarchy maintained by users.

21. The MMIS ID index will support receipt of updates when program-specific IDs are assigned or changed in other systems. Updates may be entered manually or through an interface as described in Section 5.2.1.2 and Attachment K.

22. Addition of new recipient records will require program participation data.

23. For programs for which eligibility is not read directly from the source system, recipient eligibility records will be maintained in the MMIS System.

7.2.2.1.2   Interfaces

Interfaces for the Eligibility function are:

1. Receive and send updates to recipient data from the VISION / TECS system, as required by system users and business processes. This requirement includes real-time reads directly from VISION / TECS if so decided by the State. These files will update the reference files with any changes or additions to VISION / TECS records.

2. All recipient data stored in the MMIS must be retained for at least five (5) years on the production database.

3. Receive updates from other programs in a standard format specified to match the Reference File format (e.g., ASSIST, VR, and CSHS). The system must also support manual entry of these records.

4. The system will include a data entry window to add records to the Eligibility Reference File. The system must enforce levels of security for records specific to Women's Way, Department of Corrections, CSHS, DD, Disability Determination Services (DDS), VR, the Health Department, and any other programs that need eligibility added.

5. When a recipient has current eligibility on VISION / TECS, the system must read the following types of records from that system:
   - SSI eligibility
   - SSA records, such as Medicare Eligibility
   - TPL Records
   - PCP Assignments
   - MCO or PCP Enrollments
   - Living Arrangement
   - Recipient Liability

6. When a recipient has no current eligibility on VISION / TECS, but the MMIS Master ID index indicates eligibility on another system, MMIS must read the following types of records from that system or from the MMIS Recipient file:
   - SSI eligibility
   - SSA records, such as Medicare eligibility
   - TPL Records
   - PCP Assignments
   - MCO or PCP Enrollments
   - Living Arrangement
   - Recipient Liability

   If the required records are not available on the other system, users must be able to enter the data directly into the recipient files in MMIS.

7. The system will read eligibility records from VISION / TECS. VISION / TECS will update the Eligibility Reference Table recipient data in MMIS with a frequency determined by users.

8. Receive updates from ASSIST in a standard format specified to update recipient data. If the recipient is not in VISION / TECS (not Medicaid eligible), the creation of an Individual Service Plan in ASSIST would be used to create the individual record in MMIS only if reimbursement of State funded service is authorized. The files received must include all data required by MMIS to process DD claims.

9. The MMIS will perform automatic duplicate checks on new records received from interfaces to ensure that the recipient is not already known to the system. If a match on name, DOB and SSN is obtained, the existing record will be updated without creating a new recipient. If a partial match is obtained, the record will be suspended for resolution.

7.2.2.1.3   Inputs

The Inputs for the Eligibility function are:

1. MMIS will access recipient eligibility data from VISION / TECS via the metadata layer.

2. Data received on recipients who are not eligible for medical programs but who will have payments made on their behalf through the MMIS from on-line entry or interfaces provided by the respective programs. The MMIS must be able to accept a standard recipient entry file for creating and updating recipient data from all DHS systems it does not read directly.

3. Other State programs such as DD Services, Vocational Rehabilitation and CSHS will provide eligibility records.   The system must support on-line, direct data entry of recipient eligibility records by external agency staff if they choose to enter records on-line. The MMIS system must also support updating of records through batch processes for agencies like VRIS that currently submit batch files.

4. The MMIS will receive cross-reference ID data for the MMIS ID index from the VISION / TECS systems and from all State programs supported by the MMIS, such as: DD Services, Vocational Rehabilitation, and CSHS. The system must support on-line, manual entry of this data. It will receive full recipient records from all State programs supported by MMIS that are not read directly.

5. The system will receive input from Recipient data entry screens for new recipients.

6. The system will support the receipt of 270 Eligibility Benefit Inquiry transactions.

7.2.2.1.4   Outputs

The Outputs of the Eligibility Function are:

1. The system supports on-line and batch inquiries into recipient eligibility and displays the recipient data, eligibility type, begin dates of service, and end dates of service for the recipient.

2. The system's eligibility data acquisition processes provide eligibility data to all MMIS processes, including but not limited to claims payment.

3. The MMIS will support all processes that require eligibility data, such as recipient enrollment, claims processing, Management Reporting and Prior Authorizations.

4. The MMIS will support the production of 271 Eligibility Benefit Response transactions.

7.2.2.2   THIRD PARTY LIABILITY

7.2.2.2.1   Functional Requirements

The Functional Requirements for the Third Party Liability function are:

1. The system provides on-line inquiry for State users and automatically accepts updates to the Third Party Resource File and TPL Carrier File. The system also must maintain a log of these transactions.

   *Bidder's Note: TPL information will be used by both VISION / TECS and MMIS. TPL information can be updated by either Medicaid staff or County staff with appropriate security.

2. System allows on-line inquiry to TPL Carrier File with access by carrier name and carrier number.

3. System maintains at least 60 months of historical information on third party resources for each eligible member.

4. System provides on-line inquiry to the Third Party Resource File with access by: recipient name and related ID number, policy number, Health Insurance Coverage number, coverage type, and SSN. Included is the ability to limit the search by other data elements.

5. System must identify all payments avoided due to TPL.

6. System must generate automated TPL recovery billings for recipients with Third Party coverage.

7. For automated TPL recovery billings, the system must include instructions for payment documentation with the billing. These instructions will stress:

- Requirement for payers to include the "unique tracking number" of individual recoveries on check
- Requirement to include payer contact information, in event of further questions/concerns

8. For automated TPL recovery billings, the system must assign and maintain unique tracking numbers to individual recoveries. These tracking numbers are expected to be provided by the Third Party payers on their recovery checks back to DHS.

9. When retroactive TPL is identified by the "date entered" field in VISION / TECS, the system must automatically adjust all claims that are dated after the eligibility start date and where the claim falls within the policy coverage period. A retroactive TPL change must initiate a work queuing process, where affected claims enter the queue for the appropriate automatic or manual adjustments that are necessary. DHS would identify what adjustments are simply "tracked" by the adjustment queue and which adjustments require manual intervention to resolve. Automatic adjustments of all affected claims only occur upon approval by the designated person or persons with this given authority.

10. For claims adjusted due to identification of Retroactive TPL, system can create complete lists of adjusted claims for further review.

11. Following estate settlement and receipt/posting of Estate Recovery payment, system generates "release of claim" against estate.

12. After receipt of TPL Recovery payment data (TPL dollars that have been paid against claims) from VISION / TECS, the system initiates the claims adjustment process. For partial payments, dollars must be attributed to claims from oldest to newest until the dollars are exhausted.

13. System must be capable of tracking estate recovery payments made by surviving spouses, whether or not they were paid from the estate.

14. The system must have a field within claims history that identifies total expenses accrued since the recipient's 55th birthday (or other date defined by the Department).

15. System notifies appropriate users if State hasn't received any follow-up from attorneys after claims on probates have been filed.

16. System allows creation of recipient records for surviving spouses, in order to cross-reference Vital Statistics records. These records will have no active eligibility.

17. System must generate the ANSI X12 270/271 Request / Response transactions, including the generation of unsolicited 270 transactions.

18. System must produce an ANSI X12 835 transaction for retroactive adjustments to paid claims when Third Party coverage is identified after payment.

19. System generates notification for TPL unit when TPL recovery payments are applied to claims.

20. System generates TPL billing that identifies number of calendar days to respond (e.g., 30 days for first notice, 45 days for second notice, etc.).

21. System generates billings identifying that the recovery claim has been forwarded to "collections".

22. System must generate TPL billing or produce an 837 Coordination of Benefits (COB) to send to any provider, insurer, attorney, recipient, etc.

23. System runs electronic TPL query for Medicare benefits.

24. For recipients that have TPL, system must edit to auto-deny or pend 837 claims when the provider has not made an effort to bill the Third Party.

25. System must generate TPL billing to providers that are no longer enrolled in North Dakota Medicaid. In these cases, claims are no longer submitted and therefore cannot be debited.

26. System maintains all third party resource information at the recipient-specific level, including, but not limited to:
    - Carrier name and code/identifier
    - Policy number and group number
    - Effective date of coverage and end date of coverage, if applicable
    - Add date, change date and verification date of insurance
    - Source of the insurance information Identifier
    - Type of verification of insurance identifier
    - Policyholder name, address, SSN, date of birth, relationship to insured, employer name and address
    - Specific information on types of services covered by the policy, as defined by the State
    - Medicare Part A and/or Part B
    - Medicare Managed Care plan
    - Medicare Supplemental plan
    - Drug Plan
    - TRICARE
    - Medicare Part D

27. Accept and process third party coverage information from all sources according to State-defined criteria and State-specified media.

28. System accepts and processes the monthly Medicare Buy-In records from CMS and applies Medicare coverage information to the MMIS.

29. System maintains an audit trail of all updates to recipient insurance data, including those updates that were unable to be applied.

30. For updates that could not be applied, the system maintains information identifying the reason for the failure and develops methods for resolving the failures.

31. System provides State staff with on-line update and inquiry access to TPL case tracking information and TPL accounts receivable.

32. System maintains multiple third party coverage information for individual recipients for any period of eligibility.

33. System ensures that Third Party coverage on recipient files properly interfaces for use in eligibility determination and verification, and claims processing for cost avoidance.

34. System ensures that Third Party coverage information on recipient files allows for accurate post-pay billing.

35. System must allow for on-line letter creation, generation, maintenance, modification, storage, and historical viewing of standard and ad hoc letters to recipients and their representatives, insurance companies, employers, providers, and other parties.

36. System accepts and processes electronic verification data from insurance companies and providers.

37. System updates the insurance and/or eligibility information on file as applicable, when the results of verification activities indicate that coverage information must be modified. These changes include adding, changing, or deleting insurance information and related eligibility.

38. System provides seamless integration and synchronization between the Member TPL profile and the general Member profile.

39. System supports an unlimited number of TPL policies for the Member TPL profile, past and present, including multiple concurrent profiles with a User-configurable hierarchy of utilization.

40. Assuming that a Trading Partner Agreement (TPA) is on file, the system identifies any discrepancies in TPL status using the HIPAA X12N 837 transaction to trigger X12N 270 eligibility inquiry transactions and, based on X12N 271 response transactions, updates the TPL status on file. If no TPA is on file, the system triggers a notification to the TPL unit.

41. System must merge third-party payer data and related benefit plan data based on User-configurable business rules and external business factors, including:
    • Purchase or sale of third-party payer
    • Merger between third-party payers
    • Assumption of liability by a third-party payer

42. System provides seamless integration between third-party payer profiles and benefit plan profiles with the capability to view specific service coverage.

43. System provides the capability to prevent any modification or deletion of any TPL, third-party payer, or other data that may conflict with recipient data.

44. System provides the means to conduct an automated "mass update" function, whereby an individual change can be attributed to all affected profiles.

45. System can identify potential Medicare Buy-In Recipients through a variety of approaches, including:
    • Data matching (e.g., with CMS, the Social Security Administration (SSA), and other agencies)
    • Internal data checks
    • Notices and correspondence to potential members, relationship entities, and other entities
    • Profile building of potential members

46. System will identify recipients who have dual eligibility and determine the appropriate cost sharing amounts for North Dakota Medicaid benefits.

47. The system will send a file to Medicare contractors identifying individuals as dual eligible (i.e., eligible for both Medicaid and Medicare) in order to indicate that a crossover claim should be generated.

48. System will automatically re-bill third-party payers based on user-configurable criteria including:
    • Accounts receivable aging periods
    • Time periods
    • Denial reason(s)
    • Payment amount(s)

49. System will automatically generate a notice of overpayment to a provider.

50. System must generate a claim to Medicare when a recipient is found to have Medicare coverage or an 837 COB claim.

51. System must generate hardcopy claim forms to support the TPL recovery process.

52. System must generate and distribute "pay and chase" notices.

53. System must identify the source of TPL information (e.g., VISION, 270 eligibility determination, etc.).

54. System must cross-reference insurance carriers to employers.

55. System must identify, open, and close recovery cases, including aggressively pursuing data matches with other insurers to identify recipient third party resources.

56. System must automatically link coverage codes on 837 and Direct Data Entry (DDE) claims to coverage codes that reside in eligibility files transferred from the State's eligibility system (VISION / TECS).

57. System accepts identification of "type of insurance coverage" for each policy - inpatient, outpatient, physician, pharmacy, dental, and all others.

58. System will produce computer-generated letters to recipients requesting additional information, including the specific types of coverage when a claim indicates a third party payment but there is no corresponding TPL resource record on the database.

59. System will allow for a mass update capability to update the TPL carrier data and corresponding TPL resource data when a TPL carrier changes its name, policy data, or other carrier data.

60. System will bypass TPL cost avoidance edits when service limits on the policy have been reached.

61. System edits claims against TPL coverage and applies TPL edits to the appropriate claim types and only to claims covered by the recipient's insurance coverage at the provider, recipient, service type, procedure code, and procedure modifier levels.

62. For certain drugs, even when TPL coverage exists, the system allows payment of the claim for that drug and will bill the third party insurer later. Subsequently, the system has the ability to create an 837 claim against a recipient's TPL coverage, if the State defined the initial claim as Pay and Chase.

63. The MMIS will share the TPL tables with the VISION / TECS systems. TPL records can be read and updated either from the VISION / TECS system (via the metadata layer) or MMIS.

64. The system will identify recipients who have Part D eligibility. Appropriate benefit reference tables will be built in the POS for cross-reference with recipient TPL, wrap-around data, and Dual Eligibility identification data to automate these claims.

7.2.2.2.2   Interfaces

The Interfaces for the Third Party Liability function are:

1. Interface with VISION in order to read the Department of Defense (DOD) TPL information that has been matched against the Defense Enrollment Eligibility Reporting System (DEERS) by North Dakota's Child Support Enforcement (IV-D) unit and subsequently update the necessary TPL information contained in MMIS.

2. Interface with VISION for shared TPL tables and coverage codes.

3. File interface with Workforce Safety and Insurance system for eligibility file matching. DHS needs the following information from Workforce Safety and Insurance:
   - Name, SSN, Recipient #
   - Diagnosis
   - Date & Type of Injury
   - Status (Open / Closed / Pending)
   - Claim #
   - Workforce Safety and Insurance Claim #
   - Related Medicaid identifying information for MMIS update

4. Vital Statistics.

5. Third Party Payers.

6.   Medicare Intermediaries.

7.   Attorneys.

8.   Counties.

9.   Claims processing records.

10. Insurance companies, via 270/271 transactions.

7.2.2.2.3   Inputs

The Inputs for the Third Party Liability function are:

1.   Recipient data from VISION, including demographics and third party insurance data.

2.   Payer data for billing purposes, including coverage information on Medicaid, various third party payers, and other healthcare providers. This data also includes carrier name, corresponding ID, address, and related contact information.

3.   Claim-related data, including:
     - Cost-avoided claims
     - Previously paid claims
     - Previously denied claims
     - TPL case data, including case status and case type (e.g., estate recovery)
     - Procedure, Drug, and Diagnosis data

4.   Eligibility match file from Workforce Safety and Insurance.

5.   Recipient's third party resource data.

6.   Monthly file from Vital Statistics indicating deceased individuals.

7.   BENDEX Data.

8.   Medicare Buy-In Data.

9.   Medicaid Eligibility Information.

10. Payment data from VISION.

11. Insurance Disclosure Files.

12. TPL will receive inputs from claims processed for payment in the form of third party payor data on the claims.

7.2.2.2.4   Outputs

The Outputs for the Third Party Liability function are:

1. Eligibility files for various TPL matches (e.g., DEERS).

2. Retroactive TPL claim adjustments for claims auditors.

3. The MMIS will create alerts reporting previously unknown TPL data.

4. Letters to recipients where claims have related trauma recoveries.

5. Listing of Insurance Carriers.

6. Written communication furnished to Insurance Carriers.

7. Third Party Queries to SSA for Medicare Coverage Information.

8. CMS-standard Medicare Buy-In files, at user-definable time intervals, for cases to pay and cases not to pay (no longer eligible) for the monthly Buy-In cycle.

9. Notices of overpayment to providers.

10. Pay and chase notices.

11. Recipient requests for additional TPL information.

7.2.2.3   WAIVERS AND SPECIAL PROGRAMS

7.2.2.3.1   Functional Requirements

The Functional Requirements for the Waivers and Special Programs function are:

1. The system must generate alerts when a waiver claim is being submitted for a non-authorized provider.

2. The system must generate an alert and notify the waiver program if the specific dollar amount or units are reached and future claims will not be paid.

3. The system must approve service authorization requests for waiver services up to a specific dollar amount.

4. The system must generate payments to waiver providers up to a specific dollar amount or units.

5. The system must accept a service authorization from a waiver provider with multiple recipients named.

6. Entry of a long term care screening form will trigger a process to verify living arrangement in the VISION / TECS system or the MMIS's Recipient subsystem. The system supports acceptance of long term care living arrangement verification from VISION / TECS or the MMIS's Recipient subsystem, and can alert DHS to create a long term care program record when the living arrangement verification requires the creation of the record. The system creates the appropriate alert for the assigned VISION / TECS worker to update the VISION / TECS records. If the living arrangement on record does not indicate long term care, an error message is created and the screening does not create a long term care program record.

7. The system must verify waiver claims against prior authorization criteria.

8. The system must identify individuals that have been pre-authorized for a waiver service.

9. The system must pre-populate Department-specified fields in claims forms for certain recurring claims (e.g., waiver claims).

10. The system must accept rates for waiver services including, but not limited to:
    - Individual specific rates
    - Provider specific rates
    - County specific rates
    - Program specific rates

    Rates must be specified for specific time period and be updateable by users without programming.

11. The begin and end dates of the special program record will be updated by changes in the related screening records.

12. The system must accept different start dates for different waiver programs for the same recipient.

13. The system must authorize waiver services for a specific time period (e.g., 6 months or one year).

14. The system must maintain screening records for each type of screening required. The current screening records include Long Term Care, Waiver programs and DD programs. The system will maintain templates for each type of screening and will include on-line entry for each screening type. New templates should be provided without reprogramming.

15. The system will accept batch updates to screenings from other systems in a standard format for each screening type.

16. Screening templates in the system can be user-maintained and are updateable without system programming.

17. The system must use screening data and eligibility data to create a special program record. Entry or update of eligibility and screening records will begin or end special program segments in the MMIS system. Which system events create which special program record would be a user-determined process and updateable.

18. Special program benefit packages can be maintained and updated by users without additional programming.

19. The system will support multiple non-conflicting special programs and eligibility records for a recipient for the same period of time. Only one special program record of the same type will be supported during any common period of time. Where multiple special programs exist for the same period of time, the benefit packages for the recipient will be considered cumulative.

20. The valid relationships between special programs will be maintained by the system, indicating which special programs are incompatible with other programs or eligibility categories. This set of relationships will be user maintained. Attempts to add an incompatible special program for a recipient with existing special programs will result in a suspended record and logging of an error. Windows will be available to allow users to correct the conflicts.

21. All waivers can be identified from screening files and defined as having participation in a special program. The benefits available from the waiver will be identified as the benefit package for the program that results from qualification in the screening.

22. The system will update service authorizations from screening records where the screening records indicate service levels. For example, passing a Long Term Care screening for a period of time will create authorization for that period. Where DD Screenings contain a service budget, the services indicated on the budget must be reflected in the authorization records.

7.2.2.3.2   Interfaces

The Interfaces for the Waivers and Special Programs function are:

1. MMIS will interface with ASSIST to receive Screening records for DD Services recipients.

2. MMIS will interface with VISION / TECS to obtain data on living arrangement and eligibility required to process screening records.

7.2.2.3.3   Inputs

The Inputs for the Waivers and Special Programs function are:

1. Data on eligibility and living arrangement will be read from VISION / TECS.

2. ASSIST will interface with MMIS to provide screening records on DD recipients.

3. Screening forms completed by Department staff will be used as input to qualify some MMIS recipients for services. The system must be able to accept screening information through on-line entry. These screening records must update the prior authorization records of the MMIS.

4. Waiver program screening files that are on-line or in batch programs.

7.2.2.4   EPSDT

7.2.2.4.1   *Functional Requirements*

The Functional Requirements for the EPSDT function are:

1. The system must automatically identify recipients who should be included in the EPSDT program. All children who qualify for EPSDT must be identified.

2. The system must send all recipients who qualify for EPSDT an initial notice describing the program and its requirements.

3. The system must initiate notices of an EPSDT examination due. The notices should go to the parent or guardian of the child and the PCP for the child, if one is on record. The notice must indicate the type of exam and the period that it is due.

4. The system must identify claims and encounters for EPSDT screenings and create a recipient EPSDT record that tracks EPSDT services received and indicates the screening requirement has been met.

5. If no claim for an EPSDT examination has been received in a period that is specified by users after the due date for the exam, follow-up notices to the parent or guardian and the PCP are generated by the system and sent. The notice will specify the type of exam, the due date and the number of days past due. The notice will be repeated at user specified intervals for a user-specified duration. The rules must be updateable without additional system coding.

6. The system must indicate diagnoses found as result of the screenings, as received on claims for the screening services.

7. The system must identify referrals that are made as a result of an EPSDT screening, using claims and encounter data as sources of data.

8. The system must produce reports to track conditions identified as a result of EPSDT examinations, and track referrals made as a result of the EPSDT examination to determine whether the referral resulted in service delivery.

9. The system must provide reports regarding compliance rates with EPSDT screening requirements. The report must indicate overall compliance rates, compliance rates by type of managed care program and FFS settings, and compliance rates by MCO and PCP.

7.2.2.4.2   Inputs

Inputs for the EPSDT function include, but are not limited to:

1. VISION Demographic and Eligibility data.

2. Screening and service data from claims records.

7.2.2.4.3   Outputs

Outputs for the EPSDT function include, but are not limited to:

1. Production of EPSDT notices to recipients who are eligible for EPSDT, notices regarding conditions identified in screenings and follow-up services available, and notices of past due screenings or follow-up required.

2. Management report showing the level of compliance with EPSDT requirements.

7.2.2.5   RECIPIENT LIABILITY / CO-PAYMENT

7.2.2.5.1   Functional Requirements

The Functional Requirements for the Recipient Liability / Co-payment function are:

1. MMIS will read recipient liability data from the respective systems for all recipients in the MMIS Master ID index where Recipient Liability is indicated. Ideally, MMIS must share recipient liability tables with at least the VISION / TECS systems. These tables would be read and updated from either system by users with appropriate security.

2. When a claim is denied payment or partially paid because of recipient liability, the billed amount or unpaid amount will be identified as a recipient liability payment for the claim.

3. Recipient Liability for each claim will be used by MMIS to update the VISION / TECS RL amount for the month. The system will generate an on-line listing of RL amounts identified for each recipient and research and updating capability on a window used to update the RL in VISION / TECS. The user will view the records and choose to update or bypass the RL with that record.

4. The system must support manual updates to RL from the MMIS System.

5. The system must display the history of RL for each RL period as defined by MMIS staff. This history must include the original RL amount, claims applied to the balance, source of the claim, amount of the claim and the remaining balance for the account.

6. The system must process adjustments in claims that have been applied to RL and adjust the RL account as indicated by the claim adjustment.

7. The system will link recipients of the same household to determine recipient liability (if one person in household has met threshold, recipient liability from one person can be applied to others in the household). The relationship between household members determines recipient liability obligations between members.

8. The system must create a hierarchy to determine which claims should have recipient liability deducted, based on State rules (e.g., specific providers and or services, eligibility criteria, or procedure code). The system must also either pend the claim or bypass recipient liability and pay the claim.

9. The system accepts and deducts various forms of recipient cost sharing and other deductibles including, but not limited to: recipient liability, recipient spend-down, and co-payment on applicable claim records.

10. The system must accrue recipient liability payments on paid claims until a State-defined limit has been met.

11. The system applies recipient co-payment amounts based on, but not limited to, the following parameters: type of provider, diagnosis codes, place of service, procedure code, dollar amount of co-payment and number of services, as well as the ability to identify exclusions for co-payments.

12. The system automatically deducts recipient liability amount based on the lesser of amount shown on claim or data on recipient file.

13. The system automatically deducts, from the appropriate provider's claim, remaining spend-down which may exist for an individual.

14. The system deducts either the provider reported or recipient database liability amounts from all claims, tracking remaining balances and provide the capability to invoice recipients for the remaining monthly amount due (as directed by the State).

15. System deducts applicable recipient co-payment for services and recipient groups, according to the co-payment policy set by the State.

16. The system deducts applicable recipient cost sharing amounts for services and recipient groups according to the State-defined policy.

17. System deducts recipient liability and co-payment, as appropriate, during claims adjustment processing.

18. System deducts recipient deductible and/or spend-down amounts from claims and track remaining balances using the RL table shared with VISION / TECS. This may result in moving from one level of recipient contribution and claim reimbursement to another.

19. The system excludes federal and State-defined recipient groups or specific services from the co-payment requirement (e.g., nursing home residents, pregnant women, family planning services etc.).

20. The system must allow for Recipient Responsibility to be assigned in the MMIS Recipient subsystem for programs other than where Recipient Liability is tracked in VISION / TECS. The system must have the same functionality as provided by Recipient Liability tracking functionality in VISION / TECS (i.e., tracking, adjustments, etc.).

21. The system maintains any recipient cost sharing amounts on the claims history record.

22. System must process recipient cost sharing (e.g., co-payments, LTC patient liability) on any service specified by the State using a fixed amount or percent of charges.

23. System processes retroactive changes to recipient cost sharing and/or recipient contributions and adjusts claims affected by the retroactive change.

24. The system provides the State with on-line access to recipient cost sharing data.

25. The system must track recipient cost sharing and co-payments by time or by amount, as defined by the State.

26. The system tracks recipient cost sharing and/or recipient contributions both timely and accurately to maintain the integrity of this aspect of program policy and operations.

27. The system must deduct recipient co-pay for recipients participating in the DD waiver program who do not meet Medicaid eligibility or level of care requirements, according to policy established by DHS.

28. The system must post Recipient Liability information back in to the shared recipient liability tables, in the case of an adjustment.

7.2.2.5.2   Interfaces

The Interfaces for the Recipient Liability function are:

1. Recipient liability is read from VISION / TECS (or other non-Medicaid programs' systems), including the recipient's name and program-specific ID (e.g., Medicaid ID), liability type, period, liability amount and amount applied for each period.

2. Real-time interface with VISION / TECS to read and update the Recipient Liability records. The system potentially accommodates a read and update interface for other non-Medicaid programs, if the Department so decides.

7.2.2.5.3   Inputs

The Inputs of the Recipient Liability function are:

1. VISION / TECS provides Recipient Liability data to MMIS, including the recipient name and Medicaid ID, liability type, liability amount, begin and end dates, and amount applied to date.

2. MMIS Claims data.

7.2.2.5.4   Outputs

The Outputs of the Recipient Liability function are:

1. Recipient Liability updates/adjustments to VISION / TECS.

7.2.3   DATA MANAGEMENT

It is the Department's intent that, to the greatest extent possible, data management should be table-driven. This will allow the Department to quickly accommodate policy and rule changes, and make it easier and less costly to implement enhancements. The Data Management functionality will maintain and support the management of all reference data used by the system, as well as maintain rates to be paid for services.

The functional requirements, interfaces inputs and outputs below address the following areas within Data Management:

- • Rates and Fee Schedules
- • Edits and Audits
- • Data Maintenance and Updates

<u>*Bidders' Note:</u> The edits, audits, and pricing methodologies described in this RFP must not be considered an exhaustive list.

7.2.3.1   RATES AND FEE SCHEDULES

7.2.3.1.1   Functional Requirements

The Functional Requirements for the Rates and Fee Schedules function are:

1. System must test rates against previously paid claims to support analysis activities such as impact analysis or fair market rate analysis.

2. System must compare encounter data claims and capitation fees vs. fee-for-service payment data to determine best utilization and payment scenarios.

3. System must systematically generate rate schedules that are a percentage of a base rate.

4. System must calculate rates utilizing various rate setting methodologies, while providing the ability to manipulate factors in the calculation, as defined by the user.

5. System must maintain a history of any rate for processing adjusted claims outside the current rate period and for various types of analysis (e.g., supporting rate projections).

6. System must determine rates based on user-defined calculations (e.g., variable monthly rate based on a provider's annual allocation and usage).

7. System must be capable of capturing provider cost information and using provider cost reports to assist in the rate setting process.

8. The system must include software utilizing a case mix system that sets payment based on the resources that are expected to be used to care for a resident. This methodology must also be based on the functional support requirement and medical needs of each resident.

9. If an inflation factor is set on provider rates, the system must update the rates by the specified criteria (program, provider type, procedure). The file must have an open ended effective date for the rate changes, and must display the actual rate, not the original number plus the inflation factor.

10. System must automatically update provider rate tables through an electronic means (e.g., Excel, ODBC database).

11. System must accept an electronic file from a third-party entity that contains pricing information to assist in rate setting.

12. With proper security authorization, the system must allow for on-line updates to accommodate rate changes.

13. With proper security authorization, the system can update any previous rates per DHS request at any time. Any previous rate and time periods may be selectively changed. The proposed system must reprocess all claims affected by the retroactive change through an automated mass adjustment system.

14. All rate change transactions are edited for validity and are subject to on-line audit trail, control totals and balance inquiries.

15. Where the rate change affects a group of providers (e.g., all pharmacies, all SNFs), the change will be made through a mass update by the system.

16. System maintains multiple provider specific reimbursement rates with begin and end dates including:
    (a) Case mix
    (b) Preferred provider agreements
    (c) Volume purchase contracts
    (d) Other cost containment initiatives

17. Accumulate and track all payments made for recipient services covered under the contract or covered under specific program limitations.

18. The system must calculate or apply rates for any rate-setting methodology based on a constraint of budget neutrality.

19. Develop and maintain a conversion table of ICD-9-CM diagnosis and procedure codes to enable hospitals to bill using the most current diagnoses and procedure codes to support DRG pricing.

20. The system must maintain a DRG data set that contains (at a minimum), by peer group, facility, and effective date:
    - DRG number
    - DRG description
    - DRG base rate
    - DRG outlier rate

21. The system must update code sets electronically using X12 841 HIPAA Related Code Lists transaction.

22. The system must acquire the Medicare Fee Schedule (including the lab fee schedule) and update the Medicare fee schedule annually to ensure conformance with federal requirements regarding Medicare pricing. The system must also capture the Medicare allowed amount for each service in the procedure file.

23. Develop and maintain a file to meet the objectives of the State's prospective payment systems including DRGs and support accurate PPS code assignment.

24. Factor in the following for neonatal DRGs, and provide the flexibility to add other factors, as needed:
    • Birth weight
    • Operating room procedures
    • Transfers
    • Ventilator-dependent days of care

25. Identify specific and non-specific diagnosis codes to support accurate DRG assignment.

26. Maintain multiple nursing facility (long-term care) rates, per provider.

27. Distinguish and identify interim and final nursing facility (long-term care) rates, per provider.

28. Accept and electronically update rate changes, authorizations, etc. from the State's audit agent or other State contractors.

29. The system must capture any other payer-allowed amounts for each service in the procedure file.

30. The system must update DRGs automatically when the DRG grouper is updated each October. The same process must occur for Ambulatory Payment Classification (APC) rates as with the DRGs.

31. Acquire and maintain current and historical procedure codes using the HCPCS, Current Procedural Terminology, Version 4 (CPT-4), Current Dental Terminology (CDT), and International Classification of Diseases 9th Edition Clinical Modification (ICD-9-CM) procedure codes.

32. The system must obtain and update all form locator elements (including revenue codes, discharge codes, and admission codes) with updates received from the National Uniform Billing Committee.

33. The system must accept a file from the State's MDS application and use the data to determine the appropriate payment for a Long Term Care recipient.

34. The system must maintain the Reference data that supports claims edits, audits, and pricing logic in accordance with State policy. The application of these policies is subject to change.

35. The system must pay different rates to any hospital that qualifies as both an "acute care hospital" and as "rehabilitation, drug and alcohol, or psychiatric units of acute care hospitals".

36. The system must calculate the Disproportionate Share Hospital (DSH) payment for hospital claims.

37. The system must maintain rates for the State Human Service Center financial system, known as the Regional Office Automation Program (ROAP).

38. The system must upload Nursing Home rates from MDS.

39. The system maintains a DRG file to use in pricing inpatient hospital claims. Seven (7) years of data must be maintained. The DRG file will contain, at a minimum, elements such as:
    - DRG code
    - English translation of code (DRG description)
    - Add date
    - Begin date
    - End date
    - DRG weight (relative value)
    - Outlier Days (low and high days)
    - Audit trail
    - Average length of stay

40. The system provides an automated process to acquire Medicare Pricing Profiles, and ensure conformance with federal requirements regarding Medicare pricing. Certain procedures cannot be reimbursed at an amount greater than Medicare's allowed amount.

41. The system maintains date-specific pricing segments, including a pricing action code for each segment.

42. The system provides parameters to allow the same procedure code to be priced differently based on age of the recipient.

43. The system maintains the following hospital-specific inpatient rate data, by effective date(s):
    - DRG rate
    - Percentage factors
    - Outlier threshold
    - Retroactive adjustment indicator and date

44. The system accommodates multiple inpatient hospital reimbursement methodologies including DRG, per discharge/visit, per diem, percent of change, peer group level of care for inpatient hospital care.

45. The system maintains pricing data based on:
    - Fee schedules by benefit package
    - Provider-specific usual and customary charges
    - Procedure modifiers [e.g., Durable Medical Equipment (DME)]
    - Per Diem rates
    - DRGs
    - Capitation fee for prepaid health plans or case manager services
    - Multiple-level dispensing fee for drugs (e.g., compound, enhanced, repackaging allowance, etc.)
    - Enhanced pricing [e.g., dental pediatric incentive, Health Professional Shortage Area (HPSA) pricing]
    - Maximum Allowable Cost (MAC), Estimated Acquisition Cost (EAC), Average Wholesale Price (AWP), AWP minus ten percent (10%), and direct pricing for drugs
    - Case-mix rates for LTC (in addition to facility-specific per diem rates by level of care)

46. The system maintains incentive pricing modifiers, as specified by the State.

47. The system accommodates multiple outpatient hospital reimbursement methodologies, including outpatient prospective payment, per discharge/visit, percent of charge, and FFS procedure code prices for outpatient hospital care.

48. The system must maintain reimbursement rates and effective date spans for procedures. The capability must exist to retain multiple reimbursement rates (dollar amounts and/or percentages, if appropriate) and effective dates for any single provider; any group of providers within a single type, benefit package, specialty, or locality combination; or all providers. The system must allow the effective dates of the pricing segments to be updated according to the date of service or date of adjudication as specified by the State.

49. The system must maintain information that allows procedures to be automatically priced according to State-defined rates and effective dates.

50. The system must transmit pricing files to the MCOs, providers, and County programs electronically.

51. The system must generate pricing data listings on State-specified media using selection parameters specified by the State.

52. The system must provide for inpatient hospital pricing methodologies including but not
    limited to:
    - DRG grouping
    - DRG with outlier, if an outlier is applicable
    - Per Diem
    - Days eligible
    - Percentage of charge
    - Any other method specified by the State

53. The system must determine which hospitals are DSH hospitals.

7.2.3.1.2   Interfaces

The Interfaces for the Rates and Fee Schedules function are:

1. Inbound Interface; Level of Care data from CMS MDS used for Nursing Home payments via
    RUG.

2. Inbound Interface; MDS data from the State's MDS application.

7.2.3.1.3   Inputs

The Inputs of the Rates and Fee Schedules function are:

1. DRG annual update, using the 3M grouper.

2. CPT-4 and HCPCS Procedure Codes.

3. CDT Codes.

4. ICD-9 Diagnosis Codes.

5. Relative Value Units (RVUs).

6. Medicare Fee Schedule.

7. Ambulatory Payment Classification (APC).

8. Cost information from providers.

7.2.3.1.4 Outputs

The Outputs of the Rates and Fee Schedules function are:

1. North Dakota Medicaid fee schedule available on Web and downloadable into distributable format.

7.2.3.2 EDITS AND AUDITS

7.2.3.2.1 Functional Requirements

The Functional Requirements for the Edits and Audits function are:

1. The system provides rules-based edits and audit tables to define claims processing rules. The tables must be updateable by users without system coding.

2. The disposition required for each edit and audit (including pass, suspend, and deny) must be specified in tables that can be updated by users without system coding. The disposition must also include a logical "location" and status that can be updated by users without system coding.

3. The claims processing system must have a workflow management system component that defines status and logical locations for each claim based on edit and audit rules. Access to logical locations must be defined for each claims processing staff member, and the claims must display in the order of data entry or location entry as specified by users. The claims must automatically populate the user's desktop.

4. Claims must immediately be edited and audited upon data entry. After changes to the claim data, or at the request of a user, the claims must re-enter the edit and audit cycles.

5. The data used and a description of each edit and audit must be available to users as part of on-line help functionality.

6. The system must allow users with appropriate security to override standard edit and audit dispositions, forcing a claim to pay or deny regardless of the normal disposition. The override of standard disposition should require an explanation and audit trail to identify the user who created the override.

7. The system must support the integration of commercial off-the-shelf (COTS) software for editing and auditing. The system must include functionality to perform sophisticated claims editing and auditing against historical and current records to identify incidences of improper coding. These checks include, but are not limited to: the detection and correct processing of bundled/unbundled procedures, duplicate claims and procedures, new visit frequency edits, incidental procedures from surgical procedures, pricing of multiple surgeries and multiple modifiers, assistant and co-surgeon reductions, mutually exclusive procedures, diagnosis to procedure editing, cross provider editing, re-bundling of procedures where procedure codes have been billed separately, pre-operative and post-operative services

which should be included in the global surgery procedure, application of AMA guidelines, and checks for convenience items. The system must be able to perform this claims editing line by line in either real-time or batch. The system must have the functionality for the State to modify and customize audits according to State standards.

8. Edit and audit all claims data in accordance with State and federal requirements. The edit and audit tables must be easily modified to accommodate new State and federal requirements.

9. For each edit and audit failure, a reason code and precise description of the reason for failure must be associated with the edit or audit. This reason code and description must be listed on the remittance advice and any correspondence related the failure.

10. The system must perform all possible edits and audits during each pass. Editing should not stop because a failure is encountered. However, interdependency of edits must be tracked and edit results dependent on prior edits must be suspended. The disposition of the claim line item will be the most severe of all edits and audits failed. If three edits are failed, two with suspend dispositions and one with Deny disposition, the overall claim line item disposition must be set to deny. The location of the claim will be the lowest level of the edits and audits failed.

11. As first step in editing, ensure that the syntax of all fields is correct.

12. Ensure that all fields required for the claim type and form type are complete and valid.

13. Edit each claim to ensure that the provider was enrolled and qualified to provide the billed service on all dates of service. This includes that the provider and provider location had all required licenses and certifications needed to provide the service. This would include CLIA certification. License, certification and other qualification requirements must be maintainable by users without additional coding.

14. Provide control parameters to ensure that all required attachments for the service(s) provided to a recipient has been received.

15. Edit to ensure that the recipient is eligible on all dates of service and that the service billed is included in the recipients benefit packages. Multiple benefit packages may exist if the recipient participates in multiple programs.

16. Perform edits to ensure that the service billed is valid for the recipient's age.

17. Edit to ensure that the service billed is appropriate for the recipient's gender.

18. Edit to determine whether the claim requires medical review.

19. MMIS must perform edits to ensure that prior authorization is present when required. If a prior authorization number is entered, the system must confirm that the number represents a valid and current prior authorization. Edit the units, days supply, claim amount and dates of service against the final authorization, taking into account any cutbacks.

20. Edit to ensure that claims and adjustments have been submitted in accordance with DHS timely filing limits.

21. Edit to ensure that the diagnosis on claims are present, valid and covered by the State program being billed.

22. Edit to ensure that diagnoses entered on a claim are consistent with procedures billed.

23. The system must edit to ensure that claims submitted for Coordinated Services Program recipients have the correct provider number or their designee.

24. The system edits claims for recipients enrolled with PCPs to ensure that the service provider is the PCP or a designee, or that authorization has been received from the PCP or designee.

25. Edit billing provider to ensure that the servicing provider is part of the billing group.

26. Edit billing, attending, servicing, referring and prescribing provider to ensure that all are valid for the State program being billed.

27. Edit nursing home claims to ensure the correct level of care and that the living arrangement and screening support the claim information.

28. Edit hospital claims to ensure that the bill type is correct and that the admit dates and discharge dates are consistent with the authorization.

29. Edit and audit claims to ensure that the billed units and amount do not exceed service limits. This includes cumulative levels from prior claims for the recipient over the period defined for the service limit.

30. If a service exceeds limits on dollars or units, the system must perform cutbacks to the level consistent with the service limits.

31. Edit outlier claims to ensure payment in accord with State policies.

32. Edit provider, services, and dates of service to identify duplicates and potential duplicate claims. Near duplicate claims would include claims with similar services or modifiers or the same service provided by members of the same group or network.

33. The system includes edits and audits to detect potential fraud and abuse, such as bundling/unbundling of services, medically unnecessary services, overuse of services, or cross-referrals.

34. If the recipient has other insurance or Medicare, the system must edit to ensure that the other payers have been billed. This includes:
    - Medicare Parts A, B, and D
    - Court ordered medical support
    - Private insurance
    - Workforce Safety and Insurance
    - Accident or liability insurance

35. If the recipient has no other insurance listed in the TPL files, but the claim indicates insurance or Medicare, the system must create an error exception that allows users to easily access the claim for evaluation and possible updating of the shared TPL file.

36. Maintain an on-line audit trail to display all edits and audits failed by the claim and the disposition of each. The audit trail must include all changes to claims and the source of the change.

37. The system must provide inquiry to claims based on the Provider ID, Recipient ID, Received Date, Service Date, Diagnosis, Procedure, ICN, Claim Status, Edit Location, and Override Status. The system must provide a listing of claims that match the criteria and allow the user to view the detail of each claim and the audit trail of failed edits and audits and overrides and disposition.

38. The system must provide real-time on-line suspense resolution capability for State staff. The system must support accessing claims based on the claim search criteria or based on status and location.

39. The system must provide Web-based access to claims for updating and adjustments. Providers, or their designated representative, must be able to search based on Provider ID, Recipient ID, Dates of Service, Dates Submitted, Procedure Codes, Claim Status, Diagnosis Codes, and ICN. The provider must be able to view the list of claims that meet the criteria, and then view the detail and the audit trail for each claim. They must also be able to update the claim detail, add documentation or attachments, and resubmit the claim for editing and auditing. In addition, the provider must be able to logically delete the claim, resulting in a denial status.

40. Maintain on-line claim correction screens to update claim information.

41. Maintain the original claim as submitted prior to any changes by State staff.

42. The system must verify that any providers who are billing for the administration of vaccines are participants in the Department of Health's (DOH) Immunization Program and that the service criteria (e.g., child's age) are satisfied.

43. The State must generate an unsolicited 270 to request data on insurance coverage for a recipient.

44. The system must allow State users to electronically notify providers (e.g., via e-mail or Web bulletin board) that additional information is necessary for a claim.

45. The system must provide a user-defined period for a provider to respond to a suspended claim. At the end of the period, if the provider has not responded, the claim must automatically deny.

46. The system must support standard relational edits, including:
    - Revenue Code to Bill Type
    - Procedure to Diagnosis
    - Line and header dates

47. The system must edit the status of provider and recipient on the claim to ensure that neither is on review or has a status that requires action.

48. Edit claims to ensure that the Recipient ID and name on the claim match the name for the same ID in the system.

49. Ensure that all Provider IDs and names on the claim match the corresponding provider names in the system.

50. The system must edit claims to ensure that recipient spend-down has been met. Any recipient liability must be included in adjudicating the claim.

51. The system must generate audit trail reports for all data sets showing before and after images of changed data, the user ID of the person making the change, and the change date and time.

52. The system must identify all applicable edits and audits for claims that fail processing edits.

53. Develop and maintain tables to indicate whether services always require prior authorization or after State defined thresholds are met.

54. The system must identify surgical procedures subject to, or exempt from, multiple surgery reimbursement cutbacks.

55. The system must maintain, update, and display on-line, an edit/audit criteria table to provide a user-controlled method of implementing service frequency, quantity limitations, and service conflicts for selected procedures (including revenue codes, accommodation codes, etc.) and diagnoses.

56. The system must maintain a user-controlled claim edit disposition file with edit disposition information for each edit used in claims processing, including the disposition (e.g., pay, suspend, claim correction form, deny, inactive), by submission medium (e.g., paper, EDI), within claim type and by eligibility program (e.g., waivers, State-funded programs, etc.). For each error, maintain the description of the error, Explanation of Benefits (EOB) codes, and edit recycle times and frequency.

57. The system must maintain "negative" audit relationships (e.g., do not pay for procedure unless another procedure code was paid during a specified time) on-line.

58. The system must maintain date-sensitive parameters to edit claims against all historical claims for the same recipient on the edit/audit criteria database.

59. The system must maintain positive and negative data relationships. The types of relationships shall include, but not be limited to: procedure to provider and specialty(ies), procedure-to-procedure, procedure to diagnosis, procedure to recipient age, and procedure to recipient gender.

60. The system must generate a monthly report, which identifies all new edits and audits introduced during the month.

61. The system must provide on-line capability to test and estimate the effect of new or modified edits and audits prior to their use in claims processing, and to retrospectively analyze the effect of new or modified edits and audits after they are implemented.

62. The system must perform automated audit processing using history claims, suspended claims, in-process claims, and same cycle claims.

63. The system must identify global procedures and prevent payment of services included under the global procedure.

64. The system must audit claims against defined service, policy, and payment parameters in accordance with the North Dakota MMIS plan and established State and federal guidelines.

65. The system must maintain an on-line audit trail for each claim record that shows each stage of processing, the date the claim entered each stage, and any edit/audit codes posted to the claim at each step in processing.

66. The system must provide, for each edit/audit code, a resolution code, an override, force or deny indicator, and the date that the error was resolved, forced, or denied; forced claims must carry the user ID of the operator, to provide a complete on-line audit trail of processing. These data elements must be carried on the claims history record to support provider and claims processing audits.

67. The system must change and maintain history of the beginning and end dates for each edit/audit, per State guidelines.

68. The system must edit all required data elements for presence and validity on all claims, according to State approved design specifications.

69. The system must identify all of the applicable edit/audit codes for each detail level and at the header level.

70. The system must identify and track all edits and audits posted to the claim in the entire processing cycle.

71. The system must edit to ensure that all required attachments are present.

72. The system must identify applicable error codes for claims that fail edits.

73. The system must edit to ensure that claims submitted for recipients assigned to a specific provider under the Coordinated Services Program are either billed by the assigned provider or performed by the assigned provider, or that the assigned provider is present on the claim as the referring physician.

74. The system must provide the capability to edit claims for recipients in long term care facilities to ensure that services included in the LTC payment rate are not billed separately by individual practitioners or other providers.

75. The system must provide flexible, expandable, user-friendly, on-line edit/audit tables for defining claims processing rules and edit/audit disposition codes in accordance with State health care and County waiver program policies and procedures. The MMIS must accept an unlimited number of edits/audits and updates to them.

76. The system must edit billed charges for outliers and report impacted claims to the State.

77. The system must edit and suspend claims requiring prepayment review.

78. The system must edit to ensure that diagnosis and procedure codes are present on Medicare crossover claims and all other applicable claim types.

79. The system must provide the capability to apply edits based on provider type, provider specialty, category of service, recipient eligibility code, program, plan, reference or other data to provide more flexibility in application of the error codes. Provide on-line access to the edit table for research and update of the edit criteria.

80. The system must calculate and recoup payments made for services that exceeded the original authorized units/dollars/services in cases where an appeal was filed and the appeal was denied.

81. The system must verify that services performed are consistent with State policy and medical criteria.

82. The system must edit and report travel claims for recipients who travel but do not have medical services during the period of approved travel.

83. The system must edit to ensure that a valid insurance or Medicare indicator exists on the eligibility file if insurance or Medicare is indicated on the claim.

84. The system must perform Service Plan Edits, including the following:
    a.) Recipient ID
    b.) Multiple providers (A or B or C, 12-14 providers)
    c.) Open end dates
    d.) Longer durations
    e.) Multiple service codes allowed

85. The system must perform Provider edits, including the following:
    a.) Enrollment
    b.) Program specific enrollment
    c.) PCP to Group
    d.) Specialty to Service (Report only for MDs)
    e.) Provider Type to Service
    f.) On-review status
    g.) IHS facility status
    h.) Provider name / matching Provider ID number (*potentially optional)
    i.) Persons who are related to recipient cannot provide transportation services
    j.) Providers association with clinics/group (*potentially optional)
    k.) Privileges (such as hospital admitting privileges)
    l.) Ownership

m.) CLIA
n.) Referrals

86. The system must establish relationships between providers and procedures or services for which they are authorized to bill and be paid.

87. The user must be able to set each edit on or off and establish disposition by State Program, such as Title XIX, DD Services, Aging Services, etc.

88. The system must edit data elements of the claim record for required presence, format, consistency, reasonableness, and/or allowable values.

89. The system must incorporate the CON process in the PA process (e.g., LTC, Waivers, Children<21, inpatient psych) along with the screening process used for different services (e.g., HCBS services, DD Waiver, TBI, etc.). The system must have the capability to also handle case management, level of care, assessments, etc. This would include care coordination, continued stay reviews, and pre-certification. The system must have the case management capabilities to include services such as schedule recipient appointments, tracking of recipient information, tracking of progress notes, treatment plans, goal tracking, etc. The hierarchy and definition of conflict must be maintainable by the users.

90. The system must perform all standard bundling and unbundling edits.

91. The system must support the receipt of quarterly updates of the Correct Coding Initiative (CCI) edits from CMS.

7.2.3.2.2   Inputs

The Inputs for the Edits and Audits function:

1. The system must support entry through scanning and OCR for Claims submitted in Paper. The OCR process must include verification of key fields.

2. The system must provide input windows to data enter paper claims that cannot be interpreted through OCR. The windows must include syntax editing and verification of required fields.

3. The system must accept claims in the HIPAA 837 format and update the claims database. The system must include 837 compliance verification at the front-end, and conduct syntax edits and edits of required fields prior to accepting transactions for input. Transactions that do not pass minimum compliance levels as defined by State users will be rejected or denied.

4. The system must accept quarterly updates of the Correct Coding Initiative (CCI) edits from CMS.

7.2.3.2.3   Outputs

The Outputs of the Edits and Audits function are:

1. The output of the editing and auditing processes will be adjudicated claims and suspended claims.

2. At the Department's discretion or the provider's request, the edit/audit process will generate a supplemental file to inform providers regarding suspended claims. The report must include the ICN, provider reference number, provider name, Provider ID, recipient name, MMIS ID and/or program-specific ID (e.g., Medicaid ID), service dates, procedures, diagnoses, and all edit and audit exceptions with the exception code and description. This report must be available in paper or electronic format at the discretion of the provider. The electronic version must be sent as an attachment with the HIPAA 835.

7.2.3.3   DATA MAINTENANCE AND UPDATES

7.2.3.3.1   Functional Requirements

The Functional Requirements of the Data Management function are:

1. The system must accept on-line and automated updates, additions, and deletions by tape or electronic transmission to all Reference files, with the ability to make changes to individual records or mass changes to groups or classes of records (e.g., across provider type and specialty).

2. The system acquires and maintains current and historical procedure codes using the ICD-9-CM diagnosis codes.

3. The system must perform on-line updates and provide on-line inquiry to the edit/audit criteria and disposition tables.

4. The system must provide the State with on-line inquiry capability to all current and, at a minimum, seven (7) years of historical data in Reference files, as requested by the State.

5. The system must perform on-line, real-time updates to reference files upon request by the State.

6. The system must maintain current and historical Reference data, assuring that updates do not overlay or otherwise make historical information inaccessible.

7. The system must maintain and update Reference file data for HIPAA mandated code sets not otherwise specifically listed in this RFP.

8. The system must maintain the ASA anesthesiology codes on the procedure code data set, and use them for pricing anesthesia services provided by surgeons, anesthesiologists, and other provider specialties.

9. The system must maintain date-sensitive CLIA and mammography certification data.

10. The system must support on-line inquiry capability to CLIA and mammography certification data.

11. The system must provide update capability for CLIA and mammography information using CMS supplied data.

12. Ensure that reference files incorporate all appropriate MMIS code changes and updates.

13. System defines and enforces the use of appropriate procedure coding scheme (e.g., HCPCS, ICD-9-CM, CDT) and/or diagnosis coding scheme [e.g., ICD-9-CM, Diagnostic and Statistical Manual of Mental Disorders (DSM)] based on parameters such as claim type, provider type /specialty, place of service, or service rendered.

14. The system must support and maintain review indicators for procedure, diagnosis and revenue codes and allow definition of review parameters such as claim form and Provider ID.

15. The system must generate listings of the procedure, diagnosis, drug, DRG, revenue code, medical criteria, and other files based on variable, user-defined select and sort criteria, with all pertinent record contents on one (1) listing.

16. The system must maintain diagnosis files that will contain, at a minimum, elements such as:
    - Appropriate Age Range
    - Appropriate Gender
    - Begin use date
    - End use date
    - Add date
    - Audit trail
    - Emergency indicator
    - Trauma indicator
    - Description of the diagnosis
    - Sterilization indicator
    - Family planning status
    - Primary and secondary diagnosis code usage
    - Review indicator
    - Indicators associated with selected parameters to designate whether they should be included, excluded or disregarded in claims/encounter processing

17. The system must allow access the error text file by claim type and other data that limits application of error codes (e.g., original or adjustment claim, hard copy or electronic claim).

18. The system must maintain date-sensitive data on error codes, error code descriptions, and status by claim type, media, and original claim vs. adjustment on the error text database.

19. The system must generate and distribute provider-specific fee schedules to providers, upon the request of the State or a provider.

20. System data fields must be large enough to accommodate industry standard sizes (e.g., currency fields, quantity fields, etc.).

21. The system must maintain flexibility in the procedure file to accommodate the implementation of ICD-10-CM or any later version at no additional cost to the State.

22. The system must allow word searches on procedure data, including drug codes, procedure codes, diagnosis codes, and procedure modifiers.

23. The system must perform mass updates to pricing data.

24. The system must maintain a procedure code file that will be used to ensure that claims for related procedures are not paid on the same day for the same individual. The file includes but is not limited to:
    - Related procedure or mutually exclusive code numbers
    - Complete narrative description of procedure codes
    - Modifiers
    - Multiple spans of begin and end dates
    - Audit trail
    - Add date

25. The system must identify the type of co-pay applied to the procedure (e.g., unit, occurrence, days, length of stay, etc.).

26. The system must provide and maintain a mechanism that enables the State to identify parameters for which a procedure may be performed.

27. The system must identify rendering provider types and specialties that collect co-payments from recipients or are excluded from the co-payment requirements in the on-line procedure code file.

28. The system must track changes to Reference files using on-line notes capability.

29. The system must generate an on-line report that details Reference file updates and the directives that initiated them.

30. The system must maintain revenue code files with a data set that contains, at a minimum, elements like:
    - Maximum revenue code history with a minimum of seven (7) years after the code end date of date-specific pricing segments, including, effective begin and end dates, and allowed amount for each segment
    - Maximum revenue code history with a minimum of seven (7) years after the end date of status code segments with effective begin and end dates for each segment
    - Numerous parameters used in claims processing including but not limited to: provider type, specialty, sub-specialty, lab certification, recipient age/gender restrictions, PA required, claim type, diagnosis, units of service, and review indicator
    - Indicators associated with selected parameters to designate whether they should be included, excluded or disregarded in claims processing
    - Complete narrative descriptions of revenue codes

- Indication of TPL actions, such as cost avoidance, benefit recovery or pay, by revenue code
- Indication of non-coverage by third party payers
- Information such as accident-related indicators for possible TPL, federal cost-sharing indicators, Medicare coverage, and allowed amounts

31. The system must maintain a diagnosis file of medical diagnosis codes utilizing the three (3), four (4), and five (5) character ICD-9-CM coding system, which can maintain relationship edits for each diagnosis code, including:
    - Age
    - Sex
    - Place of service
    - Prior authorization
    - Inpatient length of stay criteria
    - Description of the diagnosis
    - Accident indicator
    - Trauma indicator
    - DRG Medicare code

32. The system must be compatible with upcoming ICD-10 requirements.

33. The system must maintain separate reference file data for different programs processed in the MMIS system (e.g., CSHS fee schedule vs. Medicaid fee schedule).

7.2.4   PRIOR AUTHORIZATION

As part of the effort to improve services to providers, the Department will offer real-time access for providers to submit prior authorization requests. The ability to receive and respond to prior authorization requests through interfaces and other automated processes is also a priority for the Department.

The functional requirements, interfaces, inputs and outputs for Prior Authorization are listed below.

7.2.4.1   FUNCTIONAL REQUIREMENTS

Functional Requirements for the Prior Authorization function are:

1. The system must accept and respond to prior authorization requests / amendments in hardcopy (paper), Internet, or electronic transmission format. The system must accept and respond to electronic transmissions using the 278 Health Care Services Review standard transactions. Hardcopy requests must be supported with data entry screens that support entry of all data on the request form.

2. The MMIS must include a workflow management system for prior authorization requests based on the type of service requested and the provider type requesting authorization, and on the status of the request. The work locations and criteria must be definable by users and updateable without system coding.

3. Upon acceptance of a PA request, the system will automatically enter all PA requests to determine if they are valid. The set of edits applied to the requested service and requested dates will be the same as the edits applied to a claim except for those related to matching claims with PAs and the prohibition of future service dates.

4. The system must support service plans with multiple services over extended periods of time.

5. The system will edit for duplicate requests for authorization and near duplicate requests for the same authorization from different providers.

6. The system will edit to ensure that all documentation required for the service requested has been provided with the authorization request.

7. The Prior Authorization staff must be able to send requests for additional information on paper or electronically through the system.

8. The system must display all data and associated documentation on-line.

9. State staff must modify PA requests regarding procedure, modifiers, units of service, cost of services, begin date, or end date. An audit trail of any changes made to the authorization must be maintained by the system.

10. State staff must be able to update the status of any prior authorization request. Status values must be user-maintained in the system's reference tables.

11. Providers must be able to access their authorization requests on-line through an MMIS Web portal and to view or modify the request or provide additional documentation.

12. The system must support searching for prior authorizations based on provider name, Provider ID, recipient name, MMIS ID and/or program-specific ID, date of submission range, dates of service requested range, service requested, and status of the request. The system must provide a listing of requests that meet the entered criteria. The user must be able to view the detail of the request by clicking on one item in the list of matching requests.

13. Users must be able to enter a decision regarding the PA on-line. The system must generate notices to the provider, recipient, or other case management staff regarding the decision.

14. The system must support retroactive entry of prior authorization requests.

15. The system must edit service plans to validate that the recipient is eligible during the service period, and has the program under which the service is being delivered.

16. Multiple providers can be identified with one service plan. The system must support multiple assigned providers.

17. The system must assign a unique prior authorization number as an identifier to each prior authorization request. This number will be used to associate the prior authorization to the claim being billed.

18. The system must provide claims submission status information to State and provider staff.

19. Duplicate checks for authorizations added from external sources to MMIS will be required, and exception processes defined for cases where potential duplicates are identified.

20. The Prior Authorization process must allow approval of rate overrides for services when the user has proper authority. This will accommodate exceptional rates required for services to high risk or exceptional recipients.

21. Authorizations may require a service set concept. An authorization for one service implies authorization for other services. That is, an office visit authorization implies a set of tests or x-rays. This would support programs like Vocational Rehabilitation where the prior authorization is generic, and the necessary procedures are determined by the provider.

22. The Prior Authorization processes must contain edits that will mirror claims processing. If a request receives authorization, DHS must be able to pay a resulting claim. This requires:
    - Program specific edits for coverage and pricing - Services covered by one program may not be covered by another. The edits must be the same as those used for claims processing.
    - Program specific audits for service limits - There may be service limits within a program that must be considered in approving a request.
    - Cross program audits - If a service such as a surgery or diagnostic test has been approved under one program, DHS should not duplicate and pay for the same service under another program. There may be some services, such as diagnostic services, that can be considered potential duplicates within a specified time frame. For example, if a recipient has had an MRI of their heart within the month, DHS may want to know that as part of the approval process.

23. When an out-of-state hospital conducts eligibility verification for a recipient (via 270 transaction, Web-based transaction, or phone system), the system must provide a "trigger" that would send a notification to a "utilization review queue". This notification would alert the Utilization Review (UR) staff of an out-of-state placement (preferably via e-mail), prompting follow-up by the UR staff to contact the facility and initiate related actions. Such actions include:

    - Determination of medical necessity
    - Review diagnosis for Prior Authorization, as if the recipient were in-state
    - Approval of the recipient's stay in the out-of-state hospital
    - Provision of notification(s) for approved / denied Prior Authorization(s)
    - Follow-up to tie pended claims to related out-of-state eligibility verification transaction(s)
    - Documentation and notification that services will not be covered by Medical Assistance (i.e., services were deemed medically unnecessary)
    - Updates to MMIS data files (e.g., recipient files), if necessary

7.2.4.2   INTERFACES

Interfaces for the Prior Authorization function are:

1.   MMIS must interface with the Aging Services Division database to load prior authorizations.

2.   Prior Authorizations in MMIS will be created from interfaces with ASSIST. ASSIST Case Action Screening records will be long term care authorizations in MMIS. Services approved in ASSIST Individual Service Plans (ISPs) will create service authorizations in MMIS. Provider ID is not on the authorized services in ASSIST and may have to be added. Service code in ASSIST will have to be translated into procedure codes for MMIS.

3.   MMIS will accept authorization records through an interface with the PowerBuilder System. The files must include all data required to process claims in MMIS. A translator to convert procedure codes used in the CSHS system to MMIS procedure codes may be required.

4.   MMIS will accept authorization records for Disability Determination Services through an automatic interface from VERSA. The data included in the interface must support claims processing in MMIS.

7.2.4.3   INPUTS

The Inputs of the Prior Authorization function are:

1.   The system must support receipt of authorization requests electronically or through paper or fax with data entry.

2.   Requested authorizations from providers and MCOs.

7.2.4.4   OUTPUTS

The Outputs of the Prior Authorization function are:

1.   The system will establish an adjudicated prior authorization record, indicating: the status of the request, services authorized, the number of units approved, service date range approved, cost approved, and the provider approved.

2.   The system will produce reports on services authorized, denied and pending for the user designated report period.

3.   The system will generate notification of the prior authorization decision to the requesting provider and the recipient. County eligibility staff assigned to the recipient must have security to permit them to view these records.

4.   Various triggers for electronic / paper notifications and for determining "next steps".

7.2.5   CLAIMS

Accurate and timely claims adjudication and payment is crucial for the successful operation of Medicaid and other health programs included in the MMIS. The Department envisions the development of a Web portal that will allow providers to submit and update claims and encounters, and view the status of their claims during processing.   Providers will be encouraged to submit claims electronically in order to quickly process and pay their claims. Claims processing logic must be table-driven to allow the Department to add or change edits and audits without significant changes to the system.

The functional requirements, interfaces, inputs and outputs below address the following areas of Claims:

- Claims Entry
- Claims Processing and Adjudication
- Claims Administrative Reporting

7.2.5.1   CLAIMS ENTRY

7.2.5.1.1   Functional Requirements

Functional Requirements of the Claims Entry function are:

1. The system must perform on-line real time processing claims adjudication, pricing, and suspense processing.

2. The system must maintain the former internal control number (ICN) and former paid date on any claim that denies or pends against another claim, (i.e., duplicates, once-in-a-lifetime services, early refill, re-bundle, incidental, mutually exclusive, pre/post-operative visit, or medical visit).

3. The system must provide Web-based access that gives providers the ability to enter claims and other form types (PA forms) both individually and in batch formats. This system must provide a response to the provider indicating the status of the submitted data.

4. The system processes and adjudicates claims accurately and timely, according to State-approved guidelines.

5. Accept, control, process, and report separately, claims for Medicaid and State-only programs. Inputs include the following claim forms and transactions (in hard copy, fax, and electronic formats):
    - HIPAA-compliant electronic claims transactions (e.g., 837, NCPDP 5.1)
    - CMS-1500 paper claim form
    - CMS-1450 (UB 92) paper claim form
    - American Dental Association (ADA) dental paper claim form
    - Any other State-only forms required by special programs or service categories

6. The system must track claims that are returned to provider, including but not limited to, the date returned, and the reason for the return.

7. The system must receive claims in a variety of mediums, including, but not limited to: HIPAA-compliant electronic formats, paper documents from providers, billing services, MCOs, County waiver programs, Medicare Carriers and Intermediaries, Coordination of Benefits contractor, and non-medical electronic claims (Personal Care, Basic Care, Non-ICF/MR DD Services).

8. The system must identify, upon receipt, each claim record with an Internal Control Number (ICN) that designates but is not limited to the origin of claim record, year and Julian date of receipt, batch number, and sequence within the batch.

9. The system must accept paper and HIPAA compliant electronic attachments and link to the original claim using the ICN. Attachments must carry the ICN of the relevant claim record with a suffix or other indicator identifying it as an attachment.

10. The system must link subsequent submitted claims to denied claims so that related claims can be identified when possible.

11. The system images, stores, and provides on-line browser-based access to images of paper and electronic claims and accompanying attachments.

12. The system must accept other claim inputs to the MMIS, including but not limited to:
    - Claims for Medicare coinsurance and deductible (cross-over claims), in both paper and other electronic formats
    - Attachments required for claims adjudication, including:
    - Coordination of benefits and Medicare Explanation of Medical Benefits
    - Sterilization, abortion, and hysterectomy consent forms
    - Manual or automated medical expenditure transactions which have been processed outside of the MMIS (e.g., spend-down)
    - Non claim-specific financial transactions such as fraud and abuse settlements, insurance recoveries, and cash receipts

13. The system must process and pay claims submitted for non-Medicaid services rendered to recipients served by agencies including, but not limited to:
    - Disability Determination Services
    - Department of Corrections
    - Children's Special Health Services
    - Women's Way
    - Developmental Disabilities Family Subsidy
    - Vocational Rehabilitation
    - SPED and Ex-SPED

14. The system will identify and maintain prices for specified procedure codes (such as supply codes) where the price is dependent on supply's package size.

15. The system logs tapes, diskettes, and other electronic files upon receipt and assigns a batch number.

7.2.5.1.2   Interfaces

Interfaces for the Claims Entry function are:

1.   The MMIS will interface with the PeopleSoft system to receive an electronic claims file.

2.   The MMIS will interface with the VRIS system to receive an electronic claims file.

3.   The MMIS will interface with the ROAP system to receive an electronic claims file.

4.   The MMIS will interface with the CSHS PowerBuilder system to receive an electronic claims file.

5.   The MMIS will interface with the VERSA system to receive an electronic claims file.

7.2.5.1.3   Inputs

The Inputs of the Claims Entry function are:

1.   Claims and related documents received through OCR system, electronic submissions, or on-line screen.

7.2.5.1.4   Outputs

The Outputs of the Claims Entry function are:

1.   Claims data and other data in formats suitable for the MMIS to process the transactions.

2.   Reports with claims entry statistics for assessing claims processing performance compliance.

7.2.5.1.5   Performance Standards

Performance standards of the Claims Entry function include:

1.   The system assigns an ICN to every claim, transaction, attachment, and adjustment and optically stores (scans) every claim, attachment, and adjustment within one (1) business day of receipt.

7.2.5.2   CLAIMS PROCESSING AND ADJUDICATION

7.2.5.2.1   Functional Requirements

Functional Requirements of the Claims Processing and Adjudication function are:

1.   The system's Claim Detail screen must display amounts paid by TPL for the service, as well as the amount allowed by detail line item and must differentiate between contractual obligation and patient responsibility.

2.   Perform exceptional adjudication of claims edits and audits in accordance with State approved guidelines (e.g., deny, override) including special claims.

3.   The capability to routinely revise and update edits and audits.

4.   The system must calculate the allowed claims payment amount according to date specific pricing and North Dakota approved reimbursement methodologies as detailed in Section 7.2.3.1.

5.   The system must accommodate the development of additional edits and audits to detect and safeguard against medically unnecessary care, fraud and abuse by providers, fraud and abuse recipients, inappropriate billing practices, and clinically inappropriate or unnecessary utilization compared to nationally recognized practice parameters.

6.   The system must pend or deny claims for recipients assigned to the recipient Coordinated Services Program based on State guidelines.

7.   The system must process corrected claims data through the entire edit/audit cycle.

8.   The system must monitor services for suspected abusers, at the request of the State, using a "pay and report" Coordinated Services Program or some equivalent system function that will provide weekly reports of the claim activity for these recipients.

9.   As needed, the system must apply all of the pricing methodologies according to:
     - Geographic area by county or ZIP Code of provider or recipient
     - Individual provider number
     - MCO provider number
     - Individual recipient identification number
     - Recipient age, gender, or aid category
     - Provider type or specialty
     - Programs, such as EPSDT or waiver programs
     - Health care benefit package
     - Any other configuration specified by the State

10. The system must determine the line-item pricing methodology for each claim detail according to the date-specific pricing data and reimbursement information contained in provider files, reference files, prior authorization files, or managed care payment files (which includes data on recipient grouping including but not limited to age, gender, category, program status code, county of residence) based on date of service or date of adjudication on the claim record.

11. The system, via a Web portal, must set up recurring claims creation for providers with recurring billing cycles for the same recipient with the ability to change the DOS but keep the rest of the claims information the same.

12. The system must price claims based on the age of the recipient (e.g., an incentive payment would be added for selected services provided to children in a State defined age range).

13. The system must provide the State and providers with on-line access to claims status data.

14. The system must allow providers to have access to PA information, including PA balances.

15. The system must provide on-line access to a cross walk between local codes and State and national codes for historical claims research purposes.

16. The system must provide the State with on-line access to claims processing data. On-line access to claims processing data must be by MMIS ID, program-specific ID, Provider ID and/or ICN to include pertinent claim data and claim status.

17. The system must support, maintain, and provide on-line access to a cross-reference file that connects standard codes, rates, and COB information used by the long term care and waiver programs for pre-authorizations, claims processing, encounter reporting, research, and analysis, and benefit packages.

18. The system must provide inquiry access to the status of any related limitations for which the recipient has had services (through use of windowing, split screens, etc.), such as thirty-five (35) treatment days for therapy services.

19. The system must maintain 5 years of on-line adjudicated (paid and denied) claims and financial transactions history including all other claims for procedures exempt from regular claims history purge criteria, as defined by the State. The on-line history file shall be used in audit processing, on-line inquiry and update, and generate printed responses to claims inquiries. Adjudicated claims history data includes but is not limited to:
    - ICN, accounts receivable and remittance advice numbers
    - Benefit package
    - Claim type
    - DRG code
    - Claim source (FFS, capitation premium payment, or encounter)
    - Date of service, date of adjudication and date of payment
    - Billed, allowed, and paid amounts
    - TPL and recipient cost-sharing amounts, if any
    - Prior authorization numbers

- Detail procedure codes such as HCPCS and CDT including up to four (4) modifiers per procedure code
- Units
- Drug service codes
- Place of service
- Surgical procedure codes
- Other service and payment codes such as NDC, revenue, reimbursement level, MCO payment group and daily rate, Ambulatory Surgical Center (ASC) group
- MMIS ID and/or program-specific ID
- Recipient aid category(ies)
- Provider ID (billing, referring, performing, rendering, prescribing, and attending), provider type and specialty and/or taxonomy
- All edit/audits that have failed at both the header and detail level, including the resolution, EOBs, reason/remark codes, and user ID
- Financial information including cycle number, State/federal funding share, account code, source code
- Processing location at each step of processing and the date the claim record entered that location
- Diagnosis code(s) at the header and detail level
- A minimum of twelve (12) error codes for each detail and twelve (12) additional error codes at the header level
- Deductible, coinsurance, co-payment, patient liability, and spend-down amounts, if any
- Other insurance amounts and outcomes (e.g., denied payment), if any
- Casualty indicators
- Up to four (4) procedure code modifiers per detail
- EPSDT service indicator
- Family planning indicator
- Pricing action code

20. The system must provide the State with on-line access to the Claims Processing data, including detail or summary data, and full access for queries.

21. The system must price waiver claims/encounters in accordance with individual and program requirements as approved by the State.

22. The system must generate payment based on price established during the prior authorization process.

23. The system must override existing pricing methodologies to reflect negotiated pricing settlements.

24. The system must monitor the use of override codes during the claims resolution process to identify potential abuse, based on State-defined guidelines (e.g., emergency indicators).

25. The system must re-run claims that had a partial payment to process the adjustment for remaining dollars due.

26. The system must pay providers or groups of providers on criteria other than provider type and provider specialty as directed by the State.

27. The system must 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 North Dakota MMIS policy, including the capability to apply cutbacks to the authorized price, units, and/or service limits.

28. For pended claims, the system must be able to assign the location of the State unit, other State programs, or contractor unit that will resolve the pended claim based on criteria determined by the State. Expand the number of State pend locations from the current number of State locations to multiple State locations that specify the State program manager to which the pend should be assigned. The system also provides queues with on-line access to pended claims in each location, and the capability to re-assign claims to queues as needed.

29. The system must suspend and adjust provider claims in the normal claims processing sequence, so that facilities can receive partial payment for payable lines and only resubmit suspended portions in the next billing.

30. The system must generate a request to providers for more information in order to clear a claim.

31. The system must deny or suspend claims that are received past the applicable filing limits according to State specifications.

32. The system must assure that Medicare crossover claims and adjustments are uniquely identified on all standard claim statistic reports.

33. The system must be flexible enough to price Medicare coinsurance, co-payment and/or deductible crossover claims and adjustments through multiple methods (e.g., pay the Medicare deductible in full, pay Medicare coinsurance so as not to exceed the Medicaid maximum allowable fee, deduct Medicaid co-payment where appropriate, etc.). The system must be capable of changing the policy for paying Medicare crossovers without significant programming. The system must accommodate indicators which specify if the service was applied to Medicare deductible or coinsurance.

34. The system must support claim processing for acute care hospitals; rehabilitation, drug and alcohol, and psychiatric units of acute care hospitals; rehabilitation hospitals; residential treatment facilities, psychiatric hospitals, or specialty hospitals for all approved institutional claim types and reimbursement methodologies.

35. The system must implement and maintain an Automated Voice Response (AVR) for claims status checks.

36. The system must accept and process all paper and electronic Medicare crossovers for Medicare Part A, Medicare Part B, and Medicare Part D services in accordance with State and HIPAA requirements.

37. The system must deduct other insurance amounts reported on a crossover claim form, as appropriate, when pricing claim records.

38. The system must interface with Medicare contractors to exchange eligibility information from the VISION / TECS system, and other data as specified by the State, to utilize in matching information for Medicare crossover claims.

39. The system must price all claims and encounters in accordance with North Dakota Medicaid program policy, benefits, and limitations as defined by the State.

40. The system must identify and calculate payment amounts according to all reimbursement methodologies approved by the State including but not limited to such as provider-specific and universal fee schedules, per diems, DRGs, Medicare deductible/coinsurance, formulas, and percentages.

41. The system must provide the State with on-line access to claims pricing data.

42. The system must maintain call statistics including but not limited to the following information:
- Time and date of call
- Identifying information on caller
- Call category
- Inquiry description
- If call transferred to call management center
- Response description
- Busy
- Dropped Calls
- Call wait time
- Length of call

43. The system must process claims against automated edit/audit criteria and against the State approved error disposition hierarchy.

44. The system must establish balancing procedures to ensure claims control within the MMIS processing cycles. Track and update the claims inventory (to be processed, suspense, etc.) after each claims processing cycle.

45. The system must maintain a record of the related benefit package for each claim.

46. The system must apply all outpatient hospital pricing methodologies as well as the ability to "bundle" certain revenue codes into a flat rate per revenue code. Outpatient hospital pricing methodologies include but are not limited to:
- Rate per visit
- Flat rate per revenue code
- Rate per revenue code, service and procedure code, or billed amount (whichever is less)
- Procedure code and diagnosis code
- Percentage of charge per revenue code
- Outpatient Prospective Payment System

47. The system must maintain claim correction screens that display all claims data as received, entered or subsequently corrected.

48. The system must maintain inquiry and update capability to claim correction screens with access by ICN, Provider ID, MMIS ID, program-specific ID, and/or claim location.

49. The system must maintain and edit, in accordance with State and federal requirements, all required claims data elements or attachments to support the Medicaid program.

50. The system must maintain an adjustment reason code that indicates the reason for the adjustment and the disposition of the claim (additional payment, recovery, third party payment, third party recovery, history only, etc.) for use in reporting the adjustment.

51. The system must maintain complete on-line audit trails of changes to claims and adjustment activities on the claims history files that include IDs for the operators initiating and approving the changes or adjustment.

52. Utilize AVR to respond to provider inquiries on claims status and payment information, including but not limited to:
    - Claims adjudicated
    - Adjudicated claims and paid amount
    - Reason claims are denied
    - Claim status
    - Checkwrite for active providers for the last ten (10) payment cycles

53. The system must process individual, mass, and gross adjustments submitted on HIPAA compliant ANSI X12 837, NCPDP 5.1, and paper transactions.

54. The system must update provider payment history and recipient claims history with all appropriate financial records and reflect adjustments in subsequent reporting, including claim-specific and non claim-specific recoveries.

55. The system must exempt individual and mass adjustments from certain State approved edits or audits.

56. The system must identify the claim to be adjusted, display it on a screen, and change the fields to be adjusted with minimal entry of new data, for five (5) years of on-line active history.

57. The system must maintain and provide on-line access to adjustments and financial transactions, from data entry through to payment, with access by MMIS ID, program-specific ID, Provider ID, and/or ICN to include pertinent claim data and claim status.

58. The system must maintain the financial control number in the claim adjustment record for adjustments that were processed against financial transactions.

59. The system must control or freeze an adjusted claim or claim records by multiple parameters including no subsequent adjustments allowed by anyone, no subsequent adjustments allowed by provider, subsequent adjustments only by State staff, or allow subsequent adjustments with a deduction (percentage or dollar amount).

60. The system must process gross adjustments as needed in every regular payment cycle.

61. The system must update the gross adjustment file after processing.

62. The system must adjust claims history when providers return funds by a check or money order rather than by submitting a claim adjustment.

63. The system must carry history with an adjusted claim including the original claim (and previous adjustments, if applicable) with all of the original information (including, but not limited to, the original paid amount, the adjusted amount, the full amount gross calculated, and the net amount calculated).

64. The system must 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 ICN.

65. The system must provide a flexible mass or individual adjustment process that can be controlled by various parameters or selection criteria (e.g., procedure code, Provider ID) for all claims. These adjustment processes must be available on-line.

66. The system must display a listing of the ICNs of claims selected for mass adjustments on-line to determine the impact of the adjustment prior to the actual adjustment process. Include the ability to deselect individual ICNs prior to activating the mass adjustment.

67. The system must maintain an on-line mass adjustment function to select and/or adjust claim records with billed amounts less than allowed amounts.

68. The system must maintain an on-line mass adjustment selection screen, limited to select users, to enter selection parameters including but not limited to parameters such as time period, program, provider number(s), recipient number(s), service code(s), procedure codes, and claim type(s); claim records meeting the selection criteria will be displayed for initiator review, and the initiator will have the capability to select or unselect chosen claim records for continued adjustment processing. Require on-line approval by a user with appropriate security for mass adjustments that meet criteria defined by the State.

69. The system must prevent multiple adjustments to an original or adjusted claim.

70. The system must perform adjustments to original and adjusted claims and maintain records of all previous processing.

71. The system must allow on-line changes to the adjustment claim record to reflect corrections or changes to information during the claim correction (pend resolution) process.

72. The system must retrieve claim adjustment records on-line using multiple criteria that include: rate changes, SUR actions, medical policy requests, provider requests, and other State-generated requests.

73. The system must adjust claims that have been purged from on-line history as directed by the State.

74. The system must process and pay administrative fees for Primary Care Case Managers.

75. The system must reapply benefits and service limitations (e.g., prior authorization) based on adjustment.

76. The system must re-edit, re-price, and re-audit each adjustment, including checking for duplication against other regular and adjustment claim records, in history and in process.

77. The system must automatically identify all claim records affected by retroactive rate adjustments and, with approval, create adjustment records for them, reprocess them, and maintain a link between the original and adjusted claim.

78. The system must reverse the amount previously paid/recovered and then process the adjustment so that the adjustment can be easily identified.

79. The system must process the adjustment offset in the same payment cycle as the original or adjusted claim.

80. The system must 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.

81. The system must maintain adjustment data that includes who initiated the adjustment, the reason for the adjustment, and the disposition of the claim (additional payment, recovery, history only, etc.) for use in reporting the adjustment.

82. The system must re-price mass adjustment claim records, within the same adjudication cycle, for retroactive pricing changes, patient payment amount changes, recipient or provider eligibility changes, and other changes necessitating reprocessing of multiple claim records.

83. The system must allow that any field on the claim record can be adjusted appropriate to requestor authority and security.

84. The system must recycle a claim after an adjustment.

85. The system must deny suspended claim by a specified period of time with flexible threshold (program or error-specific).

86. The system must accommodate exception pricing for services for programs administered by the State other than Medicaid.

87. The system must maintain a method to process payments for any specific claim(s), as directed by the State, on an exception basis. The system also maintains an audit trail of all claims processed on an exception basis.

88. The system must perform exceptional adjudication of claims edits and audits in accordance with State approved guidelines (e.g., deny, override) including special claims.

89. The system must perform adjudication of claims exceptions according to State and federal billing deadlines.

90. The system must systematically accept global changes to suspended claims based on State-defined criteria and release claims for editing.

91. The system must have the capability to deny or reject all electronic claims transactions that do not comply with HIPAA mandated standards.

92. The system must link subsequent submitted claims to denied claims so that related claims can be identified when possible.

93. The system must maintain the original, calculated allowed amount, any manually priced amount, and the actual payment amount on the claims history record.

94. The system must maintain claims that have been purged from active claims history indefinitely on a permanent history archive with key elements of the history claim.

95. The system must identify and recover payments for claims denied by retrospective review.

96. For claims failing recipient eligibility edits, the system must recycle the claims on a schedule to be approved by DHS before denying the claims.

97. The system must allow electronic claim submitters to resolve suspended claims via the Web portal according to State specified edit rules.

98. The system must maintain, display, and update on-line, a user-controlled remittance and message text file with access by edit number and remark code, showing the RA message(s) for each error and the EOBs.

99. The system must track claims that are returned to provider, including but not limited to, the date returned, and the reason for the return.

100. The system must process and pay claims for school-based services using per capita, encounter, and/or fee-for-service methodology.

101. The system must accept and respond to claims status inquiries received by HIPAA transactions 276/277, Automated Voice Response (AVR) or other electronic media.

102. The system must assign claim status (i.e., approved, denied, pended, suspended, rejected) based on criteria approved by the State.

103. The system must accept HIPAA compliant ANSI X12 276, batch or real-time, transactions for claims status inquiry.

104. Respond to electronic claim status inquiries with a HIPAA compliant ANSI X12 277 transaction.

105. The system must generate an unsolicited 277.

106. Automatically route Automated Voice Response (AVR) calls for claims status inquiries to the Call Management Center at any point during the call as initiated by the provider or if entry errors occur within the AVR application.

107. The system must allow Web inquiry to determine coverage status of a drug and the reimbursement rate by NDC and date of service.

108. The system must provide Web access to claims to provide inquiry for claims and a service profile to providers and State staff. Search criteria would include:
- Recipient name,
- Program-specific ID,
- Begin Service Date
- End Service Date
- Begin bill date
- End bill date
- Claim type
- Claim Status
- Provider ID
- NDC Code
- Procedure Code
- Primary Diagnosis Code
- Procedure Modifier

110. Claims processing requires a hierarchy of funding sources. A claim must process the highest priority source that the recipient qualifies for first. If the claim denies for edits related to approvals or benefits for that program, it must process the claim for the next highest priority. The Remittance Advice would report all edit failures logged.

111. Some Non-Medicaid program staff work their own claims. For example, CSHS staff adjudicate their own claims and perform some review of services. All claims for a specific program must suspend to locations accessible to the specific program staff. That is, all CSHS claims would pend to locations CSHS1, CSHS2, or CSHS3, depending on the status of edits. CSHS staff would have access to those locations, but others, such as general Medical Services adjudicators would not. This would give CSHS the ability to access their claims without searches or sorting.

112. Users will be able to view rates and effective dates on-line. This applies to generic rates, provider specific rates, and exceptional rates approved by prior authorization. Exceptional rates would include a history of values approved for services that have no standard rates and require a determination of reimbursement levels on an individual basis. For example, in authorizing a bone marrow transplant, the user may want to view the most recent ten approvals to determine whether a specific request is reasonable.

113. Claims adjudication will display all errors on a claim rather than aborting editing or auditing after a fatal error is encountered.

114. Users will be able to view edit and audit logic on-line.

115. For out-of-state claims, the system must check for related UR staff notifications.

116. For out-of-state claims, the system must ensure that pended claims are tied to related out-of-state eligibility verification transactions.

117. The system must have the capability to allow for manual entry of contractual obligation and patient responsibility amounts per detail line when claims adjudicator entry of TPL information on the claim is required.

118. The system must have the capability to accept and process contractual obligation and patient responsibility amounts when the claim is being processed with the State as the tertiary payer.

7.2.5.2.2   Interfaces

The Interfaces of the Claims Processing and Adjudication function are:

1. Inbound Interface; Providers send claims to DDS – DDS completes CMS-1500 or UB-92 claim forms and sends to MMIS. No interface currently to VERSA, but interface is desired.

2. The system must have a direct interface with VERSA, so that when a payment is made from the MMIS, the payment information is automatically sent back to VERSA.

3. Inbound and Outbound Interface; Batch job that takes the claims right off of the VRIS application. MMIS writes check and gives the check number and related claim detail such as amount, status, reason codes, authorizations, etc. back to VRIS through batch process.

4. Outbound Interface; A Journal Voucher is used to send summary payment data to PeopleSoft Financials on a weekly basis.

5. Inbound Interface; Pharmacy claims are adjudicated on-line in the POS and paid through the MMIS.

6. Inbound Interface; Web download of codes, RVUs, and Medicare rates.

7. Inbound Interface; Web-based or EDI transactions, Network Data Mover (NDM), MDS data, and DDE transactions.

8. VISION / TECS for eligibility and enrollment data.

9. Inbound Interface; CD or Web download for codes.

10. Database used to store and access imaged documents maintained by ITD.

11. Outbound Interface; File(s) sent from MMIS to CMS.

12. Outbound Interface; Eligibility information and other data, as specified by the State, to Medicare contractors that utilize the data for matching information for Medicare crossover claims.

7.2.5.2.3   Inputs

The Inputs of the Claims Processing and Adjudication function include:

1.   Claims – Electronic and Paper

2.   Encounter Claims

3.   Crossover claims

4.   Prior Authorizations

7.2.5.2.4   Outputs

Outputs of the Claims Processing and Adjudication function include:

1.   Claims Payments

2.   Premium Payments

3.   Remittance Advices

4.   PCP Administration Fees

5.   Claims Extract for DSS

6.   Pharmacy Data to the MCO

7.2.5.3   CLAIMS ADMINISTRATIVE REPORTING

7.2.5.3.1   Functional Requirements

Functional Requirements for the Claims Administrative Reporting function are:

1.   The system must produce a report of all suspended claims by claim location. The report must include the ICN, provider, recipient, service dates, procedures, NDC codes or revenue codes, and error codes. In addition, the report must be available on-line and in paper format.

2.   Report inventory of claims by claim type, processing location and age.

3.   The system must provide a listing of all claim inputs by source for the day and the week.

4.   The system must provide a report of all edit failures for a user specified period of time, by edit failure and disposition. This is used in diagnosing failure points for claims.

5. The system must provide a report of all edit failures for suspended claim, by edit failure. This is used in diagnosing which edits and audits are contributing to backlogs.

6. The system must produce a report of claims in processing for more than user specified periods of time.

7. The system must report claims in their current locations for more than a user specified period of time.

7.2.5.3.2   Interfaces

Interfaces for the Claims Administrative Reporting function are:

1. Payment data will be sent to PeopleSoft from MMIS in an electronic file, with an automatic interface process. At a minimum, the file will include all data currently sent to Aging on hard copy reports.

2. Payment data will be returned to VRIS via an electronic file. At a minimum, the file will contain all data fields now sent to VR on hard copy reports.

3. Payment data will be sent to the ACCESS database used by Single Plan of Care (SPOC) to record expenditures.

4. MMIS will produce a payment record file to return to the PowerBuilder application. The file will, at a minimum, include the data sent to CSHS in hard copy reports by the current system.

5. Payment data files will be sent to the ASSIST system to report expenditures. At a minimum, the data in the files will be the same as data sent to ASSIST by the current MMIS or financial reports.

6. MMIS will return a payment file to the VERSA System reporting all claims paid for the DDS program. At a minimum, the file must include all data currently sent from the MMIS to DSS in paper format. MMIS will continue to produce reports produced for DDS by the current MMIS.

7. The Division of Aging Interactive Voice Response System will continue to be used and must be supported by the MMIS.

7.2.5.3.3   Inputs

The Inputs of the Claims Administrative Reporting function are:

1. The reporting system uses claims data and eligibility data as the input for reports.

7.2.5.3.4   Outputs

The Outputs of the Claims Administrative Reporting function are:

1. Claims administrative reports, as specified by the State.

2. Eligibility information and other data, as specified by the State, to Medicare contractors that utilize the data in matching information for Medicare crossover claims and Part D.

7.2.6   ADMINISTRATIVE REPORTING

It is essential to the Department's administration and staff to have access to accurate and timely reporting. User-friendly reporting tools and current, easily accessible data are priorities for this procurement.

The functional requirements, interfaces, inputs, and outputs for Administrative Reporting are listed below.

7.2.6.1   FUNCTIONAL REQUIREMENTS

Functional Requirements for the Administrative Reporting function are:

1. The MMIS must include a flexible user-oriented reporting tool such as Crystal Reports to support ad-hoc management reporting.

2. The system must produce all the reports currently listed as "needed" by users (in bidder's library).

3. Reports required to support EPSDT monitoring and enforcement must be produced by the MMIS, including:
    - Reports of screenings due, by month and within month, by county
    - Reports of screenings due, by month and within month, by PCP
    - Reports of screenings, by month due and county, grouped by month completed; These reports must display the type of screening and the recipient
    - Report of number of screenings due versus the number delivered by each county, distributed by month due and within month due by month delivered
    - Reports of screenings must be produced as defined by the State, and a match code must be added to each service reported

4. The system must produce all claims reports for display on-line, and allow the user to print reports when required.

5. The system must produce reports required to manage claims processing. These would include:

a.) Payment Lag Reports showing the average, 90% and maximum lag between key points in the claims processing system. This would be produced by the audit of status and location.
b.) Payment Distribution would report the distribution of payments made by the MMIS
c.) The Pending Claims Error Frequency Report would show the frequency of each edit and audit error for suspended claims.
d.) The Denial Frequency Report would show the frequency of errors with a disposition of denial.
e.) Claim Type Report would report the breakdown of claims received for a period designated by the user by claim type
f.) Service Type Report would report the breakdown of claims received for a period designated by the user by Service Category.

6. The MMIS would support Managed Care with the following reports:
a.) The Managed Care Comparison Report would report service profiles for user-designated services for recipients enrolled with an MCO by MCO and all enrollments from encounters and paid claims. The same profiles from claims for recipients enrolled with PCPs would be created for comparison. The report will be standardized by age range, gender and service categories.
b.) Actuarial Reports - the system will provide actuarial reports using data from encounters priced at Title XIX prices.

7. Data for the County Waiver reports (8520 reports) must be downloadable to Microsoft Access for manipulation and reporting by the DDS staff.

8. Ad Hoc provider demographic reporting is required, listing rates of care. The report must be sorted by provider type, provider number, and provider ZIP Code. Ad hoc reporting must support summary and detailed level provider data.

9. The system must have the ability to export Data from current Finance reports to Microsoft Excel or Microsoft Access.

10. The system must report providers that have a stop date and have an automatic payment.

11. Healthy Steps (SCHIP) requires the following reports:
- Report of premium payments to Noridian Mutual Insurance Company (Noridian)
- Report of Encounter data from DSS

12. Aging Services requires the following reports:
a.) Report of Aging Services recipients that have Medicaid Coverage, with begin dates and end dates of Medicaid coverage.
b.) Report of number of Aging Services recipients who received services by Service Fee Area for a user specified report period.
c.) Reports of number of individuals with open cases and closed cases for a user specified report period.
d.) Report of Aging Service recipients who have lost Medicaid coverage for a specified report period. This is a detailed report including the recipient name, Medicaid ID, Aging ID, Aid Code and date Medicaid eligibility terminated.
e.) Report of recipients in institutional settings (e.g., hospitals, swing beds, long term care facilities) and the number of days in an institutional setting during the specified reporting

period. The report would have the recipient name, days in each institution type, total institution days. The report would be subtotaled by county with a total for each type of institution for all institution days, and a percentage of service days provided to all Aging Services recipients by the county.

13. The system's Ad Hoc reports must be standard and user-definable, and be created by a flexible reporting tool. The standard Ad Hoc reports would be created and maintained by designated users, and would not be subject to modification by all users. The user defined reports would be owned by the user and could be modified at any time by the owner. All reports could be copied and created as a new report by users.

14. DDS requires an interface between MMIS and VERSA to produce the management reports standard in VERSA.

15. DD Services requires an interface to spend-down data to be able to produce required reports from the ASSIST System.

16. The system must produce an extract in Microsoft Excel or Microsoft Access containing units and unduplicated counts of recipients, by Provider and Fiscal Year, for the DD program.

17. The Accounting structure for the MMIS will include a dimension that represents federal reporting categories for Title XIX and SCHIP. This dimension must be maintainable by designated MMIS users without system coding.

18. The system must automatically assign appropriate federal expenditure codes to each expenditure, based on the type of expenditure and the eligibility and program of the recipient. The relationship between service, eligibility and program to the federal codes must be user-maintainable and updateable without system coding.

7.2.6.2 INPUTS

The Inputs of the Administrative Reporting function are:

1. The Reporting for Policy Reviews function will use MMIS data to generate reports.

2. The Reporting for Policy Reviews function will use VISION / TECS eligibility data to create reports.

3. The MMIS will use claims, expenditure, and eligibility data to create federal reports.

7.2.6.3 OUTPUTS

The Outputs for the Reporting for Policy Reviews function are:

1. Output for this function will be the reports previously specified under the Functional Requirements section.

2. Federal reports specified under the functional requirements section.

7.2.7   UTILIZATION MANAGEMENT

Monitoring the utilization of recipients and providers to identify patterns of fraud and abuse can be very complex. It is important to the Department that the tools to accomplish this must be very flexible and user-friendly, and must support parameter based inquiries.

The functional requirements, interfaces inputs, outputs and performance standards below address the following areas within Utilization Management:

- • Member Utilization
- • Provider Utilization
- • Fraud and Abuse

7.2.7.1   MEMBER UTILIZATION

7.2.7.1.1   Functional Requirements

Functional Requirements for the Member Utilization function are:

1. Provide a methodology to classify members into peer groups using criteria such as age, sex, living arrangement, geographic region, aid category, diagnosis, agency origin, special programs indicator, fund category, case-mix index, and LTC indicator for the purpose of developing statistical profiles.

2. System's Utilization Review function allows capability to query both the claims database and the Data Warehouse.

3. System can provide and store all member utilization reports, in the medium designated by DHS. System also provides all reports on-line as well as on paper and archives the reports through a Computer Output to Laser Disc (COLD) technique or comparable alternative.

4. System is capable of generating statistical profiles that summarize historical information for claims made for services to individual members or specified groups of members over a specified period of time.

5. System generates lists of members who exceed program norms, ranked in order of severity.

6. System is capable of generating member utilization frequency distribution reports, as defined within the system by users.

7. Provide a reporting function that contains these features:
    - Select/force profiles
    - Weighting and ranking of exceptions
    - Narrative descriptions of procedures, drugs, and diagnoses on reports
    - Extensive use of claim data elements for summary item definition
    - Definition of unique report groups for every user-defined category of service
    - At least 50 summary items per report category
    - User-specified selection, summarization, and unduplication criteria for claim details

8. System can generate statistical norms, by peer group, for each indicator contained within each statistical profile by using averages and standard deviations or percentiles that the State may use to set exception limits.

9. System can produce reports of claim detail, with multiple select and sort formats, which shall include but not be limited to:
    - Provider ID and name
    - Recipient's MMIS ID and/or program-specific ID and name
    - Referring provider's Provider ID
    - Category of service
    - Service date(s)
    - Diagnosis code(s), with description
    - Procedure code(s), with description
    - Therapeutic class code(s)
    - Drug generic code(s), with description
    - Coordinated Services Program indicator
    - Billed and paid amounts

10. System can produce reports, as specified by DHS, for all services received by members who:
    - Are receiving a specific service or drug,
    - Are enrolled in selected programs,
    - Have a certain living arrangement,
    - Are receiving services from certain providers or provider groups, or
    - Have a specific diagnosis.

11. System maintains an electronic record of recipient restriction and limitations data, including restricted service types/codes, assigned provider, and effective dates to support the claims processing functions.

12. System allows the application of special claims adjudication policies to claims submitted by providers who are not a Coordinated Services Program recipient's designated provider and who have no referral.

13. System maintains automated algorithms, based on criteria provided by the State, designed to identify recipients to be placed in the Coordinated Services Program.

14. System must perform scenario testing, including testing of changes to Coordinated Services Program algorithms for expected outcomes prior to modification in production system.

15. System must generate the following Coordinated Services Program related letters to recipients and providers including, but not limited to:
    - Notification to recipient of Coordinated Services Program status
    - Second letter requesting recipient to designate Coordinated Services Provider
    - Notification to recipient of Coordinated Services Provider designation
    - Notification of appeal status
    - Notification to providers listing assigned Coordinated Services Program recipients

16. System maintains an automated tracking system or real-time database to accommodate Coordinated Services Program data and activities including, but not limited to:
    - Coordinated Services Program category (e.g., physician, drug, etc.)
    - Coordinated Services Program provider number
    - Coordinated Services Program provider name
    - Coordinated Services Program effective dates
    - Note taking functionality

17. System tracks recipient Coordinated Services Program activities, including but not limited to: claims, appeals, assigned provider referrals and process status such as initial identification, recommendation for the program and re-evaluation.

18. System allows for a recipient to be locked-in for to up to twenty (20) categories of service at one time.

19. System must generate on-line Coordinated Services Program activity reports as specified by the State, including, but not limited to:
    - Number of profiles created
    - Number of individuals "locked in" and released
    - Cost savings
    - General program evaluation.

20. System must provide on-line inquiry access to Coordinated Services Program for State-approved users.

21. System links all services to a single recipient regardless of the number of historical changes in Recipient ID.

22. System must analyze treatment patterns across different claim types, such as, physician office visits and pharmacy prescriptions to hospital stays, ambulance trips, and equipment rentals.

23. System provides drill-down capability from on-line reports to analyze underlying data.

24. System must generate profiles across eligibility programs and benefit packages.

25. Claim detail reports from the system are exportable and the data can be used by spreadsheet or database software.

26. All reports from the system must be made available in data format for export and import purposes and through multiple media including paper, Compact Disc Read-Only Memory (CD-ROM), electronic file, microfilm, diskette, and tape cartridge.

27. System must meet the SUR requirements stated in the Federal Certification Checklist used by CMS in MMIS certifications.

28. System captures the receipt of prior approvals for Nursing Home admissions.

29. System tracks the receipt of Certificates of Need (CON) for residential treatment services.

30. For transplants, the system captures the receipt of letters requesting authorization for a transplant.

31. System tracks authorizations for services such as gastric bypass surgery, cosmetic surgery, tonsillectomies, and adenoidectomies, even if these authorizations are initiated by an outside entity (e.g., ND Health Care Review).

7.2.7.1.2   Interfaces

The Interfaces for the Member Utilization function are:

1. Data Warehouse.

2. ND Health Care Review, for:
   -Data sent to ND HC Review
   -On-line Prior Authorization review and approval

7.2.7.1.3   Inputs

The Inputs for the Member Utilization function are:

1. Retrospective Utilization Review Criteria.

2. Recipient Coordinated Services Program Identification Algorithm.

3. Recipient Coordinated Services Program Reports.

4. Notification Letters.

5. Medical Records.

6. Normative Benchmarks.

7. Parameter data for exception reports.

7.2.7.1.4   Outputs

The Outputs for the Member Utilization function are:

1. Annual ranking list (by dollars) for utilizing members, by program, including listings of the Top 100 for each of these categories.

2. Reports with flexible time intervals, which list all recipients in the Coordinated Services Program for the time interval and any new Coordinated Services Program recipients during the time interval. System applies all changes to reflect updates made during the time interval, as directed by the State.

3. Standard, preformatted reports that obtain and present data related to recipient claim history (paid and unpaid) and summarization of services by clinical categories. The reports must allow the user to identify Recipient IDs and date of service range, based on ad hoc requests.

4. Output files containing data that highlight patterns and/or practices that fall outside the bounds of predicted norms.

5. Recipient exception profiles.

6. Recipient summary profiles.

7. Coordinated Services Program reports.

8. Transplant recipient data profiles (from both cost and service perspectives).

9. Files to ND Health Care Review for retrospective Medical Services utilization review.

7.2.7.1.5   Performance Standards

Performance Standards for Member Utilization include:

1. System generates and issues recipient and provider notification letters within three (3) business days of the State recommended action.

2. System generates Coordinated Services Program (CSP) expiration notices within three (3) business days of CSP expiration.

7.2.7.2   PROVIDER UTILIZATION

7.2.7.2.1   Functional Requirements

The Functional Requirements for Provider Utilization are:

1.   System provides a methodology, for DHS approval, to classify providers into peer groups using criteria such as category of service, provider type, specialty, type of practice or organization, enrollment status, facility type, geographic region, billing versus performing provider, and size for the purpose of developing statistical profiles.

2.   System must generate statistical profiles that summarize historical information for claims submitted by each provider over a specified period of time.

3.   System generates lists of providers who exceed program norms, ranked in order of severity.

4.   System must generate statistical norms, by peer group, for each indicator contained within each statistical profile by using averages and standard deviations or percentiles that the State may use to set exception limits.

5.   System must produce a report of claim detail, with multiple select and sort formats, which shall include but not be limited to:
     - Provider ID and name
     - Recipient ID and name
     - Referring provider's Provider ID
     - Category of service
     - Service date(s)
     - Diagnosis code(s), with description
     - Procedure code(s), with description
     - Therapeutic class code(s)
     - Drug generic code(s), with description
     - Coordinated Services Program indicator
     - Billed and paid amounts

6.   System provides a reporting function that contains these features:
     - Select/force profiles
     - Weighting and ranking of exceptions
     - Narrative descriptions of procedures, drugs, and diagnoses on reports
     - Extensive use of claim data elements for summary item definition
     - Definition of unique report groups for every user-defined category of service
     - At least 50 summary items per report category
     - User-specified selection, summarization, and unduplication criteria for claim details

7.   System must generate provider utilization frequency distribution reports, as defined within the system by users.

8. System must provide DHS and any External Quality Review Organization(s) (EQRO) with all data necessary to audit MCO quality performance.

9. System provides and stores all provider utilization reports, in the medium designated by DHS. System also provides all reports on-line as well as on paper, if requested, and archive through a COLD technique or comparable alternative.

10. The System's Utilization Review function allows capability to query both the claims database and the Data Warehouse.

11. System generates profiles for group billers and individual rendering providers separately.

12. System associates individual providers in their practice affiliation, such as a group practice.

13. System associates services furnished in a clinic setting to both the clinic and servicing provider.

14. System associates individual providers who utilize the same billing service.

15. System generates a report of LTC physician detail, which identifies the number of visits to LTC facilities by performing providers, by provider number, and gives details for members, including date of service and amount billed.

16. System cross-references all historical Provider IDs (pre-NPI) to a single NPI; report selectively and collectively on provider utilization.

17. System performs detection and normative benchmarking of use, cost, and treatment patterns. Any provider grouping and profiling methodologies, normative benchmarks, review criteria/standards, and clinical/financial performance indicators that have been developed, implemented, and refined within the system are accurate and clinically/analytically defensible.

18. System can include a description of all procedure, drug, and diagnosis codes, CLIA certification codes, specialty, sub-specialty, and any other codes on all reports.

19. System provides drill-down capability from on-line reports to analyze underlying data.

20. Claim detail reports from the system are exportable and the data can be used by spreadsheet or database software.

21. All reports must be made available in data format for export and import purposes and through multiple media including paper, CD-ROM, electronic file, microfilm, diskette, and tape cartridge.

22. System provides an automated comprehensive audit tracking system that includes: audit scope, assigned auditor(s), related audit letters and reports, recoupment activities, and program details/comments.

23. System tracks receipt of letters of explanation for referrals to out-of-state physicians. Such letters are required from an in-state physician when a referral is made to any out-of-state physician.

24. System meets the SUR requirements stated in the Federal Certification Checklist used by CMS in MMIS certifications.

25. The system must track the approval or denial of the request and generate the necessary notifications to recipient, provider, and County eligibility staff.

7.2.7.2.2   Interfaces

The Interfaces for the Provider Utilization function are:

1. Data Warehouse.

7.2.7.2.3   Inputs

The Inputs for the Provider Utilization function are:

1. Parameter data for exception reports.

7.2.7.2.4   Outputs

The Outputs for the Provider Utilization function are:

1. Standard, preformatted reports that obtain and present data related to provider claim history (paid and unpaid) and summarization of services by clinical categories. The reports must allow the user to identify Provider IDs and date of service range, based on ad hoc requests.

2. System generates output files containing data that highlight patterns and/or practices that fall outside the bounds of predicted norms.

3. Annual ranking list (by dollars) for utilizing providers, by program, including listings of the Top 100 for each category.

4. Provider reimbursement rate research.

5. Provider exception profiles.

6. Provider summary profiles.

7.2.7.3   FRAUD AND ABUSE

7.2.7.3.1   Functional Requirements

The Functional Requirements for the Fraud and Abuse function are:

1. System performs comprehensive provider profiling and fraud and abuse detection by
    profiling providers by the following methods:
    • Rendering provider
    • Pay-to-provider
    • Unique provider
    • Referring provider
    • Health plan
    • Primary Care Provider (PCP)
    • Long Term Care Facility (LTCF)
    • Group
    • National Provider Identifier (NPI)/Provider Number
    • Restricted provider
    • Prescriber

2. System performs comprehensive recipient profiling and fraud and abuse detection by
    profiling recipients by the following methods:
    • Original program-specific ID for the recipient
    • Recipient case number
    • Enrollment recipient
    • Enrollment health plan
    • Enrollment Primary Care Provider (PCP)

3. System produces priority ranked suspect lists.

4. System performs an automated comparison of all paid claims with the identified deceased
    recipients and identify claims paid after a recipient's date of death.

5. System performs an automated comparison of eligibility data from the MMIS system against
    the Date of Death data from Vital Statistics and identify recipients that are deceased.

6. System must track Fraud & Abuse investigations, including documentation of dispute
    resolutions.

7. System must perform pattern analysis of illogical or inappropriate billing across any
    healthcare setting.

8. System must provide early detection of new billing schemes, as a means to identify new or
    emergent Fraud & Abuse billing schemes.

9. System provides an automated fraud and abuse profiling system for the ongoing monitoring
    of provider and recipient claims to detect patterns of potential fraud, abuse, and excessive

billing. The system can perform targeted or intensive monitoring of specific providers, services, procedures, diagnoses, and/or recipients over time.

7.2.7.3.2   Interfaces

The Interfaces for the Fraud and Abuse function are:

1.   Data Warehouse.

7.2.7.3.3   Inputs

The Inputs for the Fraud and Abuse function are:

1.   Date of Death information from Vital Statistics.

2.   Data requests.

3.   Fraud and abuse complaints.

4.   Claims history files.

5.   Provider demographic and enrollment data.

6.   Recipient demographic and enrollment data.

7.   Diagnosis Codes.

8.   Service codes.

7.2.7.3.4   Outputs

The Outputs for the Fraud and Abuse function are:

1.   Monthly reports of incidences, reasons, and examples of the suspected potential fraud and abuse.

2.   Monthly reports on potential fraud and abuse activities based on specifications defined by the State.

3.   Referrals to other State and federal agencies.

4.   Letters to Providers and Recipients.

5.   Provider profiles.

7.2.8   FINANCIAL MANAGEMENT

An important objective of this procurement is to create an interface between the MMIS and the PeopleSoft financial system used by the State. Automated posting and reporting of expenditures will support the Department in budget development and projections.

Making payments to providers is arguably the most critical function of the MMIS, but all the functions of the financial system are important for accountability to the stakeholders. Tracking money that has been recovered from overpayments or third party payments through the State's Accounts Receivable system is also an essential business function.

The functional requirements, interfaces inputs, outputs and performance standards below address the following areas within Financial Management:

- Make Payments
- Post Accounting Data
- Financial Reporting

7.2.8.1   MAKE PAYMENTS

7.2.8.1.1   Functional Requirements

Functional Requirements for the Make Payments function are:

1. The system must identify claims records requiring payment disposition and process for payment. This includes claims for services reimbursable under Title XIX and claims for other programs processed through the MMIS system. Determination of which program's payments will be processed through the MMIS must be a user-maintained function.

2. The system must create capitation amounts from enrollment records maintained on the VISION system. The system must use the enrollment data and capitation rate matrices to calculate the payment due to managed care providers, both PCCM Providers and MCO providers. The rate matrices contain rate cells for each program based on age spans and gender. If the managed care entity has a specific rate matrix, the system must use the specific matrix to price the capitation. If no entity specific matrix exists for a program, the system must use generic pricing matrices for each program. A history of rates must be maintained, with the time periods retained specified by the Department. At least the current and prior years' rates must be maintained. The system must be able to create or reproduce capitation payments for any time specified by DHS.

3. The system must maintain a record of all enrollment segments priced and paid. The enrollment period can be day specific or month specific, and adjustments to capitation payments may be required due to duplicate or erroneous enrollment periods. The system must be able to determine which periods have been paid and retrieve or re-create the payment amount. The system must be able to maintain a history of all enrollments segments for a time period specified by the Department.

4.   The payment process must process changes in enrollment periods and price the enrollment adjustment according to the rate matrices for the period indicated.

5.   The system must make payments through checks or EFT transactions to the managed care entities. The EFT function must be supported by the system.

6.   The MMIS must process payments for providers where no payment is actually made. This includes providers like the State Hospital, where payment records must be generated for claiming purposes, but the actual payment amount is $0.00.

7.   MMIS must allow lump sum payments where no individual recipient is associated with the payment. This would include advance payments to providers, lump sum settlement amounts such as issue resolution or settlements, and Medicare Cost Report Settlements. The user will have the option of creating a credit as the result of the lump sum payment.

8.   The MMIS must generate ad hoc checks under very strict security conditions. These checks would require two or more approval levels, and would be tracked and accounted for like all other payments. The user will have an option for creating a credit as a result of issuing the ad-hoc check. The system must have the ability to associate a check or credit to a specific provider, recipient, or ICN.

9.   The MMIS must generate insurance premium payments for recipients under the Cost Effective Premium Payment program.

10. MMIS will consolidate individual payment records into a consolidated record for payment. One check will represent multiple individual claim or capitation payments.

11. The system must provide a full audit trail to the source of payment. When claims are the source of payment, each claim included in the payment record must be linked to the payment. For capitation payments, each capitation included in the payment must be linked to the payment. Insurance premium payments must be linked to the insurance periods and recipients for which the payment is made. Lump sum and ad hoc checks must have an explanation and authorizations associated with the payment.

12. The MMIS will process adjustments to previous payments. The adjustment will be based on a claim adjustment or enrollment adjustment for a source that was previously paid. The system will process additional payments supported by the adjustments or will create receivables as a result of the adjustment.

13. The system must process credits established against advances, adjustments or other payments as part of processing payment records. Users must be able to specify a maximum amount or the maximum percentage to be used from credits for any one payment.

14. The MMIS system will create and distribute remittance advices for all claims, advances, and ad hoc payments, whether the payment amount is positive, zero or negative. The claims remittance advice will be produced in paper or as a HIPAA 835 transaction at the designation of the provider. The MMIS will create an 820 transaction for capitation payments and insurance premium payments.

The remittance advice will display all transactions represented by the payment, including: payments, adjustments, credits taken, and denials, with subtotals and totals for each category.

15. Each payment made by the financial system will have a claims record. This includes:
    - Paid Amount
    - Category of Service: Major, Intermediate, and Minor
    - Recipient Aid Category
    - Match Code: The Reimbursement Source
    - Recipient Liability
    - Date Paid
    - Claim Record Code: Claim or non-claim
    - Transaction Type
    - Transaction Status

16. The system must run payment processing on a non-scheduled basis for a selected subset of records available for payment. The user would be able to specify specific providers or payment records that will be paid.

17. Each payment will have a financial record, including:
    - Transaction Amount
    - Recipient Category of Services (Cost Center)
    - Recipient Aid Code
    - Eligibility Match Code
    - Processing Date
    - Claim Processing Code - Claim/Non-Claim
    - Transaction Type
    - Transaction Status

18. The system must provide on-line access to remittance advice through a Web-based browser. Providers must be able to view their own RA through the browser. State staff must be able to view any data they would have access to within the system.

19. The Web-based Remittance Advice must be viewable by vendors or providers or a representative designated by the provider.

20. The format of the Remittance Advice must be flexible and user-defined. It must be subject to differentiation by users across claim types.

21. The paper Remittance Advice will have:
    - Open-ended wording limits
    - Explanation of any payment, reductions, denials and payment
    - Unlimited number of EOBs per claim line and per claim
    - Summary data listing the number of claims and the number of transactions represented on the report

22. The system will support on-line retrieval of Remittance advice using user defined selection criteria including but not limited to:
    - Payment Date Span
    - Remittance Date Span

- Remittance Advice Number
- Claim ID or ICN
- Provider ID
- Warrant Number

If more than one RA meets the selection criteria, the system will display a list of possible RAs, Remittance Dates, RA Numbers, and the payment amount for each. The user must be able to select one report, open it for viewing, and download it if desired. The transaction format must be compliant with the HIPAA 835 for claims advice and the 820 for capitation or premium payment advice.

7.2.8.1.2   Interfaces

Interfaces for the Make Payments function are:

1.   VISION enrollment data, provided through a direct read of that system.

7.2.8.1.3   Inputs

The Inputs of the Make Payments function are:

1.   Adjudicated claims, used to create payment records.

2.   Enrollment records, used to create capitation payments.

3.   Payment requests from MMIS for lump sum, ad hoc, or insurance payments will generate payment records in the Financial subsystem.

7.2.8.1.4   Outputs

The Outputs for the Make Payments function are:

1.   Checks or EFT will be created by the Financial subsystem.

2.   Remittance Advices.

7.2.8.2   POST ACCOUNTING DATA

7.2.8.2.1   Functional Requirements

Functional Requirements for the Post Accounting Data function are:

1.   The system must support user maintenance of the account coding structure, to 'n' levels. Each code must be able to be related to a level above to define the structure. Under the current structure, the highest level of coding is Cost Center, such as Nursing Homes,

Medical, etc., and each cost center has one or more service lines within it. A third potential level with in service lines is the Grant Code. Under the new structure, the number of levels would be established by users and could be altered to meet accounting or reporting requirements.

In addition, more than one accounting structure could be specified for parallel purposes. The State accounting structures would constitute one dimension with multiple related layers. Federal reporting structures would be a second somewhat independent structure. The State system would be used to code for entry in the PeopleSoft system, while the federal structure would be used to formulate the CMS 64 and CMS 21.

2. The structures used to assign accounting and reporting codes to expenditure must be maintained on MMIS and be updated by users without system coding. The code assignment would be based on factors such as category of service, claim type, Procedure range, form type, recipient aid code, recipient program, etc.

3. Each record processed for payment must be automatically assigned accounting and reporting codes based on the rules for assigning codes to expenditures maintained in MMIS.

4. Following each payment run, MMIS must create Journal Vouchers to send to the PeopleSoft accounting system. The Journal Voucher contains the State accounting code at the appropriation level.

5. The system must support assigning more than one funding source to a payment, with a subset of the total payment being assigned to each funding source. The sum of all amounts assigned to payment sources cannot exceed the total amount of the payment.

7.2.8.2.2   Interfaces

The Interfaces of the Post Accounting Data function are:

1. The MMIS must interface with the PeopleSoft accounting system to enter Journal Vouchers.

2. The system must interface with Vocational Rehabilitation Systems to send payment results. The interface records include check number, amount, status and status reason.

3. The MMIS system must interface with the VRIS system to send Journal Vouchers.

7.2.8.2.3   Inputs

The Inputs for the Post Accounting Data function are:

1. The Financial System reads the payment records to generate accounting records.

7.2.8.2.4   Outputs

The Outputs for the Post Accounting Data function are:

1.   The system sends Journal Vouchers to the PeopleSoft system.

2.   The Financial subsystem generates spending reports as specified in functional
     requirements for Title XIX and programs other than Title XIX that are paid through the
     MMIS system.

7.2.8.3   FINANCIAL REPORTING

7.2.8.3.1   Functional Requirements

Functional Requirements for the Financial Reporting function are:

1.   Following each payment run, the system must produce a report of payments by program,
     such as Medicaid, VR, and CSHS. Within each program, expenditures are presented by
     county and, within each county, expenditures are presented by appropriation code.

2.   Following each payment run, MMIS must produce a report of expenditures by program, and
     also within program by appropriation and accounting codes.

3.   At the end of the year, the MMIS system must produce a 1099 for all taxable payees. This
     functionality will also allow for ad hoc production of revised 1099s.

4.   The MMIS must be able to export payment and expenditure data to a Microsoft Excel
     spreadsheet or other formats specified by DHS.

5.   The system must have a graphical reporting capability built in.

6.   The database used by the MMIS system must be ODBC compliant and support standard
     reporting packages such as Crystal Reports.

7.   The system must extract all data required to produce CMS financial reports and
     Department grant reports from the MMIS system.

8.   The system must have the ability to accept 1099 files from other systems, and combine all
     of the 1099 files for Medicaid and other DHS Human Services programs into one file to
     send to the IRS.

7.2.9   MANAGED CARE

A significant portion of the State's Medicaid and S-CHIP population participates in a managed
care program, which includes the PCCM or MCO models. The State's goals for Managed Care
include the increased ability to manage and evaluate these programs, both for quality and cost-
effectiveness, as well as the capability for expansion into other areas, such as Mental Health.

User-friendly, flexible reporting tools are important to successfully manage and evaluate the programs.
The functional requirements, interfaces inputs, outputs and performance standards below address the following areas within Managed Care:

- Maintain Managed Care Entities
- Maintain Managed Care Rules
- Process Enrollment
- Process PCP Authorizations
- Support Managed Care Payments
- Record and Enforce Penalties/Sanctions
- Process Encounters
- Stop Loss/Risk Mitigation
- Managed Care Reporting

7.2.9.1   MAINTAIN MANAGED CARE ENTITIES

7.2.9.1.1   Functional Requirements

Functional Requirements for the Maintain Managed Care Entities function are:

1. The system must support adding and maintaining data for all managed care entities, such as Managed Care Organizations (MCOs) and Primary Care Providers (PCPs) in Primary Care Case Management (PCCM) programs. As other entity types are permitted, the system must be able to add them through table entries without hard coding.

2. The system must maintain the status of each managed care entity. The status values must be table-driven, including Pending, Open, Closed, Sanctioned, and Terminated. The status must be used to indicate whether members can be assigned to the entity. "Pending", "Closed" and "Terminated" cannot have members added. "Open" indicates that members can be added in accord with general assignment rules. "Sanctioned" indicates that members can be added only manually, with no automatic assignments made.

3. The system must track what populations are served by each managed care entity. This can restrict population served by characteristics such as age and gender for PCPs, or by special conditions for MCOs that specialize in sub-populations such as mental health or DD services, or PCPs that specialize in certain conditions such as cancer, coronary or renal disease. The criteria must be table-driven and correspond to characteristics on member records. This would be used in searching for member care entities or in making automatic assignments to managed care entities.

4. The system must maintain records on which benefit packages are offered by each managed care entity.   This will be used in searching for managed care entities and in automatically assigning members.

5. The rates paid to each entity will be maintained by the system. At a minimum, rates are classified by benefit package and within benefit package by aid category, gender, and age. Users must be able to add other characteristics that affect the rates by entering the criteria

into rate tables. Age ranges in the rate tables must be modifiable by users and must be able to vary across entity type. For example, the PCP fee for children 0-18 may be the same, but for an MCO several rate gradations may exist in that age range.

6. The system must support adding, editing, and logical deletion of core managed care entities including name, identifiers, NPI, entity type, locations, addresses, phones, key staff. A history of all core data must be maintained.

7. The Managed Care subsystem supports all managed care programs, policies and practices of the Department. This includes all aspects of managing entities, enrolling members, making payment for services, processing encounters and management reporting.

8. The status of the MCO must be maintained. The system must identify and maintain the status of the MCO and PCP as accepting new enrollments, accepting members of current families only, closed to enrollment, and under sanctions. The set of statuses to be used must be user-defined through table updates, and indicate whether members can be enrolled and to what extent.

9. The system must support adding, changing or logically deleting managed care entity ratings. The data must include a rating score, component scores, date of the rating, source of the rating, and begin and end dates for the rating. The entry must be able to accommodate ratings from any system.

10. The system must support adding, editing, and logical deletion of information related to the entity's network, including identifier, role in the network, type of network relationship, begin and end dates, and status. A history of network relationships must be maintained.

11. The system supports adding, changing, and deleting network relationships for and between Rural Health Centers, FQHCs, and providers. This includes ongoing modification of identifier, role in the network, type of network relationship, begin and end dates, and status. A history of network relationships must be maintained.

12. The system must support adding, changing and deleting the characteristics of members served by each managed care entity. This would include eligibility, special programs, living arrangement, Age, Gender, Medical Conditions. The characteristics must be maintained by users rather than be hard-coded. History of populations served must be maintained.

13. The system must support adding, changing and logically deleting the State programs served by each managed care entity and the benefit packages associated with each program. History of programs served and benefit packages offered must be maintained.

14. The system must support addition, changes, and deletion of geographic areas served by each managed care entity. The area served may be defined as county, ZIP Code, or both. History of all geographic areas served must be maintained.

15. The system must support addition, changing, or logically deleting specialties or special services provided by each managed care entity. For PCCMs, this would support assignment as PCPs. The history of specialty must be maintained.

16. The system must support entering and changing the capacity of each managed care entity. Users must have the ability to enter capacity for any State program as well as the overall capacity of the entity to enroll members.

17. The system must support the ability to add and logically delete rates for capitation and other services provided by managed care entities. Under certain conditions, where the rate has not been used the rates may be changed or physically deleted. A full history of all rates must be maintained.

18. The system must support adding, changing and logically deleting incidents related to the managed care entity, including: the type of incident, dates, members included, providers or other entities included, a description of the incident, and the outcome of the incident. A full history of incidents and changes to the incident record must be maintained.

19. The system must support adding, changing, and logically deleting sanctions imposed on the managed care entity. The data must include the type of sanction, reason imposed, dates imposed, begin and end date of the sanction, and an amount if applicable. The entry of the sanction must implement the penalty, such as freezing enrollments or recovering a sum from capitation payments. A full history of sanctions must be maintained.

20. The system must support the addition, modification, and logical deletion of managed care entity reviews. The records must indicate the type of review, reviewers, dates of review, findings, rebuttal, and final results of the review. A full history of reviews and changes to reviews must be maintained.

21. The system must maintain a full history of payments made to the managed care entity, including the payment type, amount, check number, date of payment, members related to the payment, dates covered by payment, Account codes, and service amounts.

22. The system must maintain a full history of recoveries from each managed care entity, including recovery type, reason for recovery, date of recovery, period covered by the recovery, members involved, amount of recovery and comments regarding the recovery.

23. The system must maintain balances on receivables due from each managed care entity. It must be able to recover specified amounts from each payment to the managed care provider during each payment period as long as the balance is positive.

24. The system must enforce sanction, in the form of enrollment restrictions or financial penalties imposed on the managed care entity.

25. Provide for on-line maintenance of provider information, including the following types of transactions:
    a.) Add a provider and all associated demographic, rate, and date information
    b.) Change any element in the provider record
    c.) End-date any date information
    d.) Change status from active to inactive
    e.) Reinstate de-activated providers
    f.) Archive provider records
    g.) Cancel prior transactions with appropriate levels of authorization

h.) Begin and end dates for all cross-referenced entities on both the individual record and the entity record

26. The system must support the entry and maintenance of managed care entities such as MCOs and PCPs. It must maintain all data required for these entities.

27. The system must provide Web search capabilities for the MCO that include:
    a.) County
    b.) Provider Name
    c.) Provider Type
    d.) Provider Specialty
    e.) Program

7.2.9.1.2   Interfaces

The Interfaces for the Maintain Managed Care Entities function are:

1. The MMIS must interface with VISION to read enrollment records and to update enrollments with automatic assignments when recipients have not selected a managed care entity.

7.2.9.1.3   Inputs

Inputs for the Maintain Managed Care Entities function include, but are not limited to:

1. Provider Data Files.

2. Identifying information, addresses, member characteristics such as age, gender, special conditions, capacity, and geographic areas served.

3. Financial Reports.

7.2.9.2   MAINTAIN MANAGED CARE RULES

7.2.9.2.1   Functional Requirements

Functional Requirements of the Maintain Managed Care Rules function include, but are not limited to:

1. The system must maintain provider types and specialties excluded from acting as PCP for recipients based on age and gender of the recipient. For example, an OB/GYN should not be able to act as the PCP for a male.

2. The system must support addition, change or deletion of rules regarding managed care eligibility by users. This must include designation of groups for whom managed care is mandatory, those for whom managed care is optional, and those for whom managed care is

prohibited. Rules are based on eligibility, living arrangement, medical condition and recipient characteristics. The rules must include start and end dates, an audit trail of users adding or modifying the rules, and a full history.

3. The system must notify optional and mandated managed care recipients of their choices and the need to make a choice within a specified time frame. This notification will be made through the VISION system.

4. The system must automatically enroll recipients for whom managed care is mandatory after a grace period. The grace period will be updateable by users. A full history of the length of the grace period and the time period during each applied will be maintained by the system.

5. The system must maintain rules for automatic enrollment based on user-specified hierarchy of criteria. These would include enrollment history, current family or case enrollments, address, benefit program or eligibility group, the status of the managed care entity, recipient medical conditions, recipient age/gender, MCO or PCP ratings based on rates, or quality ratings such as compliance with EPSDT.

6. The system must support mass enrollments and disenrollments with managed care entities. The rules for enrollment must use the same hierarchy as the rules for enrolling members automatically.

7. The system must support user-defined compatibility of member enrollments by enrollment type. Enrollments that are compatible may exist concurrently for the same recipient. Enrollments that are not compatible cannot exist concurrently for the same recipient.

8. The system must support searches for managed care entities using a Web-based portal. Current search criteria include: geographic area, patient conditions, patient gender, patient age, entity status, type of entity, programs served, entity name, and entity specialty.

9. The criteria used by the system to search for managed care entities must be modifiable by users without re-coding the system.

7.2.9.2.2   Inputs

The Inputs for the Maintain Managed Care Rules function are:

1. MMIS must support the entry of managed care rules through on-line entry windows.

2. DHS Policy and Procedure Documents.

7.2.9.3   PROCESS ENROLLMENT

7.2.9.3.1   Functional Requirements

Functional requirements of the Process Enrollment function are:

1. For each managed care entity type, system users must be able to specify whether day specific or month specific enrollment is valid.

2. The system must allow users to enroll recipients in managed care entities according to rules maintained on the system. If day specific enrollment is valid, the enrollment must begin after a specified notification period. The notification period for each enrollment type must be user-maintained in reference tables. If month specific enrollment is valid, enrollment should begin on the first of a month following a notification period maintained on reference tables for the appropriate entity type and enrollment specific type.

3. The system must support partial month enrollment of recipients and pay capitation according rules regarding capitation payment. The rules will be user maintained and indicate whether capitation is pro-rated for the partial period or full monthly payment.

4. The system must recover capitation payments when a recipient is disenrolled for a period for which a capitation has been paid. The recovery must be indicated based on entity type and disenrollment reason, and these indication criteria must be user-maintained.

5. The system must support automatic or manual disenrollment of recipients from managed care entities. Disenrollment data must include end date of enrollment, reason for disenrollment, date disenrollment was entered and source of disenrollment data.

6. The system must automatically disenroll recipients from managed care entities based on user-defined events. These would include changes inconsistent with the entity's service definition such as age changes, address changes, medical condition changes, and living arrangement changes. The timing of disenrollment must be consistent with disenrollment rules that specify timing of disenrollment by entity type. Disenrollment rules state whether disenrollment is day specific or month specific by entity type and disenrollment reason, and what notification period is required before disenrollment is effective by entity type and disenrollment reason.

7. The system's rules regarding disenrollment must be user-maintained without requiring a coding change to modify the rules.

8. The system must support Web-based inquiry into a recipient's enrollment status by users internal or external to the Department. Criteria must include: program-specific recipient ID, Name, DOB range, SSN, and managed care entity.

9. The system must support Web-based inquiry into enrollment for a specified managed care entity. Criteria must include Managed Care Entity ID, Entity Name, Begin Date, end date, and Service area.

10. When an enrollment or disenrollment is made automatically or through the MMIS system, the system must initiate generation of enrollment or enrollment choice notices through VISION.

11. The system must evaluate enrollments entered against enrollment compatibility rules. If an entered enrollment is not compatible with existing enrollments, the enrollment must be denied and the user should end date the conflicting enrollment before the new enrollment can be added. For a system generated automatic enrollment, any conflicting enrollments must be end-dated one day previous to the new enrollment.

12. The system must allow users to specify a default benefit package for each entity type and program eligibility served, including covered services, deductible and coinsurance, and service limits.

13. The system must support user specification of benefit packages specific for a managed care entity, including covered services, co-insurance and deductibles, and service limits. The package must specify the programs to which the package applies.

14. In enrolling a member with a managed care entity, the system must select the benefit package specified for the entity and the member's program. If no entity specific benefit package exists, the system must select the default benefit package appropriate for the entity type and program.

15. The system must support daily or monthly capitation payment based on a user-specified payment schedule.

16. The system must support worker selection of a managed care entity through a Web-based portal.

7.2.9.3.2   Interfaces

Interfaces for the Process Enrollment function include:

1. The MMIS system will interface with VISION to read enrollment data and will update enrollments with records of automatic enrollment of recipients.

2. An interface with VISION to receive and send enrollment data.

7.2.9.3.3   Inputs

Inputs for the Process Enrollment function include, but are not limited to:

1. VISION data will be used to determine which recipients have not enrolled in a timely way and will generate automatic enrollments.

2. Eligibility and enrollment data from VISION.

7.2.9.3.4   Outputs

The Outputs for the Process Enrollment function are:

1. MMIS will send VISION enrollment records for recipients that have been automatically enrolled.

7.2.9.4   PROCESS PCP AUTHORIZATIONS

7.2.9.4.1   Functional Requirements

Functional Requirements for the Process PCP Authorizations function are:

1. The system must support user definition of which services require authorization by a PCP for members enrolled in PCCM. The definition must be table-driven an updateable without system programming. A history of authorization requirements, with begin dates and end dates, must be maintained.

2. The system must support entry of authorizations from managed care entities by State staff or directly from the entity through a Web-based portal. The authorizations must include, at a minimum: Authorizing Provider ID, Services Authorized, Multiple Diagnoses, Service Date Span, Service Modifiers, Maximum Units of Service, Service Provider ID, and Date of Authorization.

3. The system must support designation of alternative authorization sources for a managed care entity. The alternative source would be a provider with the appropriate credentials and specialty to act in place of the PCP assigned to the member in authorizing services. The PCP or managed care entity would designate alternative authorization sources to be entered on the system.

4. The system must maintain the list of provider types and specialties that can make referrals when acting as part of the managed care entity's network.

5. The system must accept authorizations from the managed care entity's network members with the appropriate provider type and specialty.

6. The system must support a user-maintained listing of which provider types and specialties may be used as PCPs. Enrollment of providers as PCPs would be audited against the list to ensure that the provider has the credentials to serve as a PCP. Valid managed care entities will populate the Web portal that supports PCP and MCO selection.

7.2.9.4.2   Inputs

The Inputs for the Process PCP Authorizations function are:

1. The system will accept paper or electronic PCP authorizations. The Authorization will include the services to be provided, dates of service, and the name and ID of the provider who will deliver the service.

7.2.9.5   SUPPORT MANAGED CARE PAYMENTS

7.2.9.5.1   Functional Requirements

Functional Requirements for the Support Managed Care Payments function are:

1. The system must calculate capitation payments for managed care entities based on enrollment and capitation rates specified for the enrollment periods.

2. If the enrollment period is for a full month, then monthly capitation must be paid by the system. If the enrollment period is a partial month, the daily capitation rate must be calculated by the system as a daily amount from the monthly capitation. The calculation must be user-definable and updateable without system coding.

3. The system must maintain generic capitation rates for each entity type and program. The rate record must include the amount to be paid, the period of payment (daily or monthly), and the begin dates and end dates for which the rate is in effect. The system does not allow effective periods for rates for the same period of payment to overlap.

4. The system must support user maintained capitation rates specific to an entity and an eligibility program. The rate record must include the amount to be paid, the period of payment, daily or monthly, and the begin dates and end dates when the rate is in effect. The system must not allow effective periods for rates for the same period of payment to overlap.

5. The system must maintain a full history of all capitation rates.

6. The system must support manual retroactive adjustments to capitation payments by users.

7. User-defined system events, such as a retroactive change in capitation rates (either generic or entity specific), must trigger automatic adjustments to capitation payments. The adjustment must void and replace the original payment and replace it with the new payment, creating a supplemental payment or a receivable to recover an overpayment.

8. The system must support lump sum payments to managed care entities manually initiated by users.

9. A history of all payment records and receivables created by the system must be
    maintained, including date created, date paid or recovered, check number, type of payment
    and amount.

10. The system must automatically recover duplicate payments for capitation when duplicate
    member records are identified and consolidated. The system must automatically calculate
    duplicate payments for the same period of time and managed care entity, and create a
    receivable for that amount.

11. The system must support creation of receivables from monetary sanctions levied against a
    managed care entity.

12. The system must create remittance advice in the format of the HIPAA 820 transaction for all
    payments and recoveries made during the payment period.

7.2.9.5.2   Inputs

The Inputs for the Support Managed Care Payments function are:

1. Enrollment data provides the basis for calculating payments.

2. MMIS Capitation Pricing tables.

7.2.9.5.3   Outputs

The Outputs for the Support Managed Care Payments function are:

1. The system will create payment records from this process.

7.2.9.6   RECORD AND ENFORCE PENALTIES/SANCTIONS

7.2.9.6.1   Functional Requirements

Functional requirements for the Record and Enforce Penalties/Sanctions function are:

1. The system must support user entry of sanctions for managed care entities. The sanction
    must include the type of sanction, enrollment or financial, and specify a duration for
    enrollment or amount for financial. Enrollment sanctions must be specified by the user and
    updateable without system coding.

2. The system must enforce sanctions by setting a status that limits enrollments appropriately
    or by creating a receivable in the Financial subsystem.

7.2.9.6.2   Inputs

The Inputs for the Report and Enforce Penalties/Sanctions function are:

1.   The system must support on-line entry of sanctions by users.

7.2.9.6.3   Outputs

Outputs for the Record and Enforce Penalties/Sanctions function include, but are not limited to:

1.   The system will update the status of managed care providers, affecting their ability to enroll recipients.

2.   The system will create receivable amounts for financial sanctions.

7.2.9.7   PROCESS ENCOUNTERS

7.2.9.7.1   Functional Requirements

Functional Requirements for the Process Encounters function are:

1.   The system must receive encounters in electronic format and pre-edit them for compliance with encounter standards for syntax and required fields. The format will be specific to encounter receipt requirements. If HIPAA standard transaction formats are required, the transaction will comply with those requirements. Transactions that fail to comply at an acceptable level will be rejected. Required compliance parameters must be user maintained. At a minimum, the encounters must include:
     - Recipient ID
     - Recipient Name
     - Begin Date of Service
     - End Date of Service
     - Provider ID
     - Provider Name
     - Diagnosis codes
     - Procedure/Revenue/ NDC / DRG codes
     - Modifiers
     - Units
     - Place of Service
     - Amount Paid
     - Claim Type
     - Admission Date
     - Discharge Date

2. The system must process encounters received according to edits and audits specified in Department encounter rules. The processing will be distinct from claims processing. All edit and audit failures will be recorded, and Encounters will be adjudicated as passed, suspended or failed.   The dispositions of each edit and audit and the resulting location will be user-defined and updateable. The disposition of the encounter will be based on the most severe dispositions of the edits and audits failed. Edits and Audits will include:
    - Recipient Validation
    - Provider Validation for Services Rendered
    - Syntax Edits
    - Duplicate Checks
    - Near Duplicate Checks
    - Diagnosis Validation
    - Procedure Validation
    - Date Validation
    - Service Limit Edits
    - Diagnosis/Procedure Conflicts
    - Age conflicts with Diagnosis or Procedures
    - Bundling/Unbundling Edits
    - Gender Conflicts with Diagnosis or Procedures

3. The system will provide MCOs with remittance advice regarding the disposition of encounters. The advice will be in electronic format. If HIPAA standard transaction formats are required, the transaction will comply with those requirements.

4. The system will support on-line or batch correction of suspended encounters. They system will accept changes to encounters and re-processes them to determine a revised adjudication status.

5. The system will price encounters as FFS claims and will store the result with the encounter record.

6. The system will permit MCOs to adjust and void adjudicated encounters on-line or through submission of batch adjustment files.

7. Encounters will not be suspended or failed because they represent non-covered services, but non-covered service status will be indicated on the adjudication record. These services will be priced at $0.00 for FFS Pricing.

8. Edits and audits for encounters will be user maintained. Additions, deletions, or changes to edits and audits will not require system coding.

7.2.9.7.2   Inputs

The Inputs for the Process Encounters function are:

1. Encounters will be submitted electronically by managed care entities.

2. Corrected encounters will be provided to the MMIS system by managed care entities.

7.2.9.7.3   Outputs

The Outputs for the Process Encounters function are:

1.   Adjudicated encounter data will be returned to the submitting MCO.

2.   Reports of errors on failed or suspended encounters will be returned to MCOs on-line.

7.2.9.8   STOP LOSS / RISK MITIGATION

7.2.9.8.1   Functional Requirements

Functional Requirements for the Stop Loss / Risk Mitigation function are:

1.   Maintain the cumulative cost of services provided per contract year by each member for each MCO in which they are enrolled.

2.   Calculate reinsurance payments based on contract year to date costs for selected members and on the stop loss limits and cost sharing percentages maintained in the system.

3.   Generate reinsurance payments for members enrolled with reinsurance who have exceeded stop loss limits.

4.   Process adjustments and voids to the data on which reinsurance payments are based. Calculate revised reinsurance payments due and issue additional payment or create a receivable.

7.2.9.8.2   Inputs

The Inputs for the Stop Loss / Risk Mitigation function are:

1.   Encounter Records will be used to calculate the amount spent on recipients for the stop loss period and that amount will be used to calculate stop loss payments.

2.   MCOs will be able to submit request for stop loss consideration when the aggregate amount spent on a recipient exceeds the stop loss threshold.

7.2.9.8.3   Outputs

The Outputs for the Stop Loss / Risk Mitigation function are:

1.   The MMIS will generate payment records to the Financial System when a stop loss payment is justified.

7.2.9.9 MANAGED CARE REPORTING

7.2.9.9.1 Functional Requirements

Functional Requirements for the Managed Care Reporting function are:

1. Produce all downloads required by the North Dakota Health Care Review.

2. The system must create monthly rosters in electronic format. The rosters will represent all recipients enrolled with the managed care entity for the coming month. The rosters will be produced in accordance with the Department's scheduling requirements.

3. The system must create daily rosters in electronic format. The rosters will represent changes to enrollment with the MCO since the monthly roster production date and time. The rosters will be produced in accordance with the Department's scheduling requirements.

4. Daily rosters will be available through the system's Web portal for access by managed care entity staff.

5. The system will produce statistical reports on numbers of recipients enrolled by entity type, within entity type by entity, and within entity by eligibility code and special program.

6. Report Capitation Rates by entity on line with the option to print to paper.

7. Report Utilization comparisons between members enrolled in MCOs, PCPs and no enrollment for:
   - Prenatal Care for pregnant women
   - Preventive Diagnostic Procedures Pap Smears, Prostate Specific Antigen (PSA) Levels among target populations
   - EPSDT compliance
   - Well Checks
   - Emergency Room Use
   - Specialist Use

8. Report Utilization levels by service type by managed care entity, including the following service types:
   - Prenatal Care for pregnant women
   - Preventive Diagnostic Procedures
   - Pap Smears
   - PSA Levels among target populations
   - EPSDT compliance
   - Well Checks
   - Emergency Room Use
   - Specialist Use

7.2.9.9.2   Inputs

The Inputs for the Managed Care Reporting function are:

1. MMIS data on claims, encounters, and enrollments will be used to create managed care
    reports.

7.2.9.9.3   Outputs

The Outputs for the Managed Care Reporting function are:

1. Reports specified in the functional requirements section above.

7.2.10   CALL MANAGEMENT

It is the State's objective to implement an automated system to track and manage calls that
come to DHS from providers, recipients or other stakeholders. A Call Management System will
allow the State to monitor and analyze the performance of their call center operations in order to
increase productivity and improve provider relations.

The functional requirements for Call Management are listed below.

7.2.10.1 FUNCTIONAL REQUIREMENTS

Functional requirements for the Call Management function are:

1. The Contractor must implement an automated call/contact management tracking system
    used to manage inquiries from providers, potential providers, recipients, and other
    designated stakeholders of healthcare programs provided through DHS.

2. The system must track calls/contacts with basic identifying information. The information
    must include at a minimum, but not limited to:
    - Time and date of call/contact
    - Provider or recipient name and corresponding ID number
    - Caller name (if not the provider or recipient)
    - Nature and details of the call/contact
    - Inquiry type (e.g., claim status, training request)
    - Source of inquiry (e.g., phone, written, face to face, Internet, E-mail)
    - Length of call when a phone contact
    - Caller's County
    - Customer service correspondent name and user ID
    - Response given by customer service correspondent and the format in which the response
    was given (e.g., written, telephone, E-mail)
    - Status of inquiry (e.g., closed, follow-up needed, etc.)

- Capacity for free form text of at least five hundred (500) characters to describe problems and resolutions

3. The system must assign a unique number to each recorded call/contact.

4. The system is responsible for prompting the caller to enter provider or recipient number via automated prompts to automatically populate call/contact management tracking system screens (screen pop) with relevant provider information including, but not limited to:
    - Provider certification and demographics
    - Recipient demographics
    - Claims information
    - Other related calls/contacts

5. The system provides inquiry and on-line display of call/contact records by type, original call/contact date, recipient or provider number, caller's name (if different than provider or recipient), customer service correspondent name or user ID, or any combination of these data elements.

6. The system must provide the State with on-line access to call/contact management system data and real-time activity data.

7. The system must create State-defined extract files that contain summary information on all calls/contacts received during a specified timeframe.

8. The system must provide ability to refer and track call/contact to other State or State-designated staff for follow-up. When the call/contact is referred, in addition to the basic call/contact identifying information, the referral must include:
    - Call/contact priority
    - Referral date
    - Resolution due date
    - Actual resolution date
    - Referral unit/person
    - Name and/or user ID of person resolving the call/contact
    - Description of the resolution

9. The system must generate a system notification to alert a customer service correspondent that a call/contact has been assigned to them.

10. The system must allow easy navigation from call/contact logging screens to other data relevant to providers and recipients within the MMIS, or other relevant systems such as VISION / TECS, including eligibility, demographics, and claims history information allowing multiple screen displays at one time.

11. The system must provide an automatic phone call attendant function that uses hierarchical menu-driven capability to direct calls to appropriate customer service correspondents.

12. The system must contain voicemail capability to answer calls when customer service correspondents are unavailable or after call center hours.

13. The system must provide callers with a wait time estimate.

14. The system must allow users to purge calls/contacts from the call/contact management system, as directed by the State.

15. The system must generate reports on incoming and outgoing correspondence, as defined by the State.

7.2.11   WORKFLOW MANAGEMENT

DHS is seeking a workflow management application that potentially continues use of FileNet as a back-end repository. In response to this RFP Section, bidders will provide narrative regarding how their solution set would:

a.) Continue use of FileNet, including necessary customizations to meet the functional requirements listed below.

b.) Implement their own solution to meet the functional requirements listed below.

When bidding Option A above, the bidder must be sure to propose enough technical and personnel resources to help with the functional requirement development and interface development between the new Workflow Management System, MMIS, and FileNet. Each bidder would determine on their own whether they needed a consultant with FileNet expertise on their team to assist in Workflow Management System DDI.

The Department's goal is for the MMIS Contractor to provide a Workflow Management System to be used by DHS in routing and tracking the movement and management of various work components. FileNet is only providing a basic set of functionalities presently. DHS will work with the Contractor during the DDI phase of the contract to identify required business processes and procedures and establish the workflow requirements. The Workflow Management System must provide DHS with the ability to define their business processes, install those processes as accessible applications integrated with their existing and future systems applications, and provide users with the ability to monitor, analyze, control and enhance the execution of those processes in real time. Some of these processes may be documented policies and procedures as well as the undocumented procedural rules that may exist. The Workflow Management System must be an extended enterprise application that allows processes to span multi-platform, multi-lingual enterprises and it must facilitate the use of data and software from different sources. The system must also allow for transparent access to files and tools needed in the workflow process.

In response to this Section, the bidder must provide a detailed description of how either workflow management solution could best integrate with other technical components of the desired Medicaid systems solutions, including technologies such as: business rules engines, MMIS, POS, and other components. In addition to the functional requirements listed below, the bidder is expected to fully explain their solution's capabilities for Workflow Management and identify any additional functionalities that are included in the core solution package.

State staff will be responsible for:

- Approving workflow procedures including the business rules for scanning, indexing, and retrieval of images.

- Approving workflow procedures including the business rules for document management.

- Approving workflow procedures relating to business rules for defining, creating and managing the execution of various work components in the workflow system.

- Approving the Contractor's or State's internal procedures to address and resolve issues that may occur during workflow processing.

*Bidder's Note: Solution(s) proposed for these requirements are to be priced independently of Sections of 7.2.1 through 7.2.9, in the event that DHS chooses to remove this from the mandatory requirements. An individual line item for Workflow Management must be shown in the Pricing Schedules, as instructed in Section 11 of this RFP.

7.2.11.1 FUNCTIONAL REQUIREMENTS

Functional requirements for the Workflow Management function include:

1. The proposed solution must provide an automated, user-configurable workflow mechanism that is able to respond to organizational and business process changes on an ongoing basis.

2. The workflow management solution must integrate with the State's Document and Control solution (and any solution proposed in response to the optional service identified in Section 7.2.12), providing access to images in the MMIS solution and other multiple enterprise applications.

3. Implement and maintain an automated workflow system for routing, reviewing, adjudicating, tracking, and updating of work items (e.g., PA requests / amendments, etc.).

4. The proposed solution must support workflow mechanisms for all aspects of MMIS functions, including but not limited to:
    a. Eligibility verification
    b. Member management
    c. Prior Authorization
    d. Claims processing
    e. Suspense resolution
    f. Provider enrollment
    g. Provider and customer service management
    h. Third-party liability
    i. Call management center
    j. Data management
    k. Utilization management
    l. Financial management
    m. Administrative reporting

5. The system must provide an automated user-configurable workflow mechanism that enables the user to make necessary changes in line with shifting business needs. The workflow mechanism must also provide the capability to monitor the implementation of business processes in real time, evaluate the impact of their implementation, and then manage their implementation in response to changes in business.

6. The system must allow users to configure triggers (i.e., pre- and post-event handlers) and send alerts to other users based on criteria resulting from specific data elements within the MMIS. It must be possible to send user alerts as follows:
    a. In any one or combination of the following configurations, as dictated by a user's preference:
        i.   E-mail
        ii. Log-on screen of the MMIS
        iii. Other communication devices.
    b. In order to notify users about a variety of circumstances, including but not limited to:
        i.   Timeliness of assigned work
        ii. Overdue work
        iii. High priority work
        iv. Flexible time-based required actions
        v.   Specific system threshold or performance characteristics.
        vi. Error logging and reporting

7. The system must allow users to configure managerial functions for, at a minimum, the following activities:
    a. Staff loading analysis
    b. Backlog monitoring
    c. Processing throughput statistics
    d. Monitoring of Purchase of Service Agreement standards.
    e. Statistics regarding time intervals spent on each step, including "idle-time"
    f. Comparisons for performance measurement, resource planning and business process restructuring.

8. The system must allow users to configure and manage and, if authorized, to override, modify or suppress (with explanation in free-text fields) flexible processing rules to support Workflow Management System activities.

9. The system must allow business users to define and configure automated action flows to control MMIS functions without requiring any programmatic changes to the application. The automated action flows include, but are not limited to:
    a. Routing to people, organizations, and work queues
    b. Making member assignments to providers, locations, coverage types, or any other type of member or relationship entity assignments (e.g., automatic assignment to an MCO when a member does not exercise a provider choice within a pre-defined time period)
    c. Processing of provider enrollment applications and allocation to provider groups or managed care plans.

10. The system must utilize automated workflow to transfer documents to entities for review and editing, and back to other entities for rewrites and production.

11. The system must provide for generation of an indicator to identify the entity to which the work should be distributed.

12. The system must provide the capability to automatically schedule and distribute work by type of work and individual staff members or other algorithms defined by the component managers.

13. The system must provide automated queues to access and distribute work to staff with the ability for authorized supervisors to override the automatic distribution and distribute work manually.

14. The system must provide the capability to date-stamp all activity in the work item and identify the person who performed the activity.

15. The system must provide for a version control process which includes all file system objects, directories, sub-directories and file system links, changes to store and restore functions, and an audit trail of any source changes made.

16. The system must provide the capability to assign and re-assign work items to an area, unit, or individual. Once assigned, depending on the hierarchical structure setup, the user has the option of passing the work item back to user who forwarded the work item or forwarding the work item on to the next stage of the workflow management process.

17. The system must provide the capability to prioritize work items within type.

18. The system must provide the capability to set follow-up dates on records and provide for an automatic tickler capability to notify staff when follow-up is required or timeliness standards on records are about to expire.

19. The system must provide workflow management reports to identify inventories of items in each stage of the process, new items, and completed items.

20. The system must provide reports that identify adherence to performance standards for each component (i.e., a performance report card).

21. The system must provide automatic load balancing of the volume of data / transactions traveling through the system from all avenues and across all users involved in the process.

22. The system must provide a query capability for the Workflow Management System database with appropriate security access.

23. The system must provide a mechanism to follow-up on issues raised within the organization.

7.2.12   DOCUMENT RECEIPT AND CONTROL

DHS is considering a replacement to its current Verity (formerly Cardiff) MediClaim application, in order to automate as many document receipt business processes, document handling business processes, and data entry business processes as possible. The Department's goal is to eliminate virtually all paper handling during the initial receipt of documents. To achieve this end, the proposed MMIS system must include a high-speed imaging solution capable of imaging all high volume documents received by the Department. It must also automatically route documents and convert data contained in images into MMIS data through Optical Character Recognition (OCR). DHS is interested in working with the bidder to leverage advanced OCR functionalities that would improve efficiency and lower costs.

The bidder must customize their scanning / imaging and OCR solution to meet the needs and work processes of the North Dakota Medicaid program. In response to the requirements of this section, the bidder must describe in detailed terms their proposed scanning solution (including hardware and software requirements). The bidder must also include a list of Medicaid or similar programs where the Document Receipt and Control solution(s) have been successfully installed.

The functional requirements for the desired Document Receipt and Control solution (i.e., scanning / imaging and OCR) are found below. In addition to the functional requirements listed below, the bidder is expected to fully explain their solution's capabilities for Document Receipt and Control and identify any additional functionalities that are included in the core solution package.

*<u>Bidder's Note:</u> Solution(s) proposed for these requirements are to be priced independently of Sections of 7.2.1 through 7.2.9, in the event that DHS chooses to remove this from the mandatory requirements. An individual line item for Document Receipt and Control must be shown in the Pricing Schedules, as instructed in Section 11 of this RFP.

7.2.12.1   FUNCTIONAL REQUIREMENTS:

Functional requirements for the Document Receipt and Control function include:

1. The system must provide for the capture of all paper documents and conversion to electronic documents through a high-speed scanner.

2. The system must integrate fully with data records related to scanned documents, such as claims or provider applications for enrollment.

3. The system must be able to link documents to system records, even when the linked documents are scanned at different times.

4. The scanner must provide sufficient speed and throughput to handle all documents received during a normal 8-hour business day.

5. Scanned documents must be capable of being linked to other documents and retrievable as an integrated file of records. In particular, the system must be able to link claim documentation received before the claim, received concurrently with the claim, or received after the claim with the MMIS claim record. The claim and all documentation must be treated as part of the same logical file.

6. The system must be able to automatically cross-reference Imaging IDs with ICNs in MMIS.

7. The system must include document management capabilities to support routing, storing, and retrieving documents effectively.

8. The system must be able to route documents to specified locations based on the type of document and document parameters. The locations and the parameters that determine routing must be table-driven.

9. The system's imaging functionality must have adequate backup and restore capacity to mitigate the loss of primary image records.

10. The system must have OCR capabilities.

11. The system's OCR functionality must be capable of interpreting all high volume document types used by DHS, including: claims, claim adjustments, and provider applications.

12. The system's OCR processing of all documents must be possible within a standard 8-hour workday.

13. The OCR software must be capable of identifying questionable data interpretations and identifying the applicable document for manual review. This level of ambiguity of an interpretation required to initiate manual review must be variable, based on user configuration of the software.

14. The system's OCR solution must provide DHS with the capability to easily OCR and data correct imaged claims for entry into the replacement MMIS.

15. The OCR solution must have the capability to integrate with current DHS scan hardware and imaging software (FileNet).

16. The system must integrate fully with the Contractor's Workflow Management System proposed in response to RFP Section 7.2.11.

17. The bidder must describe in detail the proposed solution, as well as all hardware and software required for the solution. The bidder must provide historical throughput statistics for CMS-1500, UB-92, and ADA claim forms. The bidder must quantify its experience with the proposed solution.

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7.3   POS REPLACEMENT SYSTEM REQUIREMENTS

The Department's objective for the replacement POS is to have a systems vendor install a pharmacy point-of-sale system that will allow for flexible benefit administration and pricing methodologies. Up-to-date technology will provide pharmacy providers with fast, accurate information about eligibility, pricing, authorizations, and claim status, but manual entry of claims will also be supported. The State will benefit from the replacement POS system by having added control over the administration of the pharmacy program through enhanced edit and audits, improved tracking of authorizations, and better cost avoidance practices.

The functional requirements, inputs and outputs for each of the following business areas of the replacement POS are listed below:

- Pharmacy Claims Processing
- Drug Utilization Review (DUR)
- Drug Rebate

7.3.1   PHARMACY CLAIMS PROCESSING

One goal of the implementation of a replacement POS system is to provide increased access to claims information and status to the pharmacy providers and State staff. DHS also wants to provide options, such as Direct Data Entry screens, to providers that would normally submit paper claims. Improved tracking and monitoring of prior authorizations will allow the Department to better manage the pharmacy program.

The functional requirements, interfaces, inputs, outputs, and performance standards are listed below for the following business areas within Pharmacy Claims:

- Prior Authorization
- Claims Entry
- Claims Processing and Adjudication
- Pharmacy Edits and Audit Data

7.3.1.1   PRIOR AUTHORIZATION

7.3.1.1.1   Functional Requirements

The functional requirements for Pharmacy Prior Authorization include, but are not limited to:

1. The POS System must capture prior authorization requests for pharmacy and other claims that allow on-line, real-time adjudication to pay or deny the claim based on State-defined criteria. In order for the drug PA to be approved on-line, diagnosis and inclusive dates need to be submitted on-line. This requirement will vary based upon the algorithm.

2. The POS System must track all PAs and PA processing.

3. The POS System must handle prior authorization requests from individual physicians and pharmacists, if required by the Department.

4. The POS System's PA process must be largely an automated process (as much as is reasonable) through real-time interaction with pharmacy and medical claims history.

5. The POS System must automatically recycle pended claims and matching PA requests to determine if newly acquired data allows for authorization and adjudication.

6. The POS System must ensure that a prior authorization has been obtained for drugs requiring prior authorization.

7. The POS System must provide a timely mechanism (in NCPDP format, as well as Web inquiry) where an NDC code can be entered and a response will designate a pharmaceutical as:
    - Covered
    - Prior Authorization Needed
    - Not Covered

8. The POS System's prior authorization component must be structured such that PA staff will enter a drug and corresponding error codes / denial reasons for override.

7.3.1.1.2   Inputs

Inputs for the Pharmacy Prior Authorization function include, but are not limited to:

1. Prior Authorizations (Web, POS NCPDP submissions, internal staff entry through paper or verbal requests).

2. NDC coverage data requests from providers.

3. Member eligibility data requests from providers.

7.3.1.1.3   Outputs

Outputs for the Pharmacy Prior Authorization function are:

1. Notices to pharmacies.

2. Notices to Medical Providers.

3. Notices to recipients.

4. Prior Authorization reports, as specified by DHS.

5. NCPDP response to PA inquiry.

7.3.1.2   CLAIMS ENTRY

7.3.1.2.1   Functional Requirements

The functional requirements for Pharmacy Claims Entry include, but are not limited to:

1. The POS System must allow pharmacy and/or State staff to enter non-electronic billing (e.g., current hardcopy claims) via the Web.

2. The POS System must process requests for adjustments, authorizations or crossover claims that are submitted on paper, as well as the capability to process electronic submissions of the aforementioned documents.

3. The POS System must support provider-initiated AND State-initiated re-bills.

4. The POS System must capture the prescribing provider number and name on all pharmacy claims.

5. The POS System must verify that the provider is an eligible, enrolled North Dakota Medicaid provider and approved for sending claims to the POS, including authentication and certification for access to the POS system. Provider eligibility verification includes dispensing providers. Prescribing provider is not required to be enrolled as a North Dakota Medicaid provider, but must be licensed with their appropriate State board.

6. The POS System must provide verification that the recipient is eligible for Medicaid and/or for payment of services issued on the date of service through POS.

7. The POS System must indicate in its response to a provider whether the member has current third party insurance coverage. If the claim is covered by third party insurance and the drug is designated for cost avoidance, the POS System provides insurance information in the POS response and denies the claim. If the drug is designated as "pay and chase," the POS System processes and pays, assuming the claim meets all other criteria for payment, and reports the claim for follow-up activities.

8. The POS System must accept and process bills for compound drugs (those with multiple NDC codes) both on-line (see requirement #1 above) and via NCPDP electronic transmission.

9. The POS System must identify Medicare eligibility for recipients requesting Medicare-payable drugs, both real-time and on-line.

10. The POS System must accept and process claims that contain either single or multiple prescriptions.

11. Upon implementation, the POS System must utilize NCPDP Telecommunications Standard Format Versions 5.1 and 1.1 claim transactions (e.g., billing, reversal, re-bill) for on-line, real-time submissions for all NCPDP 5.1 standards (e.g., P, B, N, C).

12. Upon implementation, the POS System must utilize NCPDP Telecommunications Standard Format Version 5.1 and 1.1 formats (e.g., reject, duplicate, paid, approved) for generating response transactions.

13. The POS System must preserve the originally received content of the NCPDP 5.1 and NCPDP 1.1 claim transactions. The transactions must be accessible and transferable to an electronic document for help desk troubleshooting. Data must be displayed in field format with field labels to facilitate troubleshooting.

14. The POS System must record the date and time when the response transaction was sent to the entity that originally submitted the claim. For claims with more than one prescription per claim transaction, the POS System must record the response parameters at the transaction level, not at the prescription level.

15. The POS System must issue NCPDP standardized duplicate response records as appropriate (e.g., for denial of a duplicate claim transaction).

16. The POS System must capture controlled substance reporting data from HIPAA-compliant electronic claims transaction (NCPDP 5.1).

17. The POS System must be capable of exporting the captured controlled substance reporting data for daily batch transaction delivery to a State-contracted Prescription Drug Monitoring Program (PDMP) vendor. The daily batch transaction, at a minimum, would be conducted by sending an electronic file to the PDMP vendor.

    *<u>Bidder's Note</u>: DHS plans to establish a contract with a PDMP vendor prior to Summer 2006. Depending on the contracted PDMP vendor's systems approach, the data transfer from POS to the PDMP may require a system-to-system interface. Development of this interface would be conducted as a change control.

7.3.1.2.2   Inputs

Inputs for Pharmacy Claims Entry include, but are not limited to:

1. Electronic pharmacy claims from providers.

2. Web entry pharmacy claims for providers or DHS staff.

7.3.1.2.3   Outputs

Outputs for Pharmacy Claims Entry include, but are not limited to:

1. Data for Rebate System.

2. Daily batch file for PDMP vendor that contains controlled substance reporting data from HIPAA-compliant claims transactions.

3.   Data Dump for Troubleshooting.

7.3.1.2.4   Performance Standards

Performance standards for Claims Entry include, but are not limited to:

1.   The POS System provides on-line response notifications to providers within three (3)
     seconds of receipt of incoming claim transactions.

7.3.1.3   CLAIMS PROCESSING AND ADJUDICATION

7.3.1.3.1   Functional Requirements

The functional requirements for Pharmacy Claims Processing and Adjudication include, but are
not limited to:

1.   The POS System must allow multiple sets of drug coverage limitations when the recipient
     falls in more than one pharmacy benefit category and apply a benefit coverage hierarchy to
     facilitate processing (e.g., applying Medicare recipient restrictions and Nursing Home
     resident restrictions when a recipient is on Medicare and resides in a Nursing home).

2.   The POS System must have multiple edit tables in its benefit package design functionality.

3.   The POS System must provide flexible benefit administration.

4.   The POS System must receive and process pharmacy claims according to Department
     rules, including processing pharmacy Medicare crossover claims, and maintaining a
     detailed and accurate history of such transactions.

5.   The POS System must identify an offending duplicate claim's ICN and send appropriate
     information back to the provider. This would allow for tracking of any ICNs that caused a
     "capture" or "suspended" claim. (They remain on the claim history). If an error code is
     posted due to interaction, interacting claims ICN must be displayed internally for ease of
     help desk operations.

6.   The POS System must apply limits on utilization per day (e.g., max # Rx, max $$, max
     units, etc.), as defined by the State.

7.   The POS System must process and apply ongoing maintenance of the State Maximum
     Allowable Cost (MAC) program and Federal Upper Limits (FUL).

8.   The POS System must complete duplicate checking for claims that came in to the MMIS on
     an 837 transaction and contain NDCs. This would impact the MMIS, which needs to:
     - Split the 837
     - Have separate processing
     - Bring transaction information back together for the 835 transaction

9. The POS System must handle flexible pricing methodologies.

10. The POS System must pay at program-specific rates (i.e., different than Medicaid) for the following calculations (including, but not limited to):
    - Allowed amounts for drugs
    - Dispensing fees
    - Co-pays

11. The POS System must process claims by including specifications to pay claims for discretionary periods of time (e.g., day, week, month).

12. The POS System must ensure that, if a claim is covered by third party insurance and the service is designated for cost avoidance, claims are denied and cost is avoided on the claim.

13. The POS System must handle Third Party Liability (TPL) billing, reporting, tracking, and collection (coordination of benefits).

14. The POS System must provide Pay and Chase capabilities, both manual and automated.

15. The POS System must:
    - Accommodate existing and future NCPDP standards, including on-line submission of multiple ingredient compound prescriptions
    - Receive all NCPDP data fields, voids, rebilling, partial fill transactions, and the most detailed levels of reject code specificity
    - Accommodate Department policies regarding drug program payments and benefits
    - Provide recipient eligibility verification using NCPDP standards
    - Utilize a preferred drug list, as defined by the Department
    - Supply data and information as necessary for the drug rebate data system and functions

16. The POS System must make both adjudicated and "in process" claims accessible by the Web for both the pharmacy side and the State side of transactions.

17. The POS System must identify any restricted recipient or Coordinated Services Program PCP information from MMIS data.

18. The POS System must perform on-line, real-time adjudication of pharmacy claims submitted through POS.

19. The POS System must perform all necessary validity, logic, consistency, and coverage editing for all claims submitted.

20. The POS System must reject or deny claims based on system edits supporting DHS-approved error conditions.

21. The POS System must provide adjudicated claims and payment processing data to the MMIS for payment processing.

22. The POS System must identify the lesser payment amount from a list of recognized and accepted pharmaceutical reimbursement methods. This "lesser payment amount" is the amount forwarded on for payment.

23. The POS System must ensure that ingredients that make up compound drugs are validated through all audits and ProDUR edits.

24. The POS System must ensure that claims are edited to the maximum extent possible and that all failed edits are returned to the entity submitting the claim with adequate information to allow for the least number of resubmissions of a corrected claim.

25. The POS System must override edit checks based on the existence of a related pharmacy prior authorization or other DUR responses or other codes entered or submitted by the pharmacy.

26. The POS System must apply and select multiple pricing methodologies/algorithms to determine drug payment.

27. The POS System must handle exception processing.

28. The POS System must cross-reference "rebateable drug" information obtained from CMS with the DHS drug maintenance file to ensure that DHS is not paying for non-rebateable prescriptions. This functionality must include the ability for State staff to do emergency modifications to rebate status / coverage status of drugs. Such modifications must not be overridden by system file updates (e.g., First DataBank / MediSpan updates).

29. In preparation for the Medicare Part D implementation, the POS System must process pharmacy claims for Dual Eligibles (i.e., Medicaid AND Medicare eligibility) where State-mandated full coverage or wrap-around coverage is being provided by DHS. Appropriate benefit reference tables will be built in the system and are easily cross-referenced with recipient TPL and Dual Eligibility identification data to automate these claims.

30. For claims that come in to the MMIS on an 837 transaction and contain NDCs, the POS must:
    - Accept NDC information from a "split 837"
    - Have separate processing
    - Accommodate bringing the transaction information back together for the 835 transaction

31. The POS System must be capable of accepting files from the North Dakota Office of Attorney General that identify sex offenders and, according to Department specifications, must be able to cross-reference this information with prior authorization requests and claims to determine whether the State will pay for certain prescriptions.

7.3.1.3.2   Interfaces

Interfaces for the Pharmacy Claims Processing and Adjudication function include, but are not limited to:

1. Interface with MMIS for the acceptance and transfer of claims data captured, and other recipient eligibility, recipient liability, co-pay information, provider eligibility, reference/formulary, prior authorization, claims pricing and other MMIS data needed for POS claims adjudication.

2. State-of-the-art technology and industry standard interfaces to pharmacy providers for submission of pharmacy claims for North Dakota Medicaid-eligible and other recipients [such as Women's Way, AIDS Drug Assistance Program (ADAP)].

7.3.1.3.3   Inputs

Inputs for the Pharmacy Claims Processing and Adjudication function include, but are not limited to:

1. Manual pricing for some drugs.

2. Pharmacy claim adjustments and reversals from providers.

3. Provider data from MMIS, member and TPL data from VISION / TECS and/or the Data Warehouse.

4. Prior authorization approvals.

5. Long Term Care Credits.

6. Sex offender registration files from the North Dakota Office of Attorney General

7.3.1.3.4   Outputs

Outputs for Pharmacy Claims Processing and Adjudication include, but are not limited to:

1. Paid and denied claims are forwarded to MMIS weekly for payment.

2. Adjudicated claims data for checkwrite process.

3. A weekly claim submission statistical report to DHS that identifies the number of claims and adjustment requests submitted and a breakdown of the results of processing by claims status (i.e., paid, denied, suspended, rejected) with total dollars for adjudicated, paid, denied, suspended, and rejected claims and adjustments.

4. Weekly, monthly, and quarterly reports for desk auditing and other purposes (e.g., overrides of early fills, TPL payment, no TPL on file, billed amount greater than 10 times allowed amount, and dose greater than 4 times usual dose).

5. On-demand pre-formatted reports available from the POS that provides real-time information including but not limited to physicians, prescriptions, recipients, cost reports, etc. Reports should be easily converted to a Portable Document Format (PDF) or Excel format.

7.3.1.3.5   *Performance Standards*

Performance standards for Claims Processing and Adjudication include, but are not limited to:

1. The POS System provides adjudicated claims and payment data to the MMIS according to requirements agreed upon in the design.

7.3.1.4   PHARMACY EDITS AND AUDIT DATA

7.3.1.4.1   *Functional Requirements*

The functional requirements for Pharmacy Reference Edits and Audits include, but are not limited to:

1. The POS System must accept and automatically conduct drug file updates for multiple formularies.

2. The POS System must institute drug-specific variable rates (i.e., % of Rx utilization threshold) for how soon a refill can occur. Conceptually, DHS would like to institute early refill edits based upon percentage of utilization that can vary based upon day's supply (e.g., 70% of days supply 1 – 10, 75% of days supply 10 -20, 80% of days supply 20 – 34 days), in tandem with early override capability at the drug-specific level [e.g., Generic Code Number / Generic Product Indicator (GCN/GPI), NDC, etc.].

3. The POS System must link various edits/audits for formulary, prior authorization, or benefit restriction to relevant demographic information (e.g., age, gender).

4. The POS System must perform all necessary logic and consistency editing for all submitted claims before transmittal to the MMIS or acceptance by the POS. This includes, but is not limited to, logical dates of service (e.g., valid dates, not future dates), valid NDC code, pricing, number of units consistent with State and federal policy, third-party insurance coverage, data integrity/completeness, filing limitations, etc.

5. The POS System must provide full audit capabilities.

6. The POS System must allow State users to view and make changes to the system edit and audit criteria.

7. The POS System must provide more detail error codes than are present in NCPDP 5.1 messages (e.g., error codes by GCN/GPI).

8. The POS System must edit for drugs that are covered by Medicare Part D and Medicare Part B.

9. The POS System must ensure system security for those individuals having access to any adjustment capabilities. Overall, a higher level of security is needed, as well as audit trails.

10. The POS System must allow manual adjustments to drug maintenance file for the State to respond quickly to changes in coverage. This helps the State avoid delays in implementing policy due to the drug information database file vendor's updating processes.

11. The POS System must identify Medicare Part B and Medicare Part D eligibility and edit and adjudicate claims according to disposition criteria established by DHS.

12. The POS System must maintain an audit trail of all changes to the drug file showing all additions and deletions, and showing before and after images of records that have been changed.

13. The POS System, at a minimum, must utilize the following in its drug data set:
    - Pricing of compound and generic drugs
    - Ten date-specific pricing segments/histories
    - Indicator for multiple dispensing fees
    - Indicator for drug rebate
    - Indicator for preferred drug
    - DHS-specific restrictions on conditions to be met for a claim to be paid, such as minimum and maximum days' supply, quantities, refill restrictions, member age, sex restrictions, medical review requirements and prior authorization requirements
    - Approved package size to be used in calculating maximum allowable unit cost if other than NDC-specific
    - English description of the drug code
    - Current prices, including unit dose packaging
    - Electronic notification to DHS of newly approved drug products
    - Weekly updating of the Drug Code and Pricing File in accordance with DHS timeliness requirements
    - Identification of Drug Efficacy Study Implementation (DESI, or the less than effective drug list) or recalled drugs and   any drug codes for generic equivalents in the automated system
    - Drug therapeutic class coding
    - All current information on the North Dakota drug master tape and current pricing tape
    - The information required to support the drug utilization review functions
    - Non-covered or limited drugs by drug classes or individual drug code
    - Pricing fields for each NDC code for at least the following: the federal and State MAC, WAC, Average Sales Price (ASP), EAC, AWP, Medicaid AWP, or other ingredient cost definition as determined by DHS; professional fee; name of product; description of product; drug class; therapeutic class; unit of issue; family planning code; effective date of the price; and size of package
    - For each code, information that will set various reimbursement limits and restrictions
    - On-line inquiry access to the drug code and pricing file by NDC number, partial number, and drug product name

- All existing common fields supplied by companies such as First DataBank or MediSpan

14. The POS System must maintain the National Drug Codes and the estimated acquisition costs of drugs, as defined by DHS.

15. The POS System must allow the user to define an unlimited number of edits and business rules for POS claim rejection that can be tied to standard NCPDP DUR reject codes for claim denial and/or ProDUR.

16. The POS System must produce reports that identify providers or recipients with high use of pharmacy DUR edit override codes.

17. The POS System must allow DHS to define business rules that allow the system to infer a disease state by associating prior drug history with certain conditions. Consequently, the POS System must have the capability to override the need for a pharmacy prior authorization or other ProDUR rejects accordingly (e.g., override prior authorization requirement of a cancer diagnosis when the claims history identifies that the recipient is on chemotherapy drugs).

18. The POS System must perform an edit to ensure that the recipient is eligible on the fill date of the prescription.

19. The POS System must perform an edit to ensure that the claim date does not occur on a future date (e.g., fill date is greater than the current date).

7.3.1.4.2   Interfaces

Interfaces for Pharmacy Reference Edits and Audits include, but are not limited to:

1. On-demand FTP download of the drug file from drug information database source (e.g., First DataBank, MediSpan, etc.) or any alternate source of the drug file.

7.3.1.4.3   Inputs

Inputs for Pharmacy Reference Edits and Audits include, but are not limited to:

1. Drug File from the State's designated drug information database source (e.g., First DataBank, MediSpan, etc.).

2. Manual changes to pharmacy reference edits and audits criteria.

7.3.2 DRUG UTILIZATION REVIEW (DUR)

Flexibility within the POS system is a must, in order to allow the Department to make more suitable decisions for North Dakota. Sometimes DHS may need to modify the edit and audit criteria used for ProDUR and RetroDUR, or establish new policies surrounding drug utilization (e.g., early refill thresholds), and the system must have the capability to easily implement these types of decisions.

The functional requirements, interfaces, inputs, outputs, and performance standards are listed below for the following business areas of Drug Utilization Review:

- Prospective Drug Utilization Review (ProDUR)
- Retrospective Drug Utilization Review (RetroDUR)

7.3.2.1 PROSPECTIVE DRUG UTILIZATION REVIEW (PRODUR)

7.3.2.1.1 Functional Requirements

The functional requirements for ProDUR include, but are not limited to:

1. The POS System must deny pharmacy claims if the prescribed dosage exceeds a State specified multiplier of "x" times the recommended daily dose (e.g., 4 times the recommended daily dose).

2. The POS System must deny pharmacy claims based upon severity of various interactions, including:
    - Drug / drug interactions
    - Duration of therapy
    - Drug / gender interactions
    - Drug / food interactions

3. During the ProDUR process, the POS System must build recipient profiles that include medical history. This information is used for diagnostic purposes, as well as for historical reference in the interaction review process.

4. The POS System must maintain "hard denial" capability for pharmacy claims (e.g., early refills for controlled substances) that can be flexible to conform to State needs.

5. The POS System must maintain "soft denial" capability for pharmacy claims (e.g., early refills for non-abusable drugs) that can be flexible to conform to State needs.

6. The POS System must institute drug-specific variable rates on how soon a refill can occur (i.e., percentage of prescription utilization threshold). This could possibly be accomplished by instituting a global threshold percentage (e.g., 75%), with early override capability at the drug-specific level (e.g., by GCN/GPI or NDC).

7. The POS System must allow DHS to customize ProDUR criteria that are received from the State's drug information database source (e.g., First DataBank, MediSpan, etc.), but ensure that any modified criteria are not overwritten by subsequent updates from the drug information database source.

8. The POS System must institute ProDUR screening for AIDS Drug Assistance Program or any other benefit program administered through the POS and MMIS systems.

9. The POS System must provide automated, integrated on-line, real-time ProDUR capabilities.

10. The POS System must compare a prescription claim against member claims history and explicit predetermined standards, including monitoring for:
    - Therapeutic appropriateness
    - Overutilization
    - Underutilization
    - Appropriate use of generic products
    - Therapeutic duplication
    - Drug-disease contraindications
    - Drug-pregnancy contraindications
    - Drug-drug interactions
    - Incorrect drug dosage or duration of drug treatment
    - Clinical abuse or misuse

11. The POS System must generate alerts based on clinical or program compliance issues associated with a member's prescription for a pharmacist to evaluate.

12. The POS System must maintain flexible, user-controlled parameters to adapt the situations in which particular on-line ProDUR messages will be generated.

13. The POS System must allow providers to cancel or override a ProDUR message and/or be able to comment on the ProDUR messages.

14. The POS System must produce the necessary ProDUR information to support the State in completing the CMS Annual Drug Utilization Review (DUR) report, as described in Section 1927 (g)(3)(D) of the Social Security Act.

7.3.2.1.2   Interfaces

Interfaces for ProDUR include, but are not limited to:

1. Data Warehouse.

7.3.2.1.3   Inputs

Inputs for ProDUR include, but are not limited to:

1.   State's designated drug information database source (e.g., First DataBank, MediSpan, etc.) for ProDUR criteria.

2.   Early refill criteria (presently developed in-house).

3.   Claims history data from Data Warehouse.

4.   New pharmacy claims.

7.3.2.1.4   Outputs

Outputs for ProDUR include, but are not limited to:

1.   Quarterly cost-savings reports.

2.   Quarterly ProDUR alert ranking reports.

3.   Monthly summary and detail reports showing the frequency of each ProDUR message for each provider with totals for all providers.

4.   Ad hoc reporting capabilities.

5.   Annual CMS DUR report.

6.   ProDUR message response reports from pharmacies and recipients.

7.   ProDUR criteria to the Data Warehouse, for the purposes of synchronization with RetroDUR criteria.

7.3.2.1.5   Performance Standards

Performance standards for ProDUR include, but are not limited to:

1.   The POS System processes updates to recipient profiles on no less than a weekly basis.

2.   The POS System generates a quarterly report showing cost-savings as a result of ProDUR alerts and denials.

3.   The POS System generates a quarterly report of drug ranking, by ProDUR alerts, with user-defined sort capabilities.

7.3.2.2   RETROSPECTIVE DRUG UTILIZATION REVIEW (RETRODUR)

7.3.2.2.1   Functional Requirements

The functional requirements for RetroDUR include, but are not limited to:

1. The POS System must use all of the common industry edit definitions, where appropriate.

2. The POS System must, in an "on demand" manner, track prescribing patterns for identified recipients.

3. The POS System must export ProDUR criteria to the DSS/DW for purposes of synchronization with RetroDUR criteria.

4. The POS System must accommodate RetroDUR screening for AIDS Drug Assistance Program or any other benefit program administered through the POS and MMIS systems.

5. The POS System must support analysis of prescription patterns by physician, by drug category, individual drug, geographic parameter and member demographic.

6. The POS System must develop provider profiles that offer comparisons to peers.

7. The POS System must support analysis of member utilization patterns, by drug category, individual drug, geographic parameter and member demographic.

8. The POS System must develop member profiles with comparisons to peer groups (e.g., diagnosis, procedures, age, gender, and other demographic criteria).

9. The POS System must maintain an on-line audit trail of all updates to DUR data.

10. As part of the RetroDUR process, the POS System must identify any recipients or providers that need to be referred to SURS.

7.3.2.2.2   Interfaces

Interfaces for RetroDUR include, but are not limited to:

1. Data Warehouse.

7.3.2.2.3   Inputs

Inputs for RetroDUR include, but are not limited to:

1. RetroDUR criteria input by State staff.
2. Paid claims data from MMIS.
3. Electronic pharmacy claims from providers.

7.3.2.2.4   Outputs

Outputs for RetroDUR include, but are not limited to:

1. Analytical reports on utilization by specific drug categories, as requested by DHS.

2. Analytical reports on utilization by specific individual drugs, as requested by DHS.

3. Report of pharmacies by amount paid.

4. Report of top prescribing physicians ranked by ingredient cost, number of prescriptions and average prescription cost.

5. Report of the most prescribed drugs ranked by amount paid and by number of prescriptions.

6. Report of pharmacy generic drug usage ranked by percent of generic prescriptions, based on type of reimbursement.

7. Monthly denied claims summaries that include denial reasons, denial codes, and number and percent from each provider by both individual denial code and aggregate denials as defined by DHS.

8. Pharmacy cost summary reports on a Per Member Per Month basis.

9. Report of all members with total monthly pharmacy expenditures greater than a threshold specified by DHS.

7.3.3   DRUG REBATE

DHS hopes to improve many of the functions in the Drug Rebate program by instituting electronic processes for tracking, invoicing, and receiving payments. Flexibility in the POS system will support interfaces with Federal and State applications that will allow the State to receive drug rebate data electronically and to track adjustments and interest information in the State's Accounts Receivable system.

The functional requirements, interfaces, inputs, outputs, and performance standards are listed below for the following business areas within Drug Rebate:

- • Drug Rebate Invoicing
- • Drug Rebate Tracking
- • Drug Rebate Payments

7.3.3.1   DRUG REBATE INVOICING

7.3.3.1.1   Functional Requirements

The functional requirements for Drug Rebate Invoicing include, but are not limited to:

1. The POS System must generate quarterly invoices for amounts owed by manufacturers.

2. The POS System must electronically invoice manufacturers that accept electronic invoices.

3. The POS System must calculate amount due by manufacturer or labeler for drug rebates.

4. The POS System must accomplish Drug Rebate Invoicing processes for a State-specific Drug Rebate program, if instituted by DHS.

5. The POS System must accomplish Drug Rebate Invoicing processes for a Supplemental Drug Rebate program, if instituted by DHS.

6. The POS System must avoid generation of drug rebate invoices if amount to be invoiced is below a certain threshold value (e.g., $5.00).

7. The POS System must accommodate non-generation of drug rebate invoices for State-specified reasons other than total dollars.

8. The POS System must run drug rebate invoice cycles on an ad-hoc basis at the program-specific level.

9. The POS System must allow manual adjustment to rebate invoice amounts, in the event of disputes from manufacturers and similar scenarios.

10. The POS System must capture invoice dates.

11. For interest-bearing Accounts Receivables, the POS System must accommodate account balance updates for applying Treasury Bill (T-Bill) rates to overdue balances.

12. The POS System must accommodate exclusion of certain classes of drugs from rebate participation, per State or federal mandates.

13. The POS System must generate outlier or anomaly reports that identify potential decimal quantity errors or unit of measure errors.

14. The POS System must maintain confidentiality of labeler and State information in accordance with all federal and State confidentiality statutes, regulations, and requirements.

15. The POS System must apply credit balances from previous quarters to amounts due from the current quarter prior to the invoicing process.

16. The POS System must calculate and invoice supplemental rebates separately based upon State supplemental drug rebate agreements.

17. The POS System must identify rebate-eligible claims.

18. The POS System must translate units from pricing to CMS rebate units (e.g., gm. to ea., ea. to mls) on an NDC level.

19. The POS System must identify and modify/crosswalk CPT/HCPCS codes to NDC codes for purposes of drug rebate.

7.3.3.1.2   Inputs

Inputs for Drug Rebate Invoicing include, but are not limited to:

1. Treasury Bill (T-Bill) rates.

2. Claims data from Data Warehouse.

3. Drug product data from Data Warehouse and/or MMIS.

4. Participating manufacturer drug rebate data from CMS, including but not limited to:
   - Manufacturer address
   - Rebateable drugs
   - Rebate amounts
   - Contact information for manufacturer

5. Excluded pharmacies (e.g., 340b pharmacies) whose claims will not be included in invoice generation.

6. Other data requests from vendors, as needed, due to open records laws.

7.3.3.1.3   Outputs

Outputs for Drug Rebate Invoicing include, but are not limited to:

1. Detailed claims data to manufacturer that supports invoice amount.

2. Outlier or anomaly reports identifying potential errors.

3. Claim-level detail provided over the Web for manufacturer access.

4. Drug Rebate invoice amounts to Data Warehouse for maintenance of net cost information.

5. Drug Rebate invoice amounts to Data Warehouse for use during RetroDUR.

6. Other data requests from vendors, as needed, due to open records laws.

7.3.3.1.4   Performance Standards

Performance Standards for Drug Rebate Invoicing include, but are not limited to:

1. Process CMS URA data, produce, and submit invoices to manufacturers within fifteen (15) days of receipt of the tape or within sixty (60) days after the end of each quarter.

7.3.3.2   DRUG REBATE TRACKING

7.3.3.2.1   Functional Requirements

The functional requirements for Drug Rebate Tracking include, but are not limited to:

1. The POS System must generate notices of late payment at intervals designated by the State (presently at 38-day, 60-day, and 90-day intervals).

2. The POS System must provide Internet-based capability for dispute resolutions, in which manufacturers / labelers can only see their own claim-level detail for rebates.

3. The POS System must generate and distribute electronic notices of overdue payment to manufacturers.

4. The POS System must track Unit Rebate Amounts for AIDS Drug Assistance Program or any other benefit program administered through the POS and MMIS systems.

5. The POS System must accomplish Drug Rebate Tracking processes for a State-specific Drug Rebate program, if instituted by DHS.

6. The POS System must accomplish Drug Rebate Tracking processes for a Supplemental Drug Rebate program, if instituted by DHS.

7. The POS System must maintain historical drug rebate rates for prior quarters, up to 10 years (or as otherwise designated / required by CMS or State).

8. The POS System must capture drug rebate amounts that are negotiated separately by the State with manufacturers.

9. The POS System must have separate fields in its Drug Rebate Tracking functionality to identify manufacturer, quarter, NDC, and program.

10. The POS System must capture drug rebate allocations at the NDC level for reporting purposes.

11. The POS System must accommodate NDC-specific Accounts Receivable tracking.

12. The POS System must automatically generate internal notices for Accounts Receivables that are greater than 120 days. For these balances, a special agency report must be produced and this process would be initiated by this internal notice.

13. The POS System must produce a report on "zero dollar" Unit Rebate Amounts.

14. The POS System must provide DHS with on-line access to drug rebate data.

15. The POS System must provide a code conversion table for converting HCPCS/CPT codes to NDCs for inclusion on the original invoice for manufacturers.

16. The POS System must maintain multiple manufacturer enrollment dates, termination dates, and address changes that are provided by CMS.

17. The POS System must maintain complete and accurate records of all checks received, units adjustments, write-offs, resolutions, interest paid, original and corrected units, outstanding balances and contacts with manufacturers on current and prior drug rebate/invoice information in compliance with all federal and State reporting requirements.

18. The POS System must maintain an audit trail of transactions related to the drug rebate invoices and provide the capability to display original and all revised invoice records.

19. The POS System must maintain dispute resolution data for multiple rebate programs.

20. The POS System must maintain drug rebate invoice and correspondence history for up to 10 years, or at other intervals designated by State and federal government.

7.3.3.2.2   Interfaces

Interfaces for Drug Rebate Tracking include, but are not limited to:

1. CMS for drug product data (e.g., NDCs), drug rebate data (e.g., rebate amounts per unit), manufacturer address updates, and DESI rating flags / indicators.

2. Drug manufacturers.

7.3.3.2.3   Inputs

Inputs for Drug Rebate Tracking include, but are not limited to:

1. Drug product data from CMS.

2. Quarterly drug rebate data from CMS that identifies participating manufacturers.

3. Drug Efficacy Study Implementation rating flags / indicators from CMS.

4. State-determined drug rebate amounts negotiated with manufacturers.

5.   Invoice support data from manufacturers.

6.   Rebate agreements for Supplemental Drug Rebate.

7.   Unit conversions (e.g., between First Data Bank / MediSpan and CMS units).

7.3.3.2.4   Outputs

Outputs for Drug Rebate Tracking include, but are not limited to:

1.   Drug Rebate, Utilization, and Cost reports to DHS for further dissemination to approved third parties (e.g., a Pharmacy & Therapeutics Committee).

2.   Drug rebate & claims "matched data" to Data Warehouse for data modeling purposes.

3.   38-day Accounts Receivable notices.

4.   60-day Accounts Receivable notices.

5.   90-day Accounts Receivable notices, or other time interval(s) designated by the State.

6.   Zero-dollar Unit Rebate Amounts.

7.   Outstanding balance reports, by manufacturer.

8.   Outstanding disputes reports, in total or by manufacturer within specified date ranges.

9.   Reports showing percentage of rebate recoupments, in total or by manufacturer, within specified date ranges.

7.3.3.2.5   Performance Standards

Performance standards for Drug Rebate Tracking include, but are not limited to:

1.   Drug Rebate, Utilization, and Cost reports provided to Pharmacy & Therapeutics (P&T) Committee prior to quarterly meetings.

2.   Report utilization data to CMS within sixty (60) calendar days after the end of a quarter.

3.   Invoice manufacturers for quarterly drug utilization not later than sixty (60) days after each rebate period.

7.3.3.3   DRUG REBATE PAYMENTS

7.3.3.3.1   Functional Requirements

The functional requirements for Drug Rebate Payment include, but are not limited to:

1. The POS System must accomplish Drug Rebate Payment processes for a State-specific Drug Rebate program, if instituted by DHS.

2. The POS System must accomplish Drug Rebate Payment processes for a Supplemental Drug Rebate program, if instituted by DHS.

3. The POS System must accommodate Electronic Funds Transfer for Drug Rebate payments by manufacturers and accommodates receipt of Drug Rebate payment details through ROSI electronic forms.

4. The POS System must accept Reconciliation of State Invoice (ROSI) and Prior Quarter Adjustment Summaries (PQAS) electronically.

5. The POS System must capture payment dates.

6. The POS System must match Unit Rebate Amounts (URAs) from manufacturer with the URA on file from CMS. Reports are generated identifying discrepancies.

7.3.3.3.2   Interfaces

Interfaces for Drug Rebate Payment include, but are not limited to:

1. Interface with State Financial System for accounts receivable (A/R) tracking purposes.

2. Systems providing electronic ROSI forms.

3. Systems providing electronic PQAS.

7.3.3.3.3   Inputs

Inputs for Drug Rebate Payment include, but are not limited to:

1. Manufacturer's Drug Rebate Payment data (ROSI).

2. Prior Quarter Adjustment Summaries (PQAS) from manufacturers, identifying prior quarter changes.

3. Electronic and manual data entry and adjustments.

7.3.3.3.4   Outputs

Outputs for Drug Rebate Payment include, but are not limited to:

1. Cost reports for DHS that contain both pre- and post-rebate dollar amounts.

2. Cost reports to DHS for further dissemination to approved third parties (e.g., a P&T Committee).

3. Cost reports to State policy staff.

4. Manufacturer / CMS URA discrepancy reports.

5. NDC level reports on disputes, under/overpayments by labeler.

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7.4   DSS REPLACEMENT SYSTEM REQUIREMENTS

DHS envisions that the replacement DSS and Data Warehouse will be expanded to support the data needs of all of the Department's programs with an enterprise-based system. An important goal for a replacement decision support and data management system is to make it accessible and user friendly to all program staff so that inquiries and ad-hoc report requests can be accomplished without seeking assistance from the Contractor or a State data analyst.

The functional requirements, interfaces, inputs, outputs, and performance standards are listed below for the following business areas within the DSS:

- Data
- Analytics
- Queries and Reporting

7.4.1   FUNCTIONAL REQUIREMENTS

7.4.1.1   DATA

The functional requirements for the Data function are:

1. The system must maintain all historical data presently stored in the Medstat DSS.

2. The system must maintain a minimum of 126 months and a maximum of 137 months of data history for all required Medicaid data (beginning with the start date for data housed in the current Medstat DSS if less than 10 years are currently available). The oldest data will be archived to electronic media storage once the full current year's data has been completely entered for the current Calendar Year (CY), State Fiscal Year (SFY), and Federal Fiscal Year (FFY). Therefore, the system would allow analysis upon the following example data sets:

    1.) January 1994 - December 2003 (CY94 to CY03 - 120 months)
    2.) January 1994 - November 2004 (CY94 to CY03, plus 11 months - 131 months)
    3.) July 1993 - June 2003 (SFY94 to SFY03 - 120 months)
    4.) July 1993 - May 2004 (SFY94 to SFY03, plus 11 months - 131 months)
    5.) October 1993 - September 2003 (FFY94 to FFY03 - 120 months)
    6.) October 1993 - August 2004 (FFY94 to FFY03, plus 11 months - 131 months)

    In this example, maintaining data from July 1993 to December 2003 (126 months) would accomplish the minimum data sets for Calendar Year, State Fiscal Year, and Federal Fiscal Year. Maintaining data from July 1993 to November 2004 (137 months) would accomplish the maximum data sets for Calendar Year, State Fiscal Year, and Federal Fiscal Year. The State reserves the right of official approval for archiving to electronic media.

3. The system must have its own security functionality that controls various types of data access. Security is user-specific and controls the following:
   - Access to data marts
   - Level of detail of data in the data mart
   - Limits for the records within the data mart (e.g., only show those records for current recipients)
   - Read/View versus Write/Update access

4. The system must maintain an audit trail of all updates/changes to data in the Data Warehouse and must be capable of generating audit trail reports that show:
   - Before and after images of changed data
   - User ID of the individual that changed the data
   - Date that the change was made
   - Time that the change was processed

5. The system must terminate, reverse, or back-out a data update in the event it is discovered that the update is erroneous or corrupted.

6. The system must allow for "intelligent" data load processing to the Data Warehouse. All load processes must include, but not be limited to, the following functionality:
   - Identify if an error occurred during the load process and automatically notifies a list of contacts by email and/paging
   - Confirm that the data loaded was the data expected to have been loaded and if not, automatically notifies a list of contacts by email and/or paging

7. The system must employ proven database design and data management methodologies to validate, edit, scrub, and transform raw data prior to loading/updating the Data Warehouse on an ongoing basis. After loading/updating, the system's database(s) must be "analytically ready" to support the Data Warehouse. These methodologies must, at a minimum:
   - Analyze completeness of updates based on historical and projected data volume for the source
   - Integrate various data types and formats received from a variety of sources, such as: medical claims, fee schedules, encounters, eligibility information, and provider information
   - Standardize data into a common format to enable normative comparisons
   - Customize database design in accordance with the State's analytical and ad hoc reporting requirements
   - Assess and improve the quality of data contained within the database

8. The system must accept loading of budget allocations for various categories and subcategories of service and eligibility groups for the fiscal year and be capable of measuring expenditures on an ongoing basis.

9. The system must capture other medical payments made through the North Dakota financial accounting system. Such payments may include:
   - Health Insurance Premium Payments or Co-payments on behalf of Recipients
   - Medicare Buy-In Premiums
   - Supplemental DSH Payments
   - Other Gross Level Payments or Adjustments

- Premium payments made by recipients such as through the Workers with Disability Program
- MCO Capitation Payments
- SCHIP Premium Payments

10. The system must capture recoveries for the State, as reported by other DHS contractors, or State agencies, including:
   - Estate Recoveries
   - TPL
   - Drug Rebates
   - Fraud and Abuse Recoveries
   - Recipient Overpayment Recoupment
   - Child Support Recoveries for Medical Support Payments
   - Provider Overpayments

11. The system must accept the full claim record for HIPAA compliant X12 837 formats, in addition to accepting the full claim record for proprietary formats used by HCBS, Basic Care, and DD (non-ICF/MR facilities). This includes paid claims, denied claims, adjustments, and associated financial transactions that are tied to the claims.

12. The system must save extracted data within the Data Warehouse, based on selected storage parameters, and have the ability to retrieve the saved extracted data for use at a later time.

13. The system must ensure that all electronic data transfers and access comply with all applicable federal HIPAA Privacy and Security requirements.

14. The system must invoke standard data validity checks prior to queries being submitted or run (e.g., correct data type, non-zero, required).

15. The system must accept and aggregate data from sources other than the MMIS, such as:
   - Workforce Safety and Insurance
   - Department of Health
   - Geographic Information Systems (GIS) Hub

16. The system must access new data fields populated with historical data where available.

17. The system must define new data fields to the Data Warehouse. Data fields to be included in the Data Warehouse will be defined and agreed upon during DDI and a process will be developed to address the addition(s) of new fields to the Data Warehouse. Timeline and prioritization for requested addition(s) will consider the reason and/or priority for the addition (e.g., federal or legislative changes that require additional fields for immediate reporting will be given higher priority).

18. The system must maintain historical cost information received from providers.

7.4.1.2 ANALYTICS

The functional requirements for the Analytics function are:

1. The system must allow data files to be imported, exported, and manipulated from various spreadsheet applications, word processing applications, database management tools, and databases.

2. The system must access (i.e., easily look-up) Data Warehouse information such as subsets, norms, benchmarks, query creation and all other objects and functions.

3. The system must allow for summary by State Fiscal Year, Federal Fiscal Year, calendar year, and any combination thereof, and year-to-date, fiscal year-to-date, from any point in time.

4. The system must accommodate all levels of users and allow users to retrieve data without relying on programmers.

5. The system must allow users to develop queries for modeling, data analysis, forecasting, and trend analysis.

6. The system must provide non-technical end users with an extensive array of executive-level, powerful, and highly flexible capabilities to identify and test assumptions about the Medicaid program, including:
   - Budget Management
   - Cost Containment
   - Utilization Management
   - Program Operations
   - Quality of Care

7. The system must track claims on both an incurred (date of service) and paid (date of payment) basis.

8. The system must construct and utilize compound expressions that evaluate more than one comparison at a time, using any valid combination of logical operators (AND, OR, NOT, IF, ELSE, THEN), comparison operations (<, < =, >, > =, <>, LIKE, NOT LIKE, not equal to, +, -, *, /, Arithmetic Functions [Abs(x), Cos(x), Random(S), etc.]; String Functions [Char_Length(s), Substring(s, pos, len), etc.], Date Arithmetic Functions, Date Component Functions, Date Conversion Functions, Type Conversion Functions [Char(x), Float9x), etc.], and parentheses.

9. The system must provide calculation capabilities, including: count, sum, average, mean, median, mode, standard deviation, sum cumulative, first, last, unique count, transpose row to column, standard error, coefficient of variation, skewness, count of zero values, percentiles, minimum, maximum, subtotaling and grand totaling, simple and complex cross-tabulation, and comparisons (e.g., amount paid versus a percentage of billed charges).

10. The system must provide a selection of pre-defined, standardized calculations for use in generating queries such as: age, member months, elapsed time, utilization rates, per number of members, and ratios.

11. The system must have selection parameter capability to utilize any correct/valid value, set of individual values, or range of values.

12. The system must generate random samples from all specified items (e.g., providers, recipients, claims) in the database, or from the results of a query, (e.g., all recipients under age 21, all providers with claims paid on specified dates).

13. The system must have a sampling capability that can generate statistically valid, stratified random samples of items in the Data Warehouse database with appropriate descriptive statistics and confidence levels.

14. The system must perform a minimum of four (4) level sorts for a requested query and drill-down to identifiable data.

15. The system must analyze billing practices by individual providers, provider types, or combination of providers.

16. The system must analyze expenditures, by data elements contained in the Data Warehouse.

17. The system must analyze the various areas of expenditures to determine areas of greatest cost or variance. Expenditures shall be inclusive of adjustments.

18. The system must analyze progress in accrediting eligible Medicare Buy-In beneficiaries and analyze the cost-effectiveness of purchasing coverage.

19. The system must analyze provider referral patterns and service delivery patterns.

20. The system must analyze the impact of policy changes made in the program.

21. The system must compare current costs with previous period costs to establish a frame of reference for analyzing current expenditures.

22. The system must develop third-party payment profiles to determine where program cost reductions might be achieved.

23. The system must forecast program costs accurately and evaluate cost containment and quality improvement initiatives.

24. The system must identify high-cost cases to better focus utilization review and case management programs.

25. The system must perform geographic analysis of expenditures, beneficiary participation, provider participation, etc.

26. The system must project the cost of program services for future periods based on past and current trends.

27. The system must perform quality of care measurements, such as:
    a.) Admissions
    b.) Readmissions
    c.) Discretionary surgeries
    d.) Complications of treatment
    e.) Cesarean sections
    f.) Deaths

28. The system must review claims processing and payment information to determine if providers are being reimbursed without unnecessary delay.

29. The system must allow review of provider participation, with respect to the number of beneficiaries served, and analyze the capacity of providers to handle projected service demands.

30. The system must allow review of the utilization of services by various beneficiary categories, locations, or other indicators to determine the extent of participation and relative cost.

31. The system must compile a summary and comparison of utilization, costs, expenditures, and services.

32. The system must provide trend analysis (as related to costs, utilization, expenditures, services, disease categories) for all elements in the database.

33. The system must analyze and model proposed changes in program coverage, benefit coverage, or other characteristics.

34. The system must provide users with executive-level features for the statistical and economic analysis of information.

35. The system must allow for the identification of inpatient and preventive ambulatory episodes of care.

36. The system must provide the capability to support budget forecasting.

37. The system must provide users with the ability to compare aggregate and summary-level information in order to identify program problems and opportunities.

38. The system must provide analytical and decision-making capabilities/tools for Medicaid users to access, extract, and analyze expenditure, demographic, and service utilization data.

39. The system must utilize predefined calculations to compute amounts for groups of records or for all of the records combined in a query (sum, average, count, standard deviation, variance, date range, etc.) and utilize customized calculations to perform numeric or date calculations using data from one or more fields. Results can be displayed or used for additional calculations.

40. The system must access claims history data based on user-specified parameters.

41. The system must invoke system-generated, statistically valid, random sample selections for all claims that allow the user to set high-level selection parameters (e.g., provider, recipient, disposition, etc.), as approved by the Department.

42. The system must combine and compare large amounts of data across multiple data sources in a cross-table where dimension views can be rotated as well as drilled up or down.

43. For each appropriation category and subcategory specified by the user, the system must trend expenditures forward using the average rate of increase for the history period selected.

44. For each appropriation category and subcategory specified by the user, the system must allow the user to enter parameters representing the rate of increase. Using the projected rates of increase, the system must project budget amounts for a user-specified period of time.

45. The system must include standard statistical packages to support analysis and projection of spending on medical services.

46. The system must support simulation capability to allow the user to simulate policy actions for each appropriation category and subcategory selected. The parameters to be used for the simulation include:
   - Average Rate
   - Average Rate increase
   - Average Units
   - Average Service increase
   - Co-payment per claim
   - Average Recipient Liability
   - Average Recipient Liability increase rate

7.4.1.3   QUERIES AND REPORTING

The functional requirements for the Queries and Reporting function are:

1.   The system must notify users of any long running queries, processes, or systems maintenance delays that could impact the Data Warehouse's ability to provide a timely response on a user request.

2. The system must allow users the ability to schedule "windows" during evenings or weekends where long running queries can be executed.

3. The system must prompt users to schedule "windows" for long running queries to run during off-peak hours on Monday thru Friday, unless otherwise approved by DHS.

4. The system must prioritize queries and reports according to State-defined parameters at the individual query/report level and at the user level. Prioritization of queries and reports can be updated based upon instructions from assigned DHS staff who have the security and authority to prioritize requests.

5. The system must execute queries that perform unduplicated counts (e.g., unduplicated count of recipients receiving services), total counts (e.g., total number of services provided for a given aid category), or a combination of unduplicated or total counts.

6. The system must provide access to the full range of data attributes on the database for building queries.

7. The system must provide the capability for automatic and manual termination of queries that exceed State pre-defined processing time thresholds, including the capability for the user and/or system administrator level to manually terminate a query from the user workstation.

8. The system must recreate query results that were previously generated, by use of an "as of date".

9. The system must save generated data sets automatically in a variety of different formats (e.g., .xls, .dbf, .txt, and html) to a specified directory on the LAN and/or WAN.

10. The system must provide an on-line library/catalog for storage and retrieval of standardized or frequently used queries, with some type of security levels (creator, user, read-only) to eliminate inadvertent changes to the query.

11. The system must retain query results for access by others.

12. The system must have options to select query report presentation to be displayed on-line, in multiple media.

13. The system must estimate the query processing time to pre-define a maximum query processing time for both on-line and batch retrieval requests.

14. The system must have a flexible and easy to use, on-line capability for specifying query selection criteria (data element-specific for ad-hoc), query computation, sort, and format (report presentation) characteristics and the capability to save and view or print the criteria used in the query.

15. The system must provide a user-friendly graphical query language to construct database queries that accommodates varying levels of user skills (from the basic, occasional user to the power user).

16. The system must capture the user's ID for each query and store the processing time of the query (by user ID).

17. The system must prompt users with suggestions of query structure for more efficient operation (i.e., "wizard"-type building for queries).

18. The system must allow Ad Hoc queries of Drug Rebate information.

19. The system must maintain query libraries with documentation of query parameters and data fields that is available for all users.

20. The system must allow the user to cancel submitted jobs at any time before results have been returned.

21. The system must allow the user to query any data element or combination of data elements available in the system, regardless of the source system that contributed the data to the Data Warehouse.

22. The system must allow the user to query claims, regardless of claim status.

23. The system must allow the user to query benefit packages, by any of the data fields used to define that package, in order to associate that benefit package to the recipient.

24. The system must use common language labels for field names and their descriptions.

25. The system must maintain a personal and shared library of queries for future reference.

26. The system must allow for a single user to run multiple queries simultaneously.

27. The system must allow for the use of complex Boolean logic to select subset data (e.g., a query engine that allows users to choose Boolean operators from a menu) and to utilize more than one operator in a query, allowing a user to "nest" operator parameters.

28. The system must employ query optimizations tools on user defined queries to ensure most efficient and highest performance processing of Data Warehouse functions.

29. The system must allow the user to dynamically query the units that have been applied to a PA from the associated paid claims. (e.g., multiple units may be prior authorized and must be able to be applied as each claim is submitted).

30. The system must allow the user to query a claim line item and the associated, applicable PA.

31. The system must generate the documentation of query parameters and data elements for record-keeping purposes.

32. The system must allow the user to query service limit unit utilization by CPT code, recipient, and/or provider type.

33. The system must allow the user to sort query results by any data field in the query.

34. The system must allow the user to store query results for access and review by multiple users simultaneously.

35. The system must allow the user to define the output and medium of query/report results.
    - Output examples: MS Excel, Comma Separated Value (CSV), XML, etc.
    - Medium examples: print, file, magnetic

36. The system must allow a user to query any claim to obtain all transactions performed for that one claim, including: all denied claims history, resubmitted claims history, adjustments, associated financials, etc.

37. The system must allow routine requests for summary information and one-time queries without relying on programmer analysts or other technical experts.

38. The system must provide a selection of report templates (as defined by DHS) for information used by DHS in the management of its programs and decision making. The system must also contain templates for reports that include the scope of information typically sought by Medicaid agencies to assist program management, quality improvement, and decision making.

39. The system must allow user-defined headers, footers, columns, and rows with header/footer information including items such as: date, run time, and page numbers on reports.

40. The system must have page formatting features for creating presentation quality reports.

41. The system must have report writing capabilities that support the efficient use of format, text type/fonts, screen grid designs, and illustrations to enhance the visual display of information.

42. The system must segregate and subtotal data, and define page breaks based upon user-defined parameters within reports.

43. The system must allow customization of chart attributes, including: orientation, legends, tic marks, intervals, and scaling.

44. The system must provide a range of graph types for data presentation, including:
    - Bar chart
    - Pie chart
    - Stacked
    - Side-by-side bar charts
    - Single and multiple line charts
    - Three (3) dimensional graphs
    - Tree graphs
    - Probability plots
    - Trend lines
    - Other common-use graphical presentation methods

45. The system must provide users with extensive and highly flexible capabilities for the visual presentation of information in tabular and graphic/chart form.

46. The system must present all information in reports in well-designed, polished tables and high-quality graphs, charts, and maps.

47. The system must offer enhanced graphical representation capabilities that can interface with other programs, such as MS PowerPoint and Web-based applications.

48. The system must use modern type and typographic techniques to provide a high degree of legibility and readability, and also to provide the capacity for printing to high quality laser printers.

49. The system must offer standard editing capabilities for reports, as well as optional capabilities for shadowing, mirroring, highlighting, and flipping horizontal/vertical axes.

50. The system must make reports available on a variety of electronic media, including:
    - On-line
    - Magnetic Tape
    - Cartridge
    - Diskette
    - CD-Rom
    - Other COLD storage

51. The system must allow the user to manipulate the font style and size of any embedded text or numeric information for reports.

52. The system must offer gray-scale and pattern printing and a symbol library.

53. The system must generate random samples from all specified items in the database (e.g., providers, recipients, claims) or from the results of a query (e.g., all recipients under age 21, all providers with claims paid on specified dates).

54. The system must provide access to a "notes" or "comments" field for the input of user information on the purpose of the query or other informational messages.

55. The system must compress reports to create self-executable compressed files to electronically transfer either inside or outside the agency using appropriate security measures for transfer of data.

56. The system must produce comparison reports between valuation, pricing, and payment.

57. The system must produce outcomes measurement reports, as defined by the user.

58. The system must produce quality measurement reports, as defined by the user.

59. The system must produce rates of care/access to care reports, as defined by the user.

60. The system must produce reports to support forecasting and budgeting activities, as defined by the user.

61. The system must use built-in measures of experience relevant to Medicaid and other healthcare programs for Utilization, Cost, Quality of Care, Outcomes, Prevention, Access to Care, Eligibility and Administrative Performance for reporting purposes.

62. The system must make available on-line all routine requests from queries and standard queries for management, such as budget, operations, and utilization statistics, to avoid the need to print and distribute hardcopy reports. The system must allow analysts wishing to review service delivery and utilization for a particular group to obtain the information at their desk, thereby eliminating need to search through hardcopy reports.

63. System must produce and update on-line DHS detailed reports to be made available for external users such as providers, legislators, or recipients.

64. Using the federal coding structures, the system must generate the CMS 64.

65. Using the federal coding structures, the system must generate the CMS 21.

66. The system must include support for budgeting for claims expenditures using CMS 64 federal reporting categories for previous periods. Using parameters inserted by the user, the system must create expenditure projections for each category for a user specified future period.

67. Using the expenditure projections created in sequence 5, generate the CMS 37.

68. The system must include support for budgeting for claims expenditures using CMS 21 federal reporting categories for previous periods. Using parameters inserted by the user, the system must create expenditure projections for each category for a user-specified future period.

69. Utilizing the expenditure projections created by MMIS for each federal reporting category, generate the CMS 21A.

70. The system must report historical spending for a specific period of time defined by the user. The spending must be summarized by accounting code structures to a level of coding specified by the user.

71. The system must produce monthly provider profiles for physicians and ranking reports showing the top ten providers and where a single provider ranks compared to his peers or within a specialty. Profiling is done for particular procedures or payments received.

72. The DSS must produce reports to see volume distribution for all error codes by pharmacy, recipient, or physician to identify abuse or misuse of prescription drug benefits.

7.4.2   INTERFACES

Interfaces for the Data Warehouse include, but are not limited to:

1. CMS.

2. VISION / TECS.

3. POS.

4. MMIS.

7.4.3   INPUTS

Inputs to the Data Warehouse include:

1. Budget Allocations for various categories of service.

2. Eligibility Data.

3. Claims Data, including specific identification of:
    - Adjudicated Claims
    - Pending Claims
    - Claims adjustment data

4. Encounter Data.

5. Financial Data.

6. Reference Data.

7. Provider Data.

8. Recipient Data.

9. Estate Recovery Data.

10. Casualty Data.

11. Prior Authorization Data.

12. Drug Data (Clinical Tables, Contracted Drug Pricing Service).

13. Drug Rebate and Supplemental Rebate Data, including information necessary for Invoicing, Tracking, and Payment.

14. Point-of-Sale (POS) Transaction Data.

15. Waiver Programs Data.

16. Lead Screening Data.

17. Normative Data.

18. RetroDUR Data.

19. ProDUR Data.

20. Information requests from various sources.

21. Data Warehouse queries.

22. BENDEX and SDX Data.

23. CLIA Data.

24. Federal Poverty Level information from U.S. Department of Labor, as printed in the Federal Register.

25. EPSDT Data.

26. TPL Data.

27. Vital Records Data.

28. Data from other databases, such as:
    - Department of Health
    - Geographic Information Systems (GIS) Hub
    - Workforce Safety and Insurance

29. Claims and expenditure data, in order to create financial projections and simulations.

7.4.4   OUTPUTS

Outputs from the Data Warehouse include:

1. Monthly audit trail report on usage of the data in reports.

2. "Update and balancing" reports to DHS, in order to verify file updates on the Data Warehouse.

3. Query Results.

4. Expenditure vs. Budget Allocation reports.

5.   Defined Reports, per Functional Requirements section above.

6.   The outputs from any financial planning and simulations will be on-line projections of
     spending and programs costs, which can be printed at the user's discretion.

7.4.5   PERFORMANCE STANDARDS

Performance standards for the Data Warehouse include:

1.   The system refreshes Data Warehouse claims data tables within twenty-four (24) hours of
     the completion of the claims adjudication cycle.

2.   The system completes updates from non-MMIS data sources within twenty-four (24) hours
     of receipt of the valid data.

3.   Any extraordinary updates will be performed in a timely and accurate manner at time
     intervals determined by DHS.

4.   The system can complete complex ad hoc requests within two (2) business days of receipt
     of the request, unless an alternate timeframe is approved by DHS.

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7.5   OPTIONAL MMIS SYSTEM REQUIREMENTS

The following optional services may also be bid by bidders on the MMIS Contract. The bidder must describe in detail their proposed solution to the selected optional service(s). The following is a brief description of each optional service requirement.

7.5.1   CLAIM SUBMISSION SOFTWARE

In this optional service, the MMIS bidder must develop and provide state approved provider claim submission software to allow electronic claims submission by electronic transfer or any other media approved by the State. The software must include the following features:

- Operate on personal computers with Windows 98 or higher operating system.

- User instructions.

- Allow for submission of all North Dakota claim types.

- Include reference tables to automatically fill claim fields or to create drop-down list boxes to help the submitter in selecting data fields. These tables must be included for the following data: Provider, patient, procedure code, diagnosis code, condition code, revenue code, occurrence code, ICD-9 surgical code, and value code.

- Ability to submit, store, retrieve, and resubmit claims.

- Ability to print a prepared claim, in the event that the software is unable to connect to MMIS.

The bidder must describe in detail the proposed solution. The bidder must quantify its experience with the proposed solution and must provide a sample of the proposed software on CD.

7.5.2   AUTOMATED FINGERPRINT CAPTURE

In this optional service, the MMIS bidder would provide a system that facilitates automated fingerprint capture for criminal background checks. This system will be used to support provider enrollment activities.

The bidder must describe in detail the proposed solution as well as all hardware and software required for the solution. The bidder must quantify its experience with the proposed solution.

7.5.3   THERMAL RECIPIENT IDENTIFICATION CARDS

In this optional service, the MMIS bidder would provide a system that has the ability to produce thermal identification cards. Specifically, this is an optional requirement to provide the State with the necessary hardware, software and any other peripheral equipment necessary to produce plastic magnetic stripe thermal recipient identification cards. This solution must be

capable to support the production of cards upon demand. Supplies and card stock to support two (2) years' production must be provided. The bidder must provide all installation, testing, and training to DHS staff. A one (1) year maintenance contract must be provided for a 24-hour response time during business days.

8.0 START-UP ACTIVITIES

8.1   OVERVIEW

Start-up Activities are those activities conducted by the Contractor(s) in conjunction with the State during the Design, Development, and Implementation (DDI) phase of the Contractor's contract. This section describes the tasks required to transfer the Contractor's base system(s), design and develop necessary system modifications, install, test, and implement the specified North Dakota solutions. Following implementation, the State will own the implemented MMIS and POS, will have ongoing responsibility for the operation and maintenance of the replacement MMIS and POS, and will provide any application programming support for ongoing changes and enhancements. Where applicable, the Contractor may also be expected to takeover some existing application(s), modify, maintain, and turnover the application(s) to the State of North Dakota. The DDI phase encompasses tasks related to the design, development, and implementation of the procured system(s), as well as all activities related to the Contractor's facility, equipment, personnel, telecommunications, and office needs that support the DDI effort.

In order to be consistent with Institute of Electrical and Electronics Engineers, Inc. (IEEE) Standard 1012-1998 (Standards for Software Verification and Validation)[4], the DDI phase activities have been allocated across a core set of Software Verification and Validation processes. These processes, as defined by IEEE, are:

- Management Process – A process that "encompasses generic activities and tasks, which may be employed by any party that manages its respective processes".[5]

- Acquisition Process – A process that "begins with the definition of the need to acquire a system, software product, or software service. The process continues with the preparation and issuance of a Request for Proposal (RFP), selection of a supplier (i.e., bidder), and management of the acquisition through acceptance."[6]

- System Supply Process – A process that "…is initiated by signing and entering into a contract with the acquirer to provide the system, software product, or software service. The process continues with the determination of procedures and resources needed to manage the project, including development of project planning materials and execution of the plans through delivery of the system."[7]

- System Development Process – A process that contains the activities and tasks of the developer. The process contains the activities for requirements analysis, design, coding, integration, testing, and installation and acceptance related to [system and] software products."[8]

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[4] Standard for Software Verification and Validation (IEEE Std. 1012-1998); The Institute of Electrical and Electronics Engineers, Inc., Software Engineering Standards Committee of the IEEE Computer Society
[5] ibid., p.10.
[6] ibid., p.10.
[7] ibid., p.11.
[8] ibid., p.11.

- • System Operation Process – A process that encompasses the operation of the system and/or software product(s) and any operational support provided to users.[9]

- • System Maintenance Process – A process that is "activated when the software product undergoes modifications to [both the] code and associated [system / software] documentation. [Such modifications are] caused by a problem or a need for improvement or adaptation."[10]

Due to the fact that these Start-up Activities are being described within the context of a prepared RFP, our Start-up Activities section does not describe activities within the Acquisition Process.

Within their proposals, bidders will propose their approach to completing each of the applicable DDI deliverables that are presented below. A summary table identifying DDI deliverable requirements for each of the contracts has been provided as Attachment F. It is important to understand that the anticipated content presented establishes the State's basic expectation for the deliverable. The State understands that an individual bidder's methodology and approach to complete the tasks for a deliverable may conflict or cause slight variation from the anticipated content of a deliverable. The State expects that any alternate approaches to DDI activities (or DDI deliverable content) that are proposed by a vendor will remain focused on the greater goal: successful implementation of fully-functional, well-documented, flexible, user-friendly systems. Bidder approaches must include information such as:

- • Descriptions and timeframes for tasks and sub-tasks that the Contractor will complete as part of production of the deliverable. All tasks and sub-tasks referenced should be tasks and sub-tasks that exist in the Contractor's Detailed Project Work Plan.

- • Identification of any critical pathway tasks or sub-tasks whose successful completion is directly tied to on-time submittal of the deliverable.

- • Identification of any alternative approaches and/or tasks that the bidder is proposing to meet the objective of an individual DDI deliverable.

- • Identification of any additional content, other than what has been specified below, that the bidder is proposing to include in individual DDI deliverables.

Section 7.0 of this RFP presents system functional requirements and performance expectations for the MMIS, POS, and DSS/DW Replacement projects. Clearly, many of these system functionality and performance capabilities must be designed and developed. The activities and deliverables to accomplish this process have been described below.

*Bidders' Note: In explaining its approach to meeting the DDI task and deliverable requirements of this Section (Start-up Activities), bidders would explain any COTS or vendor proprietary tools used to complete the task or deliverable. DHS reserves the right to accept, reject, or require an alternative for any of the tools proposed.

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[9] ibid., p.15.
[10] ibid., p.15.

8.2   MANAGEMENT PROCESS

8.2.1   PROJECT MANAGEMENT ACTIVITIES

8.2.1.1   OBJECTIVES

Project Management Activities are activities that require ongoing administrative oversight throughout all DDI Processes. Objectives for the Project Management Activities include, but are not limited to the following:

1.   Establish reporting requirements and communication protocols with the DHS project manager.

2.   Prepare and present a preliminary conversion plan. It is critical that planning and detailing of this activity begin in the early stages of the project. The conversion plan must include data conversion (for MMIS, POS, or DSS/DW), as well as plans for provider transition from current claim submission requirements to new (if different).

3.   Establish and use a DHS-approved project management system for the entire project control and reporting. Make the project management system available to DHS users, on-line. The bidder will provide a detailed description of their proposed project management system.

8.2.1.2   DELIVERABLES

At a minimum, the following deliverables will be included:

1.   **Detailed Project Work Plan** – Within 4 weeks from the start of DDI, the Contractor will develop a Project Work Plan that includes a schedule and Gantt chart (for all project tasks, subtasks, and activities), milestones, and deliverables. Contractor and State resources must be included for all tasks, subtasks, and activities that exist as line items within the Project Work Plan. The Contractor's Project Work Plan will also maintain the following date-related information:

- Originally scheduled Start and End dates for all tasks, subtasks, and activities (including milestones and deliverables)
- Anticipated Start dates for future tasks, subtasks, and activities, if schedule fluctuation has occurred
- Anticipated End dates for all current and future tasks, subtasks, and activities, if schedule fluctuation has occurred
- Actual Start dates for all current and completed tasks, subtasks, and activities
- Actual End dates for all completed tasks, subtasks, and activities

The State prefers that this Detailed Project Work Plan be developed in Microsoft Project 2003 or a comparable tool that supports Earned Value reporting responsibilities of the Contractor. It is expected that the Contractor will maintain the Detailed Project Work Plan on an ongoing bases and, as quickly as possible, identify issues that affect

deadlines. Detailed Project Work Plans for MMIS, POS, DSS/DW, IV&V, and State project teams will be coordinated as a group and merged into a single master schedule by the State's Project Manager.

2. **Project Control and Project Management Plan** – This deliverable presents the Contractor's plans for managing all phases of the project, including:

- Work Hour and Time Estimating Methodology – This section of the deliverable presents the Contractor's established methods for estimation of Contractor and State staff work hours that are necessary to complete tasks. This methodology provides the baseline against which the actual work hours (as described by the Time Tracking Plan below) will be measured.

- System Development Methodology – This section of the deliverable presents the Contractor's established system and software development methodology, including: approach and standards, resource utilization, tool sets, Web-based applications, hardware and software environment, methods, processes, standards, evaluation criteria, security and privacy of information, terminology, variables, parameters, and procedures. This must also include specific information regarding:

  o *Requirements Analysis Methodology* – The Contractor presents methods for conducting a detailed requirements analysis and review. Note that the requirements as defined by the RFP and finalized during the Start-up activities will become the baseline requirements upon which all project deliverables will be based. Changes to these requirements will be managed through the Project's change management process and tools.

  o *Design and Development Methodology* – The Contractor presents its methods for completing the design and development requirements. This methodology must also address the approach to development during DDI, including the identification of any concurrent development steps and phased / sequential development steps.

  o *Data Conversion Methodology* – The Contractor presents a preliminary conversion plan. It is critical that planning and detailing of this activity begin in the early stages of the project. The conversion methodology must include data conversion (for MMIS, POS, or DSS/DW), as well as plans for provider transition from current claim submission requirements to new (if different).

  o *Testing Methodologies* – The Contractor presents methods for developing and maintaining test scenarios, test sets, test cases, test steps, etc. Testing methodologies must also address the Contractor's approach to documenting test procedures and test results.

- Risk Management and Resolution Plan – This section of the deliverable provides a description of the tasks and activities that will be performed as part of the Contractor's Risk Management Plan. At a minimum, the risk assessment will include the following:

  o *Preliminary Risk Assessment* – A description of the most significant project risks that are within the Contractor's control or within the control of DHS and a description of proposed mitigation strategies for each risk. This assessment also includes a description of the impact associated with any identified potential failures.

o   *Ongoing Risk Identification Plan* – A description of the Contractor's ongoing approach to the identification of potential risks, tracking of potential risks, and provision of information to DHS that supports the monitoring of risk across the project.

o   *Risk Response Plan* – A description of the Contractor's ongoing approach to the development of options and to the determination of actions necessary to reduce threats and enhance the Project's activities. Where applicable, contingency plans for various risks should be documented and contingency plan triggers should be identified.

- <u>Issue Management and Resolution</u> – This section of the deliverable presents a description of the Contractor's standard process for resolution of problems identified and reported by the Contractor, IV&V Contractor, and DHS/ITD staff. This description must include the Contractor's plan for ensuring that issues, requests, and decisions are recognized, agreed upon, assigned to an owner, incorporated to an issue log, monitored, documented, and managed. The Contractor shall include sample Issue Management Reports. This process will serve as the Bidder's "best practices" recommendations for issue management, to be reviewed and incorporated by the State as best benefit the Project.

  <u>Work Plan Management Plan</u> – This section of the deliverable presents a plan for ongoing management of the Detailed Project Work Plan. At a minimum, this includes information on frequency of updates, a description of how schedule-related issues will be addressed, and a strategy for integrating elements of the Work Plan with Issue Management, Status Reports, and other related project management deliverables. Note that all work plans, work breakdown structures, and schedules will be developed and maintained in such a way as to be compatible with the Project's work management process and scheduling tool (currently planned to be Microsoft Project 2003). All contractors' schedules must support the regular (i.e., weekly) reporting of Earned Value, and must also be able to be imported into a master schedule for the Project. The Contractor must fully describe its methodology for reporting Earned Value management concepts and calculations such as: Planned Value, Earned Value, Budgeted Cost, Actual Cost, Schedule Variance, and other related indices.

- <u>Time Tracking Plan</u> – This section of the deliverable describes how the Contractor will track the working time (actual work hours) of its employees. Since this will be a fixed price contract, time tracking reports will be provided to DHS only upon request.

- <u>Status Reporting Plan</u> – This section of the deliverable presents the protocol for submittal of Status Reports, including the format and media for submittal and the procedure(s) for submittal. Key information for these reports includes: variances in schedule or budget, summary of recent accomplishments, identification of and resolution plans/documentation for critical issues and risks (from issue and risk management tools), activities planned for the next reporting period, and a summary of the project's progress according to the schedule, budget, and task list. Schedule monitoring will include identification of any slippage that has occurred. DHS will stipulate a weekly progress status report, as well as a formal month-end report that will be incorporated into a monthly report to DHS and other State management.

3.   **Configuration Management Plan** – This deliverable describes the administrative and technical procedures used by the Bidder to be used throughout the software development lifecycle to control modifications and releases of the software. Key goals for this deliverable include:

- Describe the configuration management policies and procedures that will be executed
- Describe the process for recording and reporting the status of items and modification requests
- Describe the Contractor's plan/process to ensure the completeness, consistency, and correctness of releases
- Describe any controls put in place for the storage, handling, and delivery of the software releases

The Configuration Management Plan will cover the initial design, development, and implementation (DDI) as well as ongoing maintenance, enhancement, reuse, reengineering, and all other activities resulting in software products. The Contractor is expected to provide the insight into, and description of any tool(s) for monitoring, the processes to be followed for configuration management, the methods to be used, and the approach to be followed for each Configuration Management activity. Portions of the Configuration Management process may be bound separately if this approach enhances their usability. At a minimum, the plan must include:

Configuration Management Tasks – This Section will describe the tasks and activities that will be performed as part of configuration management. These tasks and activities include:

- *Configuration Identification* – Describe the types of items that will be under configuration management control, how the Contractor will set and maintain baselines, when items enter controlled status, how the labeling and numbering scheme is applied to configuration management items, how the identification scheme addresses versions and releases, and which people or groups are responsible for each item.

- *Configuration Control* – Describe the following:
  - o   Change Control – The mechanism for identification, submission, tracking, evaluation, coordination, review, and approval/disapproval of proposed changes to items under configuration management.
  - o   System Change Requests – The forms used to report problems or identify changes, and the procedures for using the forms including the method for tracking problems. The Section will also include samples of the forms to be used.
  - o   Interface with Other Groups - The interface and relationships between the Contractor's configuration control process, DHS, and other organizations and teams on the Project.
  - o   Priorities – The method for prioritizing changes.
  - o   System Release Management - The plans for releasing deliverables to DHS, including developing a release procedure, instructions for preparing version description documents, repository establishment and operation.

- o Version Control – The process to control an identified and documented body of software, including identifying version naming conventions and the configuration management actions required for modifications to a version of software (resulting in a new version).
- o Audit Control - The process to control and audit accesses to items.

- *Configuration Status Accounting* – Account for management records and status reports that show the status and history of controlled software items, including the baseline. Reports shall include: number of changes for a project, latest software item versions, release identifiers, the number of releases, and comparisons of releases. This Section will describe how information will be captured to anticipate common inquiries and provide the information in a form where it is easily accessed. The Section will also include a list of reports with the frequency and distribution.

- *Configuration Evaluation* – Describe the process to document the functional completeness of the software against their requirements and the physical completeness of the software items (whether their design and code reflect an up-to-date technical description).

- *Release Management and Delivery* – Describe the process to control the release and delivery of software products and documentation. This Section will describe the archive and retrieval process and the retention schedule for archived items, noting that master copies of code and documentation shall be maintained for the life of the software product.

Configuration Repositories – In this deliverable section, the Contractor will describe the use and maintenance of configuration repositories, including definition of the types of configuration repositories in use (i.e., physical or electronic), control mechanisms, and retention policies and procedures. The Contractor must also discuss its approach for managing the Configuration Management Environment Software Load deliverable, as defined further in the System Design section below.

Configuration Audits and Reviews – In this deliverable section, the Contractor will describe any audits or reviews of the configuration management process or library that will be conducted during the Project (e.g., audit of product baseline, audit of configuration library, review of configuration management plan, etc.).

This collective Configuration Management Plan description will serve as the Bidder's "best practices" recommendations for configuration management, to be reviewed and incorporated by the State as best benefits the Project.

4.   **Configuration Management Environment** – This deliverable refers to the establishment of a configuration management tool for ongoing project management of configuration items, per the approved Configuration Management Plan. DHS recognizes that the proposed bidder solution for the Configuration Management Environment may be integrated with the proposed solution for the Electronic Project Library deliverable. At a minimum, this deliverable is expected to manage:

- Requirements
- Design deliverables
- Source code

- Ancillary software configuration items, such as COTS code libraries or controls
- Test artifacts
- Training documents
- Project presentations
- Status reports
- Database definition and control elements

5.   **Quality Management Plan** – This deliverable will contain, at a minimum:
   - Quality Management Approach – Description of the Contractor's approach for assuring the quality of work and deliverables that are completed during the Project. At a minimum, this deliverable section will address the following:

     o *Quality Assurance Activities* – Description of the quality assurance activities to be performed by the Contractor during the term of the contract

     o *Quality Control Activities* – Description of the quality control activities to be performed on all deliverables before submission to DHS by the Contractor during the term of the Contract

     o *Quality Assurance Process and Procedures* – Description of the Contractor's internal processes and procedures for conducting quality assurance activities, including requirements for State staff time to review and approve of Contract deliverables

   - Quality Assurance Roles and Responsibilities – Description of the roles and responsibilities of the Contractor, DHS, and ITD for the quality assurance activities. At a minimum, this Section will include:

     o *DDI Contractor Roles and Responsibilities* – Description of the quality assurance team members from the Contractor's organization and will at a minimum include the following:
       - Position Title
       - Functions to be Performed
       - Qualifications for the Position
       - Start and End Dates

     o *DHS / ITD Roles and Responsibilities* – Description of the quality assurance team members from the DHS and ITD organizations and will identify the roles and responsibilities of each team member.
       - Position Title
       - Functions to be Performed
       - Start and End Dates

     o *Problem Reporting and Resolution*, including:
       - Integrated Issue Management
       - Problem Escalation: Description of the process the Contractor will use to address problems and resolve conflicts that cannot be resolved by a single team or business area, or that require a decision from upper level management.

       This section will serve as the Bidder's "best practices" recommendations for problem reporting and management, to be reviewed and incorporated by the State as best benefits the Project.

     o *Preliminary Schedule* – Provide a preliminary schedule of the quality assurance activities including a list of deliverables and other items that will require quality assurance reviews. At a minimum, the list must include:

- Deliverable(s) to be Reviewed
- Anticipated Date(s) for Review
- Participant(s) from the Contractor's own staff
- Participant(s) from other Contractors' staff (e.g., POS, DSS/DW, IV&V)
- DHS / ITD Participant(s)

6. **DDI Incident Reports** – Upon the Contractor's discovery of any problem or issue that may jeopardize the successful or timely completion of its DDI tasks and responsibilities, the Contractor must follow the State's incident management process. The verbal notification must be no later than the close of business of the day if the problem is discovered before 3:30 p.m. Central Time. If the problem is discovered after 3:30 p.m. or on a non-business day, notification must occur no later than 8:00 a.m. on the succeeding business day. The Contractor must follow the verbal notification with a written analysis within one (1) State business day of discovery and verbal notification. The written analysis must be sent to the State's Project Directors and include a recommendation for expeditious resolution of the problem.

    If the problem or issue results in detection of a possible requirement, design, conversion, or testing change, then the Contractor is expected to comply with the Project's change management process, formally document the problem, and propose corrected changes to the Project Directors or designated DHS business function team leads. These potential problems may result from requirements definition issues or Contractor research problems, but are not in any case expected to delay DDI progress or entail additional reimbursement claims by the Contractor. Upon the Contractor's discovery of such problems or issues that will not be corrected or resolved within the approved project schedule, the Contractor shall provide the DHS Project Directors with verbal notice within one (1) business day of assessment or incorporate the issue in the next written status report. The Project Directors will review any issues or problems that impact proposed deliverable or task completion and make a determination on any required corrective action or timeline or staffing adjustment.

7. **Electronic Project Library** – The Contractor is required to use an Electronic Project Library solution that serves as a foundation for defining, managing, and monitoring the Contractor's efforts on this Project and also acts as a repository to retain and track critical project information. The library will include both current and historical versions of the Detailed Project Work Plan, Project Control and Project Management Plan, and all other project deliverable documents. The library will be maintained throughout the life of the contract, including during system operations and maintenance (if these phases are contracted with DHS). The Contractor will train staff from DHS, ITD, and the State's IV&V Contractor on the technology and use of the Electronic Project Library. All parties will be given appropriate folder-level and file-level access/restrictions according to standards agreed upon between the Contractor and DHS. The Contractor will provide a description of the security measures that will be put in place to ensure that only authorized personnel have access to the Electronic Project Library. As appropriate, all materials in the Electronic Project Library will be indexed for easy retrieval. Each Contractor's designated documents and files will be maintained as part of the Project's Master Project Library.

    Upon delivery of the framework for the Electronic Project Library, the Contractor will provide a description of the process the Project Team will use to add new items and

update items in the Electronic Project Library. This documentation will also describe the management of historical records and retention period(s) and procedures for archiving documents. The Contractor will also provide a description of the Contractor's procedures for managing version control on all materials added to the repository.

8.3   SYSTEM SUPPLY PROCESS

8.3.1   PLANNING ACTIVITIES

8.3.1.1   OBJECTIVES

The bidder must present a structured approach for "kicking off" their project activities. The net effect of the planning approach should be the fully operational implementation of the required system(s) in an efficient and timely manner with minimal impact on providers, members, and DHS.

All project planning activities outlined in this section should be consistent with the structured system development methodology presented by the bidder. Key objectives for the set of Planning Activities include, but are not limited to:

1. Establishing a DHS-approved project team
2. Reviewing and discussing project timelines
3. Establishing resource assignments
4. Determining standards and templates

8.3.1.2   DELIVERABLES

At a minimum, the following deliverables must be included:

1. **Documentation Standards Plan** – It is assumed that every bidder has established standards for how systems, applications, work flows, and business processes are documented. The contents of this plan must include, at a minimum:
   • Formats for plans, deliverables, and other documentation
   • Formats for any system/application user manuals
   • Formats for any Detailed System Design (DSD) or General System Design (GSD) documentation that is necessary
   • Protocol for maintenance of user manuals for any COTS applications / software included in Contractor's solution
   • Standards for documenting the Contractor's work flow and business processes
   • Documentation maintenance plan

   Note that the successful bidder will incorporate and integrate the State's Project standards whenever work packages are to be delivered outside of the development effort.

2. **Project Staffing and Facility Plan** – This deliverable discusses the bidder's plan for establishing a DHS-approved project team. Included will be a modified version of the Contractor's on-site staffing plan that indicates:

    - What individuals will be on-site / off-site
    - When individuals will be on-site / off-site

    It also establishes reporting requirements and communication protocols with the DHS contract manager and establishes their facility plans for an office site.

    From a facilities perspective, this plan must also address Security and liability insurance (for facility and Contractor staff)

3. **System Technical Standards Plan** – This deliverable presents the Contractor's plans to meet the technical standards that have been set forth by the State in the General System Requirements. Also included will be a description of any unique features, advantages, or benefits offered by the Contractor's solution(s).

4. **Equipment / Technology Acquisition Plan** – This deliverable will address all equipment and technology acquisition activities, by project process / phase (i.e., Planning, Design, Development, Implementation, and Operations and Maintenance), including, but not limited to:

    - Building and data center security (e.g., alarms, card-key access systems)
    - Telephones
    - Provisions for telecommunications for remote work, if applicable
    - Office supplies for DDI Contractor staff, including storage facility sufficient for all staff
    - Data storage
    - Technical library
    - Full compliance with HIPAA Security Rules
    - PCs and workstations for DDI Contractor staff

5. **Staff Training Plan** – This deliverable discusses how the Contractor will train Contractor and State staff, identify how the bidder will validate that established business processes are followed, and discuss all implementation related contingency plans.

6. **Facility Security & Data Security Plan** – This deliverable documents the Contractor's plan for maintaining a physically secure office site, in addition to the Contractor's plan for ensuring that all data [particularly Protected Health Information (PHI)] is secure. This document includes policies and procedures that will be followed and any additional documentation that DHS and ITD require to document adherence to information security standards. At a minimum, policies and procedures must be established that address the following:

    - *Training Plan* – Policies, procedures, and materials for training employees on specific facility and/or data security issues.

    - *Incident Reporting and Response* – Policies and procedures for reporting and responding to breaches of facility and/or data security.

    - *Sanctions* – Identification of the disciplinary actions that will take place if an

employee has exposed the facility or data to security risk(s).

- *Supervision* – Policies and procedures established for the supervision of employees with access to facilities and/or data that are related to this contract.

- *Clearance and Termination* – Policies and procedures for establishing or terminating employee access to facilities and/or data that are related to this contract.

7. **Business Continuity and Contingency Plan** – The Business Continuity and Contingency Plan (BCCP) deliverable presents the Contractor's plan, policies, and procedures for maintaining a systems environment and business operations environment that will be minimally impacted by hardware and software failures, human error, sabotage, natural disasters, or other emergencies that have the potential to interrupt operations. This plan must address the establishment and maintenance of an adequate and secure backup for all software, operating systems, databases, systems, operational capacity, and user documentation. A plan of this nature generally includes information regarding:

- Weekly system and data backups
- Daily system and data backups
- Backup data storage at a secure, off-site location
- Media utilized for off-site data storage
- Physical security, security policies, and security procedures for protecting against unauthorized access, use, or disclosure of information.
- Responsibilities of Contractor staff when the BCCP has been activated
- Appropriate checkpoint/restart capabilities and other features necessary to ensure reliability and recovery, including telecommunications
- Continued processing of all business transactions assuming loss of the primary processing site, including provision for interim support for the on-line component of the system
- Description of data file and back-up retention
- Location of procedure manuals and other documentation for the MMIS operations
- Procedure for updating off-site materials (acquisition and maintenance of the offsite storage facility shall be the responsibility of the Contractor)
- Recovery procedures for loss of manual files and hardcopy documents.
- Annual testing plan for the BCCP

As part of the overall project BCCP, the Contractor will deliver the final version of the operational BCCP at least thirty (30) calendar days before the system is fully implemented. The plan must address the operational recovery of business areas, business functions, business processes, human resources, and the underlying technology infrastructure.

8. **Transition Plan (Applicable for DSS/DW contract only)** – This deliverable establishes "cut-off" dates for operation by an incumbent contractor and discusses how work will be transferred from the existing contractor to the new contractor. In the event that DHS contracts out for a Fiscal Agent or a "System Operations and Maintenance" (i.e., Facilities Management) contractor under a future procurement, this Transition Plan must present the plans for transitioning both Contractor-run and State-run business and systems operations over to the successive contractor(s).

8.4   SYSTEM DEVELOPMENT PROCESS

The system development process traditionally refers to the software design and development to support the business activities required by the contract. For the MMIS component, the development effort includes the transfer and DHS-specified enhancement of an existing certifiable MMIS system. The Detailed Project Work Plan deliverable prepared and maintained as part of the ongoing Project Management Activities needs to identify all the key activities in these sub tasks and dates for accomplishing the Contractor responsibilities.

The bidder must explain its approach to acquiring, confirming, and developing the system and business process requirements. The bidder must also describe how its approach to system development tasks is consistent with their proposed system development methodology and describe the type of tools, if any, planned for use in the development activity.

DHS does not want to expend an exhaustive effort in negotiating the cost for each newly identified requirement, but instead wants its partnership to focus effort on those activities that will lead to successful implementation. The State fully expects that the Contractor will meet all identified requirements to help ensure that the State obtains the functionality and services to meet its business needs. Another aspect of this partnership is that the State is looking to the selected vendor and other bidders to identify alternative solutions to the defined requirements that could reduce administrative or program expenditures or enhance the management and operation of the associated programs.

8.4.1   CONCEPT VERIFICATION & VALIDATION (V&V) ACTIVITIES

8.4.1.1   OBJECTIVES

The POS and DSS/DW Contractors are required to supply system solutions that, through enhancements, will meet State-specified systems and business process requirements. The MMIS Contractor will be required to transfer a certifiable MMIS to North Dakota and make a number of enhancements to the base MMIS system in order to meet State-specified systems and business process requirements. The system enhancements that will be necessary for vendor systems to meet North Dakota requirements are designed to:

1.) Make the system user friendly and accessible to designated stakeholders

2.) Fit the system to any unique elements of North Dakota's Medicaid program administration model

3.) Meet additional requirements for State monitoring

4.) Identify any missed requirements and leverage the transferred system's capabilities to meet these requirements

These enhancements include: Web-based access for providers and reports production / storage in electronic format accessible from the user's desktop.

8.4.1.2   DELIVERABLES

At a minimum, the following deliverables will be included:

1.   **Requirements Analysis Document** – This deliverable captures and confirms the Contractor's understanding of the new requirements to be developed for the system(s) and communicates the methods and timeframes that will be used to ensure that requirements are met in the design and development activities. The Requirements Analysis Document will address, at a minimum, the following information:

    a.) Methodology to be used for developing system functionality that meet the RFP requirements
    b.) Overview of system architecture and components
    c.) Hardware and software to be used, including a platform configuration chart
    d.) Network configuration, including any alternatives
    e.) Data model, including data elements used in each function, their derivation, source, validation, definition, residence, and use
    f.) Metadata management requirements
    g.) Business process models for all automated and manual functions, including linkages between processes
    h.) Functional requirements for each business process
    i.) Input and output documents, screens, and files
    j.) Internal and external Interfaces and data acquisition
    k.) Recommended cycle times, report frequencies, database update schedules, etc.
    l.) Information technology requirements
    m.) Meeting notes from all requirements analysis meetings
    n.) Open items
    o.) Other issues affecting the North Dakota Medicaid Systems implementation, including any recommended DHS or Contractor action

    For the purposes of this deliverable, the broader term "requirements" refers to:

    • "General Requirements" listed in Sections 6, 7, and 9 of this RFP
    • "Technical Requirements" and standards listed in Section 7.1 of this RFP
    • System "Functional Requirements" listed in Sections 7.2, 7.3, and 7.4 of this RFP
    • Development or continued use of "Interfaces" listed in Sections 7.2, 7.3, and 7.4 of this RFP
    • Ensuring acceptance of "Inputs" listed in Sections 7.2, 7.3, and 7.4 of this RFP
    • Ensuring production of "Outputs" listed in Sections 7.2, 7.3, and 7.4 of this RFP
    • "Contractor Responsibilities" listed in Section 9 of this RFP (for the DSS/DW Contractor only)

    *Bidder's Note: During Concept Verification & Validation and Requirements Verification & Validation the State and its Contractors will establish further detail on existing RFP requirements, as a means to provide the level of definition needed for design and development activities. Such further detail and definition is considered within the scope of the original RFP requirements and contract, unless it is clearly established by both parties as a new requirement. Any such new requirements will be addressed using the established Change Service Request process.

2. **Traceability Matrix** – The traceability matrix deliverable is created to associate finalized requirements with the work products that satisfy them. Where appropriate, the traceability matrix will be used across DDI phases to ensure completeness of requirements design, development, and testing. During testing, tests are associated with the requirements on which they are based and the satisfying work products are tested to meet the requirement. This deliverable may also provide documentation of any open Change Orders, as well as any requirements subsequently identified in Joint Application Design (JAD) sessions related to a function(s) and process(es).

3. **Gap Analysis** – This deliverable identifies the differences in capability between the "base system" being transferred or supplied to North Dakota and the North Dakota requirements defined in Sections 6, 7, 8, 9, and 10 of this RFP. At a minimum, the Gap Analysis deliverable must include:

- *Description of the "Base System"* – This section describes the base system that has been transferred to the State, including the following information:
  - o The operational environment and its characteristics
  - o Major system components and the interconnections among these components
  - o Interfaces to external systems or procedures
  - o Capabilities/functions of the "base system"
  - o Charts and accompanying descriptions depicting inputs, outputs, data flow, and manual and automated processes sufficient to understand the Base System or situation from the user's point of view
  - o Performance characteristics, such as speed, throughput, volume, frequency
  - o Quality attributes, such as reliability, maintainability, availability, flexibility, portability, usability, efficiency
  - o Provisions for safety, security, privacy, and continuity of operations in emergencies

- *Summary of Required "Base System" Changes* – This section must describe the changes that will be needed to the base system to bring it in alignment with DHS' requirements. It will include the following information:

  - o Description of needed changes – Description of the new or modified capabilities/functions, processes, interfaces, or other items needed to respond to DHS' requirements.
  - o Justification for change – Description of the new or modified aspects of user needs, threats, missions, objectives, environments, interfaces, personnel or other factors that drive the changes.
  - o A summary of deficiencies or limitations in the Base System or situation that make it unable to respond to these factors.
  - o Changes considered but not included – Description of the changes considered but not included and rationale for not including them.
  - o Assumptions and constraints – Description of the assumptions and constraints applicable to the changes identified in this Section.

- *Analysis of the Gap* – This Section must be divided into the following areas:

o Summary of advantages - This summary shall include new capabilities, enhanced capabilities, and improved performance, as applicable, and their relationship to deficiencies identified in Justification for Changes.

o Summary of disadvantages/limitations - This paragraph shall provide a qualitative and quantitative summary of disadvantages or limitations of the new or modified system. These disadvantages and limitations shall include, as applicable, degraded or missing capabilities, degraded or less-than-desired performance, greater-than-desired use of computer hardware resources, undesirable operational impacts, conflicts with user assumptions, and other constraints.

4. **Build Strategy / Schedule** – The Build Strategy / Schedule deliverable will present the schedule upon which "builds" of solution systems / applications will be delivered to DHS. During development, DHS is targeting regular build deliveries out of the development environment into the test environments. The DHS preference for build deliveries is at least on a monthly basis, when practical to do so, in order to reduce project risk. DHS' objective is for this project to include numerous and frequent deliveries of software (i.e., "builds") for verification and validation purposes. The sequence of builds is often referred to as a "build strategy", and when dates are assigned to build deliveries the build schedule is developed. The specific build schedule must be determined and approved by the Department very early in the DDI phase of the project and consistently be incorporated into all project schedules. The Build Strategy / Schedule will be based upon the business and technical requirements for this project and the priorities of requirements. This may be supplemented, if required, by architectural and developmental priorities. The Build Strategy / Schedule will be reviewed and approved by DHS before being implemented.

5. **MITA Assessment** – The MITA Assessment deliverable will describe the MITA maturity level of the MMIS to be implemented for DHS. The assessment must utilize the current CMS MITA Assessment documents to perform this task. At the time of this RFP's release, the current version is: MITA Capability Matrix – Technical View and MITA Capability Matrix – Business View, May 2004 (Version 1.0). At a minimum, the deliverable must include:

• *MITA Self Assessment* – This section of the deliverable shall document the MITA Self Assessment. This document must include:

o Business View Mapping: Evaluate DHS Medicaid systems mapped to business areas against the MITA Capability Matrix: Business View. Determine the capabilities those systems provide and document.

o Technical View Mapping: Evaluate the replacement system against the MITA Capability Matrix: Technical View. Determine the capabilities the system exemplifies and document.

o Identification of Other State Capabilities: List additional MMIS capabilities, both business and technical, not included in the MITA Capability Matrix, using the operational definitions provided in the MITA Maturity Model and maturity level descriptions. Describe those capabilities in the appropriate cells in the MITA Capability Matrix.

o Map to MITA Maturity Model: Most likely, the North Dakota MMIS will not show concentration around only one level of the Maturity Model. Determine with which

level the replacement system most closely aligns. Document and explain the reasoning.

- *MITA Enhancement Plan* – This section of the deliverable will recommend an enhancement plan for North Dakota to undertake during DDI or during the operational phase for the replacement systems in order to improve the system's maturity and compliance with MITA. This Plan will assist the State in planning for enhancement activities during operations and maintenance. At a minimum, the deliverable must include:

  o Identify Enhancement Area: The Contractor will identify the capabilities on higher levels of the MITA Maturity Model that best align with North Dakota's Medicaid goals and that could provide the most benefit to North Dakota. From the identified capabilities, the Contractor will recommend the five top-priority enhancements that should be considered for further advancing North Dakota's Medicaid systems to a higher MITA maturity level.

  o Outline Plan for Acquiring New Capabilities: The Contractor will outline how the State can modify the replacement system to obtain the capabilities desired at higher MITA Maturity Levels. The plan must define the level of effort, changes in system resources required, and timeline required to obtain each new capability.

  o Transition Plan: The Contractor shall prepare a recommended Transition Plan for making MITA enhancements to the replacement system including a prioritization of each enhancement and a recommended timeline.

8.4.2   REQUIREMENTS VERIFICATION & VALIDATION (V&V) ACTIVITIES

8.4.2.1   OBJECTIVES

Requirements V&V activities addresses those tasks necessary to ensure the correctness, completeness, consistency, and testability of all requirements heading into Design Activities. The end result is approved documentation of design specifications for the advanced systems that will be implemented to support North Dakota's Medicaid program. Note that all design, development and implementation activities and deliverables will be based upon and traced to the approved set of requirements provided, controlled, and maintained by the State.

*Bidder's Note: During Concept Verification & Validation and Requirements Verification & Validation the State and its Contractors will establish further detail on existing RFP requirements, as a means to provide the level of definition needed for design and development activities. Such further detail and definition is considered within the scope of the original RFP requirements and contract, unless it is clearly established by both parties as a new requirement. Any such new requirements will be addressed using the established Change Service Request process.

8.4.2.2   D\ELIVERABLES

At a minimum, the following deliverables will be included:

1. **Data Model / Entity Relationship Diagram for the Entire System** – This deliverable
    includes data elements to be captured in each function, their derivation, definition, and
    use.

2. **Business Process Models for all Automated and Manual Functions** – Business
    Process Models for all MMIS-related and POS-related automated and manual functions
    must be developed incorporating the required enhancements and including edits and
    audits for each of the inputs and processing systems. MMIS and POS Contractors must
    also include proposed alterations to the business process models for the Data
    Warehouse update process.

3. **Document Imaging Requirements** – This deliverable presents formal documentation
    by the MMIS Contractor of the processes, standards, and business needs surrounding
    North Dakota's document imaging requirements under the new systems environment.

4. **Implementation Plan (Version 1)** – This deliverable describes the Implementation
    Strategy and outlines how the objectives of the strategy will be achieved. There will be
    three versions of the Implementation Plan, one each as a deliverable during
    Requirements Analysis, Design, and Implementation. Versions 2 and 3 shall be updates
    to the prior version. At a minimum, the deliverable must include:

    - *Installation Overview* – This section shall be divided into the following paragraphs to
      provide an overview of the installation process.
        1.) Description – Description of the installation process to provide a frame of
            reference for the remainder of the document. A list of sites for software
            installation, the schedule dates, and the method of installation must be included.
        2.) Contact point - The organizational name and telephone number of a point of
            contact for questions relating to this installation.
        3.) Support materials – Description of the type, source, and quantity of support
            materials needed for the installation. Included must be items such as magnetic
            tapes, disk packs, computer printer paper, electronic forms, and other special
            forms.
        4.) Tasks - Description of each task involved in the software installation.
        5.) Personnel - Description of the number, type, and skill level of the Contractor's
            personnel needed during the installation period.
        6.) Security and privacy – description of the security and privacy considerations
            associated with the system.

    - *Site-Specific Information for Data Center Operations Staff* – This section of the
      deliverable provides information for installation of the software in the computer
      center(s) or other centralized or networked software locations.
        1.) Schedule – Description of the schedule of tasks to be accomplished during
            installation. It must depict the tasks in chronological order with beginning and
            ending dates of each task and supporting narrative as necessary.
        2.) Software inventory – Description of the process to provide an inventory of the
            software needed to support the installation.

      3.) Installation team – Description of the composition of the installation team. Each team member's tasks must be defined.

      4.) Installation procedures – The step-by-step procedures for accomplishing the installation. The procedures must include the following, as applicable:

         a.) Installing the software

         b.) Checking out the software once installed

         c.) Initializing databases and other software with site-specific data

         d.) Conversion from the Base System, possibly involving running in parallel

         e.) Dry run of the procedures in operator and user manuals

         f.) Data update procedures – Description of the data update procedures to be followed during the installation period

- *Implementation Issues* – This section must provide a description of the process to document issues, plan issue resolutions, and document issue solutions.
- *Transition Planning* – This section will explain the Contractor's approach for developing a cooperative working relationship with DHS staff in anticipation of transitioning to system support.

5.   **Provider Communications Plan** – The initial Provider Communications Plan produced by the MMIS and POS Contractors will address the following items:

- Examples of similar initial provider communications material generated and distributed to the provider community soon after award of a new systems contract;
- A proposed schedule for issuing initial and subsequent communications to providers regarding the replacement MMIS and POS, technology features, and system business operations;
- Recommendations on what provider types to send communications to first and what material that has been proposed to share with them;
- Best practices to recommend in contacting different provider associations about upcoming changes;
- Proposed assessment tool to use in measuring effectiveness of communications;
- Proposed methods for receiving provider feedback;
- Proposed use of Web-based communications versus paper mailings; and
- Examples of reports prepared for other customers on results of provider communications activity.

6.   **Workflow Process Management Requirements Gap Analysis** – This MMIS Contractor deliverable must identify and describe the gaps between the "As Is" business processes, business rules, and organizational structure and the "To Be" business processes, business rules, and organizational structure. In addition, it must provide a recommended plan to transition to the new processes. For each gap identified in the Gap Analysis, the MMIS Contractor shall provide the following information:

- Gap [Item #] and [Item Name]
- Gap description including:
  - o Impact on business processes and business rules, along with a description of the impact on those business processes and business rules.
  - o Affected organizational units
  - o Description of the business areas that will be affected by the changes.
  - o Resource impact
  - o Description of the impacts on personnel, hardware, software, or other DHS resources resulting from the proposed modifications/enhancements.

- Schedule for implementing all new business processes including:
  - o Coordination with stakeholders and user staff
  - o Scheduling and completion of training that may be required
  - o Development of new user and desk manual materials
- Resource requirements for hardware, software or personnel resources that will be required in order to implement the proposed business processes.

7.   **Final Formats for all Input and Output Files** – This deliverable provides documentation of any proposed alterations to the formats for all input and output files, including all reports.

8.   **Interfaces and Data Acquisition** – This deliverable provides further detail on interfaces and data acquisition processes, including proposed changes to current interfaces and data acquisition processes. The document must also identify if the interface is a one-way or two-way interface or if data is shared across various platforms. Also included should be any protocols in place prior to accepting data uploads and downloads.

9.   **System Architecture Document** – This deliverable presents supplementary documentation of the full system architecture, including documentation of any recommended maintenance to system architecture.

8.4.3   SYSTEM DESIGN ACTIVITIES

8.4.3.1   OBJECTIVES

The proposed system's design must address all the general, system, and ongoing business process requirements desired for the procured North Dakota Medicaid systems. The MMIS Contractor is responsible for supplying an MMIS that is fully certifiable by CMS, when combined with the other required MMIS-related components, and the MMIS must provide for all of the data and information access requirements of State users and outside stakeholders.

8.4.3.2   DELIVERABLES

At a minimum, the following deliverables will be included:

1.   **Design Overview Document** – This deliverable highlights the features of the implemented system, including State-specified required enhancements. This also includes documentation of the requirements for interfacing with other systems and other systems or professional services contractors.

2.   **System Design Documents** – Describes the system or the subsystem-wide design and the architectural design of a system or subsystem. The System Architecture and Design must have both high-level and detailed specifications. It must include business process models and data models of the entire system and all system and operations functions, showing inputs, processes, programs, interfaces, program interrelationships, and outputs. It must also include a cross-reference to the corresponding Sections of Part 11 of the State Medicaid Manual. The deliverable will follow the Contractor's proposed and

DHS approved development methodology. At a minimum, each DSD deliverable shall include:

General System Design Documentation - This deliverable section will define the high-level architecture and design of the system, including the following items:
- A narrative describing the entire system
- System standards manual, listing all standards, practices and conventions, such as: language, special software, identification of all test and production libraries, and qualitative aspects of data modeling and design
- A description of security standards maintained by the system
- A description and flowcharts showing the flow of major processes and data within the system
- A description of the operating environment
- A description of all system files and processing environment
- Function documentation, including narratives for each functional area and feature of the function, job streams, input and output definitions, and control reports
- Hardware requirements, including configuration, usage estimates, sizing, bandwidth, and response time
- Software requirements, including number of users, concurrent users, and location of users; number and type of licenses
- Development tools, including required software, number of users and concurrent users, number and type of licenses
- Communication tools, including required hardware and software, number and type of licenses required, and total number of users
- Final system configuration diagram showing all hardware and software
- Software specifications that define software components: 1) to be developed specifically for North Dakota, 2) that will use Base System software, 3) that will use software proprietary to the Contractor, and 4) that will use Commercial-Off-the Shelf (COTS) software

Detail System Design Documentation – These deliverables will provide the detail system architecture and design specifications for the system, including:
- Detail program specifications:
  - Program narratives including process specifications, purpose, and relationships between the programs and modules
  - A list of input and output files and reports, including retention specifications
  - File/database layouts, database names and dispositions
  - Detailed program logic descriptions
  - Listings of edits and audits applied to each input item
  - Detailed pricing logic for all claims processed by the system
- Table descriptions, including:
  - A description of all tables used in the system
  - A listing of table-driven or key elements, their values, a written description of the element, and to which subsystems they apply
  - Cross-reference listings or matrices of related elements or values, showing allowable relationships or exclusions (e.g., Provider Type/Provider Specialty cross-reference)
  - A business rules repository
  - A table of contents, by function, table and element

System Interface and Integration Specifications – This deliverable section will describe the interface characteristics between systems and will include the following:
- System configuration diagram showing all interfaces
- Interface design descriptions, including:
  - Interface identification, including type of interface (such as real-time data transfer, storage-and-retrieval of data, etc.) to be implemented
  - Characteristics of individual data elements and data element assemblies (records, messages, files, arrays, displays, reports, etc.) that the interfacing entity(ies) will provide, store, send, access, receive, etc.
  - Characteristics of communication methods and protocols that the interfacing entity(ies) will use for the interface
  - Other characteristics, such as physical compatibility of the interfacing entity(ies) (dimensions, tolerances, loads, plug compatibility, etc.)
- Traceability to requirements addressed by the interfaces
- Changes required of other DHS systems to ensure an effective interface with the replacement Medicaid systems

3.   **Data Dictionary** – This deliverable presents a dictionary of all data elements (or attributes) that reside in the various systems and subsystems. At a minimum, the Data Dictionaries must include:

- A unique data element number and standard data element name
- A narrative description and definition of the data element
- A table of values for each data element
- The source of each data element
- Descriptions of naming conventions used to create data element names and a list of data names used to describe the data element
- A cross-reference to the corresponding State Medicaid Manual, where applicable
- A list of programs using each data element, describing the use of input, internal, or output
- A list of files containing the data element

  - 4.   **Configuration Management Environment Software Load** – This deliverable consists of the program source code, databases, and documentation used as the baseline to develop the replacement Medicaid systems. New versions of this software are developed and delivered on an ongoing basis during DDI, as defined in the Configuration Management schedule developed and agreed upon in the activities described in Section 8.2.1

5.   **Draft Operational Procedure Manuals** – This deliverable presents the draft version of operational policies and procedures governing systems and business processes for North Dakota Medicaid under its new systems environment. Wherever possible, the Contractor may leverage existing Departmental Procedure Manuals as a baseline for this updated documentation.

6.   **Edit and Audit Rules** – This deliverable presents documentation of the edit and audit rules within the MMIS and POS systems that guide the processing of any transaction, update, data entry, etc. These Edit and Audit Rules have been applied to the system according to the State Medicaid Manual, Federal law, CMS standards, and other sources of Medicaid program governance.

7.   **Updates to Previous Deliverables** – During Design Activities, previous deliverables will be updated, as requested by the State. Examples of "living" documents include:
      • Updated Entity Relationship Diagrams
      • Updated Data Structures and Data Flow Diagrams
      • Updated Process Flow Diagrams
      • Updated Information System Model
      • Updated Security and Disaster Recover Plan

8.4.4 *S*YSTEM *D*EVELOPMENT *A*CTIVITIES

8.4.4.1   OBJECTIVES

The development and testing of the procured North Dakota Medicaid systems will be in accordance with the Detailed System Design deliverable(s) approved by DHS. The systems will meet or exceed the functional and technological requirements prior-approved during the Concept V&V, Requirements V&V, and Systems Design activities. During this activity, the Contractors will work with the State and any other systems contractors who will interface with the system to ensure that all requirements for the supporting systems are met. Although DHS and its consultant resources (including the IV&V Contractor) will be available for consultations, the Contractor should not heavily count on State resources for support of Contractor system testing activities. System development and testing will all be done on State hardware, as provided by ITD. Any change in system specifications or timelines will not be accepted unless prior-approved by the DHS.

Key elements associated with this activity are:

1.   Install and enhance or modify components of the proposed system according to the specifications developed and approved by DHS in the Concept V&V, Requirements V&V, and System Design activities.

2.   Test all aspects of the system both in "unit test" mode, "integration test" mode, and "system test" mode including:
      • Performance testing (i.e., load testing, stress testing, volume testing)
      • Running the tests
      • Producing and reviewing test outputs
      • Submitting final test results to DHS for approval
      • Providing a weekly report of testing activity, including identification of test status (i.e., passed, failed, rerun)

3.   Provide frequent "builds" to DHS, in compliance with the Build Strategy / Schedule determined during Concept V&V Activities (per Section 8.4.1.2).

4.   Provide monthly technical system walkthroughs and system demonstrations to DHS staff
        and its consultants.

5.   Provide monthly technical system walkthroughs and system demonstrations to other
        contractors (e.g., RetroDUR, DSS/DW, etc.) for system functions to be used by the
        contractors.

6.   Demonstrate all on-line system functionality.

7.   Present all standard output reports.

8.   Demonstrate that all hardware, software, and teleprocessing linkages are functional and
        will support the State's requirements.

9.   Demonstrate functionality of all external interfaces.

8.4.4.2   DELIVERABLES

At a minimum, the following deliverables will be included:

1.   **Comprehensive System Test Plan** – This deliverable presents the Contractor's plan to
        conduct a comprehensive system test, including testing of all interfaces.

2.   **Completed Test Criteria** – This deliverable provides documentation of all criteria that
        will be used to judge a system test as completed / not completed. In addition, this
        document must also establish the expected outcomes of tests.

3.   **Systems Documentation** – The Contractor is responsible for providing to DHS
        complete, accurate, and timely documentation of the system. During the final phase of
        the DDI activities, the Contractor must prepare updates to the Systems Documentation
        to incorporate all changes, corrections, or enhancements to the system(s), or those
        modifications that have resulted from the completion of open items and defects noted in
        acceptance testing. Updates to the Systems Documentation must be made prior to DHS
        sign off of the change, unless otherwise agreed to by DHS. Final Systems
        Documentation must be provided within sixty (60) days following State approval of the
        operational start date of the implemented MMIS, POS, or DSS/DW.

        Three (3) hard copies and one electronic copy of the final version of the Systems
        Documentation must be provided to DHS. The Contractor will be responsible for
        supplying any additional copies of the Systems Documentation that are required by
        CMS.

        The MMIS, POS, and DSS/DW Systems Documentation must:

        • Be available and updated on electronic media (e.g., CD-ROM, diskette, tape,
          cartridge) and must be maintainable after turnover
        • Have all narrative created and maintained in Microsoft Word 97 (.doc format) or
          higher (compatible with State version) and be provided to DHS on request on CD-
          ROM or other designated media
        • Have all narrative also maintained in .html or .htm format for on-line use

- Be organized in a format which facilitates updating and any revisions must be clearly identified
- Include system, program, and application narratives that are understandable by non-technical personnel
- Contain an overview of the system, including:
  - A narrative of the entire system
  - A description and flowcharts showing the flow of major processes in the system
  - Multiple sets of hierarchical, multi-level charts, that give a high, medium, and detail view of the system, for both on-line and batch processes
  - A description of the operating environment; and
  - The nomenclature used in the overview must correspond to nomenclature used in subsystem documentation (all subsystems must be referenced, and documentation must be consistent from the overview to the specific subsystems and between subsystems).
- Documentation of data/file retention requirements contain the following documentation for each subsystem:
  - Subsystem name and numeric identification;
  - Subsystem narrative, including each function and feature of the subsystem;
  - Subsystem flowcharts, identifying each program, input, output, and file;
  - Job streams within subsystems identifying programs, input and output, controls, job stream flow, operating procedures, and error and recovery procedures;
- On-line teleprocessing tables and entries;
- Identification and listing of all Contractor internal control reports;
- For all forms, screens, tapes, and other inputs: input definitions, including names, descriptions, sources, examples, and content definition;
- For all screens, reports, tapes, and other outputs: output definitions, including names, numbers, sources, destinations, examples, and content definition; tape/cartridge specifications, file descriptions, and record layouts must be included for all data stored on electronic storage including tape or cartridge;
- Listings of edits and audits applied to each input item, including detailed edit logic, claim and provider types affected, edit disposition, suspense and override data, and corresponding error messages
- Program documentation to include, at a minimum:
  - Program narratives, including process specifications for each, the purpose of each, and the relationships between the programs and modules
  - A list of input and output files and reports, including retention
  - File layouts
  - File names and dispositions
  - Specifics of all updates and manipulations
  - Program source listing
  - Comments in the internal identification division of the listing, identifying changes to the program by date, author, and reason
  - Comments in the internal procedure division of the listing, identifying each subroutine and each major entrance, exit, and function of the subroutine

- Detailed program logic descriptions and edit logic (or decision tables), including, at a minimum, the sources of all input data, each process, all editing criteria, all decision points and associated criteria, interactions and destination links with other programs, and all outputs
- Detailed pricing logic for all claim records processed by the system
- Physical file definitions
- For all files, including intermediate and work files: file descriptions and record layouts, with reference to file names and numbers; data element names, numbers, number of occurrences, length, and type; record names, numbers, and lengths; and file maintenance data, such as number of records, file space, and any other data necessary to manage the data or utilize the documentation; and lists, by identifying name, of all files, inputs, and outputs with cross-references to the programs in which they are used
- Contain a data element dictionary which will include, for each data element:
  - o A unique data element number
  - o A standard data element name
  - o A narrative description of the data element
  - o A list of data names used to describe the data element
  - o A table of values for each data element
  - o The source of each data element
  - o A cross-reference to the corresponding data elements in Part 11 of the State Medicaid Manual
  - o A list of programs using the data element, describing the use of input, internal, or output
  - o A list of files containing the data element
- Contain operations run documentation with schedules and dependencies
- Contain documentation of all business rules contained within the system
- Support State and Federal monitoring activities

4. **System User Manuals** – The Contractor must prepare user manuals for each business area. User manuals will be made available on-line, for continual reference by State and State-designated staff. Draft user manuals will be prepared during the Development Task and updated during the Implementation Task. This deliverable is intended to provide a system user with the appropriate instruction on how to perform work activities assigned to their job, produce reports, fix errors, and troubleshoot based on the "To-Be" Practices and Processes that have been developed as a result of the Concept and Requirements Analysis activities. The System User Manuals must include instructions for providers based on the approved "To-Be" Practices and Processes for Providers. At a minimum, the deliverable must include:

- Error message descriptions for all fields incurring edits, and the steps necessary to correct such errors.
- Tables of valid values for data fields (for example, provider types and claims types), including codes and descriptions in English, presented on screens and reports.
- Illustrations of screens used in the subsystem, with all data elements on the screens identified by number; and all calculated or generated fields on the screens described clearly.

- Instructions for requesting reports or other outputs with examples of input documents and/or screens.
- Instructions for file maintenance, with descriptions of code values and data element numbers for reference to the data dictionary.
- Each process and procedure must identify the user, their location within the organization and the purpose (outcome) of the process or procedure.

The Contractor will be responsible for the production and distribution of all user manual updates in a timely manner. The manuals must be available on-line, provide an on-line search capability and must facilitate updating. DHS requires one (1) paper copy using 8-1/2" x 11" pages in three-ring (3) binder form, pages numbered within each section, and a revision date on each page. Revisions must be clearly identified in bold or underline print. Other requirements for user manuals are as follows:

- User manuals must be created and maintained in Microsoft Word 97 or higher (consistent with the current State standard) and must be provided on request to DHS on diskette or CD and also be maintained in .html or .htm format in order to be accessible via the Web to users during the operations phase;
- User manuals must be written and organized so that users not trained in data processing can learn from reading the documentation how to access the on-line windows/screens, read subsystem reports, and perform all other user functions;
- User manuals must be written in a procedural, step-by-step format;
- Instructions for sequential functions must follow the flow of actual activity (that is, balancing instructions and inter-relationship of reports);
- User manuals must contain a table of contents, an index and include a search capability within the electronic version;
- Descriptions of error messages for all fields incurring edits must be presented and the necessary steps to correct such errors must be provided;
- Definitions of codes used in various sections of a user manual must be consistent;
- Mnemonics used in user instructions must be identified and must be consistent with windows, screens, reports, and the data element dictionary;
- Abbreviations must be consistent throughout the documentation;
- Field names for the same fields on different records must be consistent throughout the documentation;
- Each user manual must contain "tables" of all valid values for all data fields (for example, provider types, claim types), including codes and an English description, presented on windows, screens, and reports;
- Each user manual will contain illustrations of windows and screens used in that subsystem, with all data elements on the screens identified by number;
- Each user manual will contain a section describing all reports generated within the subsystem, which includes the following:
  - A narrative description of each report
  - The purpose of the report
  - Definition of all fields in reports, including detailed explanations of calculations used to create all data and explanations of all subtotals and totals; and
  - Definitions of all user-defined, report-specific code descriptions; and a copy of representative pages of each report.

- Instructions for requesting reports or other outputs must be presented with examples of input documents and/or screens;
- All functions and supporting material for file maintenance (for example, coding values for fields) must be presented together and the files presented as independent sections of the manual;
- Instructions for file maintenance must include both descriptions of code values and data element numbers for reference to the data element dictionary;
- Instructions for making on-line updates will clearly depict which data and files are being changed; and
- Draft user manuals will be used as the basis for User Acceptance Test training, unless otherwise specified by the State, as well as final versions will be used for training prior to start of operations.

5. **Draft and Final Operating Procedures** – This deliverable provides operating procedures to clearly document the system. The Draft version of this deliverable will be developed during the System Development Activities. The Draft version will be updated during Implementation Activities, resulting in the Final version of the deliverable. The purpose of the Operation Procedures documentation is to assist programmers and other technical staff in operation and maintenance of the system. These procedures help define and provide understanding of system operations and performance. Operating procedures will:

- Provide operations technical staff the knowledge to efficiently operate and maintain the system
- Be maintained on-line
- Be revised with any changes resulting from acceptance testing, training, or changes in procedures during on-going operations

The Operations Procedures will address all facets of the technical operation of the system including the following topics:

- Application and database design and architecture
- Application structure and module/sub-module/program/subroutine relationships
- Application start-up/shut-down procedures
- Application backup, recovery and restart procedures
- Data dictionary structure and maintenance procedures
- Database logical and physical organization, and maintenance procedures
- Application and system security features
- Audit and testing procedures
- System data input, error checking, error correction, and data validation procedures
- User help procedures and features
- System troubleshooting and system tuning procedures and features
- System administration functions, such as code management and copy file management
- Setting and changing system User ID and Password
- System interface processing
- On-line and batch processing procedures.
- Unique processing procedures.
- Report generation procedures.

- Menu structures, chaining, and system command mode operations.
- Job scheduling.
- Job cycles (daily, weekly, monthly, quarterly, annually, and special).

8.4.5   DATA CONVERSION ACTIVITIES

8.4.5.1   OBJECTIVES

The Conversion Task includes data conversion from existing systems to the replacement MMIS, POS, and DSS/DW. These activities are described below.

Data conversion refers to the transfer of all data files (as specified by the Department) from existing system(s) and contractor(s) to the new system(s). In the case of the MMIS system transfer, the Contractor must validate existing historical files and attempt to clean up errors and discrepancies in records. The MMIS and POS Contractors (in conjunction with ITD) will be required to convert five (5) years of history from the current North Dakota MMIS and POS systems, measured retrospectively from the end date of the DDI phase. The quality of this data has not been fully assessed by DHS; however, bidders must note that the conversion will encompass primarily the standard HIPAA transactions and other special cases (as specified by the Department). The accurate conversion of historical files is a critical component for success in any system transfer or takeover.

The bidder must outline, in detail, its plan to ensure that the entire conversion task will result in accurate conversion. All appropriate steps must be defined and documented. The proposal must include the staffing needs for this activity along with a contingency plan if conversion cannot be accomplished timely and accurately. At a minimum, the proposal must outline the following approaches in detail:

1.) Approach to identify all files and tables to be converted / validated

2.) A data mapping approach

3.) Approach to correct error situations in the existing data

4.) Approach to resolve data inconsistencies and missing data situations

5.) Approach to automated and manual conversion effort

6.) Approach to provider re-enrollment (this task must occur approximately 6 months prior to the system's "Go Live" date)

7.) Contingency plan

*Bidder's Note: The extent of the data conversion task will depend upon the quality and completeness of data in the current North Dakota Medicaid systems, as presently operated by DHS. Conversion tasks may be less or more complex than described in this section.

North Dakota currently utilizes a SeeBeyond translator that translates both inbound and outbound HIPAA transactions. The MMIS Contractor will be responsible for utilizing the State's HIPAA translator solution as a HIPAA compliant "front end" to meet requirements for accepting and processing all ANSI X12 standard transactions, and will also be responsible for using

HIPAA compliant code sets. If the Contractor can prove to the State that it is resource prohibitive (i.e., time, cost, staff support, technology, etc.) to utilize SeeBeyond with its solution, the State may entertain an alternative proposal during contract negotiations.

In addition, the MMIS Contractor must ensure that the overall solution that allows all North Dakota providers to become compliant with the HIPAA requirements for transactions and code sets. Providers will be free to pursue their own independent strategy for use of clearinghouses or other means in order to make their own internal administration HIPAA compliant. The MMIS Contractor will be expected to provide information on the new requirements and provide options for meeting compliance.

8.4.5.2   DELIVERABLES

At a minimum, the following deliverables will be produced for Data Conversion activities:

1.   **Conversion Quality Assurance Plan** – This deliverable presents the metrics to be used by the Contractor to monitor the quality of data and the quality of the data conversion.

2.   **Data Conversion Strategy** – This deliverable presents a strategy for converting required MMIS, POS, and DSS data into the new systems and validating the conversion. The strategy must also include how all interfaces will be achieved. At a minimum, the deliverable must include:
     - *Approach to Developing the Conversion Strategy* – Describe the general approach that will be used to complete the data conversion processes for the new systems. The strategy must address all data conversion requirements, regardless of whether an automated or manual method is recommended. This Section shall address and discuss the following:
       o Determination of whether any portion of the conversion process must be performed manually.
       o Management of the conversion effort, including strategies for dealing with delays, back-up plan, back-up personnel, process verification
       o Procedures for tracking and correcting conversion problems when encountered
       o Procedures for notifying DHS of conversion problems encountered
       o Identification of default values, where necessary.
       o Determination of whether parallel runs of the old and new systems will be necessary during the conversion process.
       o Understanding of the function of the data in the old system and determine if the use will be the same or different in the new system.
       o The order that data is processed in the new systems.
       o Volume considerations, such as the size of the database and the amount of data to be converted, the number of reads, and the time required for conversions.
       o User work and delivery schedules and timeframe for reports.
       o Determination of whether data availability and use must be limited during the conversion process.
       o The plan for handling obsolete or unused data that is not converted.

- *Scope* – Provide a general description of the boundaries of the data conversion effort. Include discussion as to whether the conversion process will be implemented in phases. This Section must address the following:
  - o Conversion objectives, impact and resources
  - o Files/data that will be converted or linked to the new system as an interface
  - o Plans for normalization of data to be converted
  - o Evaluation of DHS ad hoc databases that facilitate Medicaid processes and whether their data needs to be converted and incorporated into the new system
  - o The processes that will be used to complete the conversion including verification procedures and acceptance responsibilities
  - o Conversion support requirements including use of the system, policy issues and hardware
  - o List of conversion tools
  - o Schedule for completing the conversion processes
  - o Conversion preparation task outline
  - o Plans for necessary manual conversion and data cleanup activities
  - o Approach to ensure the accuracy of the converted data
  - o Plans for ensuring that the current MMIS, POS, and DSS/DW data will be continually updated with changes from the interfacing systems and changes from the new systems until all components of the new systems have been implemented.

3. **Data Conversion Plan** – This deliverable shall elaborate on the Data Conversion Strategy deliverable and outline how the objectives of the strategy will be achieved. At a minimum, the deliverable must include:
   - *Data Conversion Tasks* – This Section will identify in detail the tasks and subtasks that must be performed in order to effect necessary file conversions. Tasks must be listed in order of required occurrence. All task dependencies must be identified. This information may be depicted in the form of a work breakdown structure and appended to the Detailed Project Work Plan. The conversion plan must include the following:
     - o Perform an inventory of the universe of data to be converted and identify the data needed to populate the system so that the new systems are fully functioning. Include data that is currently archived in the inventory. Establish the criteria for selecting archived data for conversion; identify archived data to be converted. Document physical location, media, and logistics involved in the conversion. Identify all data elements, data element mapping, files, and systems that will be converted including:
       - ▪ Name
       - ▪ Source form or record layout
       - ▪ Storage medium
       - ▪ Physical Location of storage medium
       - ▪ Size
       - ▪ Access method
       - ▪ Security and privacy considerations
     - o Identify all control procedures and contractor/user validation criteria used to ensure that all data intended for conversion has been converted.
     - o Plan any interim file maintenance requirements.
     - o Develop conversion programs including:
       - ▪ Specifications

- Program coding
- Error/exception processes
- Test plans
- Hard-copy manual data entry screens if necessary

- *Resource Requirements* – Identify the required personnel, equipment, and DHS staffing resources needed to perform each identified task and subtask. Information on staffing resources may be depicted in the above referenced work breakdown structure appended to the plan. The conversion plan must address the following resource requirements:
  - Identify necessary computer processing workloads during conversion that may affect system/server capacities and/or levels of stress on the systems and servers
  - Identify and plan manual support requirements
  - Identify the Contractor and DHS/ITD personnel needed to participate in the conversion of the data
  - Plan any special training for conversion activities
- *Schedule* – Identify the time required to complete each task and subtask. This information may be depicted in the above referenced work breakdown structure and attached to the plan.

4. **Conversion Mapping Document** – This deliverable presents data element mappings, including the mapping of values of the old system data elements to the new system data elements, as well as new data elements to old data elements to ensure all data elements have been addressed.

5. **Comprehensive List of Input Files and Tables** – At a minimum, this deliverable will discuss:
   - Interim reporting on each file conversion within twenty-four (24) hours of each scheduled conversion, to include:
     - any problems encountered and the impact on the rest of the conversion schedule;
     - before and after versions of each converted file, including default values, formatted for review by non-technical personnel (in certain cases, DHS may require only a portion of the file be formatted for review)
   - Listings of versions of manually and automated converted files available for review on-line, where appropriate.

6. **Conversion Test Results** – This deliverable includes documentation of the executed data conversion and the subsequent testing performed to validate that data conversion programs are working correctly. Interim reporting on each file conversion test should occur within twenty-four (24) hours of each scheduled file conversion test. Conversion test results reports must include the following:

   - *Test Scope* – Identifies the system and software to which the test applies, provides a background of the system's use and users, and describes the purpose of the test

   - *Detailed Test Results* – Provides information on the following:
     - Testing log information (e.g., date, time, location, staff, hardware, and software utilized for each test)
     - Test data set

- o   The results of the testing, in the format approved by DHS
- o   Completion status of each test case associated with the test
- o   Identification of any problems encountered and impact on the schedule, if any
- o   When results are not "as expected", identification of the test case with an explanation of the problem(s) that occurred
- o   Identification of the test procedure step(s) in which problems occurred
- o   Documentation of the number of times the procedure or step was repeated in attempting to correct the problem(s) and the outcome of each attempt
- o   Identification of each test case in which deviations from test case / test procedures occurred, rationale for the deviation, and assessment of the impact on the validity of the testing

- • *Additional Notes* – Provides any supplemental information for the details listed above

7.   **Error Correction Plan** – Recommendations for corrections of identified errors or deficiencies in data within the Enterprise Data Warehouse.

8.   **Contractor's Plan for HIPAA Compliance** – This deliverable includes both Contractor compliance activities and approach to provider technical support. Also included will be the Contractor's assessment of options for provider HIPAA compliance along with description of obstacles and recommendations. Upon acceptance of a HIPAA compliance strategy, the Contractor will also include informational materials, user manuals, and training materials related to the Contractor's HIPAA solution(s).

8.4.6   STRUCTURED SYSTEM TEST ACTIVITIES

8.4.6.1   OBJECTIVES

The objectives of the Structured System Testing Activities are to ensure the new North Dakota Medicaid systems are based on a thoroughly tested, modified system that meets North Dakota specifications and performs all processes correctly. Through extensive internal testing, MMIS Contractor staff will prove that the replacement MMIS will appropriately process and pay all claim transactions, process and report encounter and eligibility data, update all types of files, and produce required reports and other outputs through performance of unit, integration, system and parallel testing. All systems and modules will be tested prior to start of operations. Components of the test will require that the Contractor demonstrate readiness to perform all Contractor functions and contractual requirements, including manual processes. DHS will identify the schedule for test cycles and delivery of output.

One of the important outcomes of the system testing task will be to demonstrate, through integrated testing, that the system (and possibly also the Contractor) is ready to perform all required functions for their system and provide applicable information to any supporting systems, as designated by RFP requirements, CMS certification criteria (MMIS Contractor only), and all State-approved change orders.

Acceptance testing will be conducted in a controlled and stable environment. The Contractor must also design and implement an Integrated Test Facility during this task. This test facility will contain the system tested version of all North Dakota Medicaid systems software. The Integrated Test Facility will be used to acceptance test all software changes and additions.

Software will be migrated to the Integrated Test Facility only after State signoff of system test results. Software will subsequently be migrated to production from the Integrated Test Facility only when DHS approves all of the acceptance test results. These migration and authorization steps must be documented in the Integrated Test Facility procedures.

8.4.6.2 DELIVERABLES

At a minimum, the following deliverables will be included:

1. **System Test Tracking Tool** – An automated tool to store and track system test metrics must be provided. At a minimum, the automated tracking tool must:
    - Capture or assign unique ID to each system test scenario;
    - Cross-reference to the approved Requirements Specifications Document (RSD) and Detailed System Design (DSD) requirements met by the test scenario
    - Store scenarios and test results by business function; and
    - Define and report system testing scenario status including:
        - Total number of test cases identified
        - Test cases ready for testing
        - Number released for model office testing (this week)
        - Number passed in model office (this week)
        - Number of test cases in work (under further research after initial results)
        - Number of test scenarios signed off for testing
        - Number of defects identified during testing (with access to supporting detail for defects)
        - Number of test scenarios passed and signed off by the State (each week) and number of failed test scenarios (this week)
        - Remaining test scenarios (this week) to be tested
        - Grand total of test scenarios involved in system testing
        - Percent complete

    In addition, system test results must report the correction needed, retest results, begin and end dates for the statuses tracked in the metrics, ID for the tester, analyst ID and estimated end dates for completion. Other weekly reports need to present results by status, subsystem, tester, analyst, and date.

2. **Testing Problem Tracking and Resolutions** – Metrics from System Testing will be reported weekly from the automated test scenario tracking tool reporting the current status of every test scenario currently available for testing or in progress. At a minimum, the automated tracking tool must:
    - Define the System Testing universe
    - Capture or assign a unique ID to each test scenario
    - Store scenarios and System Testing results by business area
    - Cross-reference to RSD requirements satisfied by each test scenario
    - Define and report System Testing status by:
        - number of System Testing scenarios identified for the business function
        - number ready for testing
        - number released for System Testing
        - number of System Testing test scenarios that have passed

- o number of System Testing test scenarios that have failed
- o number of defects identified
- o number of test cases under further research after initial results
- o number of System Testing test scenarios passed in the Integrated Test Facility (ITF) and signed off by the State as completed and number of System Testing test scenarios that failed
- o number of System Testing test scenarios to be retested
- o number of remaining test scenarios to be tested/retested
- o grand total
- o percent complete

- In addition, System Testing test results must by analyzed to identify any corrections needed, the retest results, begin and end dates for the statuses tracked in the metrics, ID of the tester performing the test, ID of the State analyst reviewing and approving results and estimated end dates for completion

3. **System Testing Test Strategy** – At a minimum, this deliverable will:
    - Define the approach to system testing
    - Identify anticipated State and Contractor resources involved in testing
    - Define Internet readiness testing
    - Define the scope and criteria for acceptance and operational readiness testing for all business functions
    - Outline the scope of the system testing process
    - Describe the development of the test scenarios to ensure that all applications and functions of the system are evaluated and acceptable
    - Define the schedule of the system testing effort
    - Describe how the system testing process is tracked and monitored to ensure that all testing and re-testing has been satisfactorily completed.

4. **Detailed System Testing Test Plan** – This deliverable, at a minimum, must include information on the following:
    - Test criteria and data sets

    - Test plan and schedule for each system module and subsystem, as well as for the integrated system and automated parallel testing; performance/load testing; integrated system testing must include testing all system features including those which involve more than one (1) subsystem or system component, such as updates to recipient or provider records based on paid claims, interfaces between TPL records and claim records payments, processing of claim records from input through reporting; automated parallel testing must be conducted to show the same processing through the existing system and the newly developed system

    - Description of every test scenario, linkage to the approved RSD and DSD, State policy and/or business function and expected test results

    - Organization plan showing Contractor personnel responsible for testing

    - Discussion of management of the testing effort, including strategies for dealing with delays in the testing effort, high volume of defects, back-up plan, back-up personnel, and related issues

    - Plan for updating documentation based on test results

    - Plan for organizing and presenting test results for DHS review

5.   **Corrective Action Plan** – This deliverable presents procedures for notifying DHS of problems discovered in testing, testing progress, adherence to the test schedule, and so forth; and procedures for tracking and correcting deficiencies discovered during testing;

6.   **Structured System Test Results** – This deliverable must be prepared and submitted to document the outcome of system testing. Minimum content requirements for this deliverable are:
   - Summary of the testing process, including number of problems identified and corrected, by type
   - Listing of all test scenarios that passed system testing by functional area within the business model
   - Descriptions of problems identified, details of defects created and corrective steps taken
   - Description of problems outstanding at the end of system testing and acceptance testing, the plan for resolution, and the impact on operations
   - All test results, including screen prints, test reports, and test inputs, cross-referenced to the expected test results in the System Test plan
   - Corrective actions taken and retest documentation for all problems identified in the initial tests and all retests
   - System performance benchmarks resulting from load testing/capacity analysis
   - Integrated system test results which show that the system can perform all integrated functions and can process all claim types from input through reporting; specific claim records must be tracked by control number through the system
   - Automated parallel system test results which show the results of the same processing run through the existing system and the newly developed system, including an explanation for any discrepancies in the results
   - Automated parallel system test results which show the results of processing data through the existing DSS/DW and migration of that data to the new system, including an explanation for any discrepancies in the results
   - Summary of the status of testing, including numbers of problems identified by type of problem, numbers of problems corrected, any significant outstanding issues, the effect of any findings on the implementation schedule, and any other relevant findings

7.   **Updated User Documents** – This task involves updates to system documentation and user manuals, per any modifications that have resulted from development and testing activities.

8.   **Updated Operational Procedures Document** – This task involves updates to operational procedures, per any modifications that have resulted from development and testing activities.

9.   **Updated Business Continuity and Contingency Plan** – As part of the System Test Task, the Contractor must update its Business Continuity and Contingency Plan and ensure that it addresses:
   - Checkpoint / restart capabilities
   - Retention and storage of back-up files and software

- Hardware backup for the main processor and any other supporting platforms
- Hardware backup for data entry equipment
- Network backup for telecommunications to support Internet access and POS operations
- Continued processing of North Dakota transactions (claim records, eligibility verification, provider file, other updates to the system, etc.) assuming the loss of the Contractor's primary processing site; this will include interim access support for the State to the on-line components of the system
- Back-up procedures and support to accommodate the loss of on-line communication between the Contractor's processing platform and State facilities in North Dakota; these procedures will not only provide for the batch entry of data and provide the Contractor with access to information necessary to adjudicate claim records, but will also provide the State with access to the information and processing capabilities necessary to perform its functions
- Detailed file back-up plan and procedures, including the off-site storage of crucial transaction and master files; the plan and procedures will include a detailed schedule for backing up critical files and their rotation to an off-site storage facility; the off-site storage facility will also provide for comparable security of the data stored there, including fire, sabotage, and environmental considerations
- Maintenance of current system documentation and source program libraries at an off-site location

Each aspect of the Business Continuity and Contingency Plan must be detailed as to both Contractor and State responsibilities, be in accordance with requirements detailed in the RFP, and (for the MMIS Contractor) must satisfy all requirements for CMS MMIS Certification. A live demonstration of the operation of the Business Continuity and Contingency Plan will be tested as part of Acceptance Testing.

*Bidder's Note: The North Dakota Medicaid Systems Replacement Contractors will have limited involvement in post-System Test activities such as defect resolution, test environment support, etc.

8.4.7   OPERATIONAL READINESS TEST ACTIVITIES

8.4.7.1   OBJECTIVES

Operational Readiness and Operability Tests will be conducted with all Contractors and will focus on testing the State's (and any Contractors') readiness to assume and start operations in all the following areas:

- Hardware and software installation
- Hardware operation
- Telecommunications
- Interfaces
- Staffing
- Contractor Staff training
- State staff training
- All system, user, and operations documentation

- Facility
- Toll free and other phone lines
- Claim forms distribution
- Mailroom operations
- Imaging operations
- Workflow Process Management operations
- System security
- Confidentiality of data
- Report generation and distribution processes
- AVR and Voice Response System readiness
- System back-out procedures
- Coordination of responsibilities with other system and professional service contractors

The Operational Readiness and Operability Test will involve testing all the operations and hardware/software/telecommunications aspects of the North Dakota Medicaid Enterprise. This test will involve preparing extensive checklists and testing all operational components of the system against these checklists. Each Contractor will be responsible for tracking and responding to all problem conditions reported in their areas of responsibility during the Operational Readiness and Operability Testing tasks of DDI and preparing a corrective action plan for problem correction and resolution. The key components of the Operational Readiness and Operability Testing are:

1.) Complete operational readiness/operability test plan.

2.) Schedule staff for the entire test.

3.) Prepare test environment and load test data sets.

4.) Complete operational readiness / operability checklist.

5.) Conduct operational readiness / operability test.

6.) Implement corrective action plan for all problems identified during operational readiness / operability testing.

7.) Correct the problems and retest.

8.) Prepare weekly test results document.

9.) Monitor operational readiness / operability test results.

The operational readiness test is designed to ensure that the Contractor is ready to process all inputs, price claim records correctly, meet all reporting requirements, utilize a properly functioning data communications network, and have a demonstrated back-up capacity. Operational readiness testing will include a volume test of several days of production capacity claim records volumes to demonstrate that the system is prepared for full production. Operational readiness will also examine other potential State or Contractor responsibilities such as mail room operations, document imaging, customer service, correspondence management, drug rebate, financial operations, quality assurance, fraud and abuse oversight, processing for grievances and appeals, publications and other analytical services. For the MMIS and POS Contractors, operational readiness testing may include a pilot test of actual claims processing in a full operational environment through the checkwrite process.

8.4.7.2   DELIVERABLES

At a minimum, the following deliverables will be included:

1. **Checklist Matrices** – In this deliverable, the Contractor will produce complete operational readiness checklist matrices for:

   - System Hardware and Software
   - System Network Operations
   - Ongoing Contractor Operations (DSS/DW only)
   - Mailroom Activities
   - System Training Activities
   - System Interface Operations
   - System Documentation Activities
   - Business Process Documentation Activities
   - System Functional Operations
   - System Data Conversion Activities
   - Outstanding Issues and Problems with Resolution Plans

2. **Updated Operational Procedures Documents** – The Operational Procedures define the relationships and responsibilities of Contractor and/or State personnel for MMIS, POS, or DSS/DW operations. Minimum requirements are:

   - Must be written in a procedural, step-by-step format
   - Operating procedures must be created and maintained in Microsoft Word 97 (or higher, consistent with the State standard) and must be available on-line and provided on request to the State on diskette or CD
   - Instructions for sequential functions must follow the flow of actual activity
   - Operating procedures must contain a table of contents and be indexed and include an on-line search capability
   - Include all procedures for MMIS and State staff business operations including: mailroom, cycle balancing, production control, file updates, quality assurance analysis, OCR, imaging, data entry, etc.
   - Descriptions of error messages for all fields incurring edits must be presented
   - Definitions of codes used in various sections of a manual must be consistent
   - Naming conventions used in operating procedures must be identified and must be consistent with windows, screens, reports, and the data element dictionary
   - Abbreviations must be consistent throughout the documentation
   - Instructions for making on-line updates will clearly depict which data and files are being changed
   - Operating procedures must contain any internal reports used for balancing, or other internal reports, that are not MMIS outputs. All fields in reports must be defined, including detailed explanations of calculations used to create all data

3. **Operational Readiness Report** – The Contractor will submit a report that details the results of the operational readiness assessments and certifies that the replacement systems and their supporting software programs, applications, functions, processes, operational procedures, staffing, telecommunications, and all other support is in place and ready for operation.

8.4.8   PILOT TEST ACTIVITIES

8.4.8.1   OBJECTIVES

DHS, with support from the IV&V Contractor and other DHS systems and professional services contractors, will conduct pilot tests to confirm the stability and production readiness of the system in a tightly controlled environment. Pilot testing with providers will be limited to DHS-selected providers. DHS will define the scope and select providers to be trained and included in the pilot tests. The Contractor is responsible for developing the details of its system's pilot test plan. Pilot testing for the MMIS and POS will be conducted in an environment using fully operational components of the systems and operationally ready staff resources.

Pilot tests are designed to demonstrate that the Contractor(s) are ready to process all inputs, pay and adjust claims correctly, meet all reporting requirements, utilize a properly functioning data communications network, and have a stable back-up capacity. Pilot testing will include actual claims processing in a full operational environment, from receipt of claims through financial processing, history update, and reporting. Both the MMIS and the POS will have their claims processing capabilities fully tested. Production of output files and reports will be required.

8.4.8.2   DELIVERABLES

At a minimum, the following deliverables will be included:

1.   **Provider Implementation Support Materials** – The Contractor will describe in detail the type and various materials they will utilize to meet the requirements of this activity. At a minimum, the deliverable must include:
    - *Types of Provider Implementation Support Materials* – All implementation support materials developed will become the property of DHS. Provider Implementation Support Materials will include:
        - Provider Log-In materials (Security)
        - Develop training manuals that parallel the content of user and procedure manuals
        - Provide samples of training course outlines, instructors' classroom materials, training packets, presentations, and related documentation, including materials that meet DHS alternate format requirements
        - National Plan and Provider Enumeration System (NPPES) system and staff materials
        - Description of audio/visual presentations and Web-based tutorials
    - *Content of Provider Implementation Support Materials* – Provider re-enrollment materials will cover, at a minimum the following topics:
        - Re-enrollment schedule
        - Re-enrollment forms
        - Re-enrollment contract agreements
        - List of Providers and Category
    - Provider Log-In materials will cover at a minimum the following topics:
        - Confidentiality requirements

- o Log-In ID re-assignment
- o Forms for documenting Log-In ID's
- Provider communication materials will cover at a minimum the following topics:
  - o Schedule for each task and subtask identified
  - o Schedule for each communication event
  - o Communication materials
  - o System requirements/configuration

2. **Provider Training Plan, Materials, and Reports** – This document shall identify the provider training that must be conducted and will contain, at a minimum, the following information:

- *Training Session Plans* – This section will cover the following topics:
  - o Providers to be trained
  - o Training date(s) and length of training

- *Provider Training Curriculum and Materials* – This section will cover, at a minimum, the following topics:
  - o System overview
  - o System benefits
  - o Data inputs, outputs, and reports generated
  - o User manual contents and usage
  - o Alternate formats and bilingual languages.
  - o System Usage
  - o Entering data and data validation
  - o Data correction and user help functions
  - o Menu and system function traversal
  - o Problem recovery
  - o Report contents and report generation.
  - o Search and inquiry features
  - o Record update procedures
  - o System operation
  - o Seeking technical help

- *Follow-up Training Report* – This section provides:
  - o Contractor comments regarding the training session
  - o List of providers who were scheduled for training who did not attend

3. **Draft Provider Handbooks** – Provider handbooks are used to enable the provider community to submit claim records in the proper format for adjudication. Draft provider handbooks will be prepared during the Development Task and updated during the Implementation Task. Each handbook must be specific to individual provider type(s) or groups of related provider types. The minimum requirements are to:

- Contain an introduction, policy section, billing instructions, billing examples, and rate methodologies;

- Must be created and maintained in Microsoft Word 97 or higher (consistent with the State standard), must be provided to DHS(on request) on diskette or CD, and must be maintained in .html or .htm format in order to be accessible to providers via the Web during the Operations phase;

- Provide general program information and highlight differences in programs and in processes among programs;

- Contain a table of contents and be indexed;

- Include an on-line search capability for the electronic version;

- Describe provider certification (enrollment) and re-certification procedures, general participation requirements, and termination procedures;

- Describe general medical record content and record retention procedures and audit procedures and responsibilities;

- Describe third party resource (coordination of benefits) identification and recovery procedures, including Medicare benefits;

- Identify methods of verifying recipient eligibility, describe information contained or accessible through Recipient Identification Cards, describe all relevant recipient information supplied to the provider, describe each eligibility verification access method available and how to utilize it, and describe why this information is relevant to providing services;

- Identify covered services and service limitations;

- Identify reimbursement procedures, including co-payment requirements and managed care procedures;

- Identify any special forms needed and describe how to complete them and submit them (for example, Prior Authorization, sterilization consent);

- Provide detailed billing instructions and filing requirements, for all billing methods, including electronic and paper submission;

- Describe the process to do adjustments and make refunds;

- Describe utilization review and control procedures; and

- Describe methods to access data and submit provider inquiries.

4.   **Provider Implementation Support Plan** – This deliverable will describe the general approach and plan(s) that will be used to complete provider implementation support tasks. The plan must address compliance with the requirements of HIPAA National Provider Identifier (45 CFR Part 162). This deliverable must address and discuss the following at a minimum:

- *Understanding of Provider Community* – The Contractor must demonstrate their understanding of North Dakota's provider community and provide a general description of the provider implementation support effort. Include a discussion as to whether the provider implementation support task will be implemented in phases. This Section must address the following:

  o   Provider implementation support objectives, impact, and resources
  o   Processes and tools that will be used to gather and store the necessary information, the processes that will be used to conduct credential verifications, and the processes that will be used to transfer the data to the replacementMMIS
  o   Identify number of DHS and ITD staff (including skill levels) needed to assist in the implementation support effort

- o   Strategy for business/operations support
- o   Strategy to meet requirements of the NPI and the National Plan and Provider Enumeration System (NPPES) as specified in HIPAA 45 CFR Part 162
- o   Strategy for Provider Training

- *Provider Communications* – In this Section the Contractor will identify and describe the communication approach and schedule of events it will conduct to ensure that the providers have the appropriate level of knowledge and skill to understand how the replacement MMIS and POS can be accessed and to keep the provider community informed of the changes necessary to support the implementation of the replacement MMIS and POS. Provider communications at a minimum will cover the following:
  - o   Communication with the provider community about the re-enrollment plan and process.
  - o   Communication with the provider community about the Log-In ID assignment that meets DHS standards and the requirements for DHS and HIPAA security.
  - o   Communication with the provider community about the HIPAA 45 CFR Part 162 (National Provider Identifier) requirements
  - o   Training to Medicaid providers to ensure that providers understand how to access the new system(s).
  - o   Communication with the provider community about specific provider user trainings.
  - o   Communication with the provider community on how to access the replacement MMIS and POS and their specific provider information.
  - o   The preparation of specific communication materials.

- *National Provider Identifier* –Tasks shall be listed in order of required occurrence. All task dependencies must be identified. This information may be depicted in the form or a work breakdown structure and appended to the plan. The provider implementation support plan must address the following:

  - o   Identify all data elements needed to populate the system so that the provider enrollment data in the replacement MMIS is fully functional and meets NPI
  - o   Plan for an interim file storage
  - o   Plan for merging interim file storage with the replacement MMIS
  - o   Plan for maintaining existing data and keeping it updated
  - o   Plan for conducting credentialing verification
  - o   Plan for gathering IRS tax identification numbers (TIN) and verification of the TIN's as per IRS rules
  - o   Plan for conducting provider training and meeting the training requirements listed in the statement of work
  - o   Plan for conducting MMIS log-on administration
  - o   Plan for updating current provider enrollment applications
  - o   Plan for updating Web-accessed site with new applications
  - o   Plan for conducting provider communications

5.   **Provider Implementation Support Report** – The Contractor will be required to submit a final report reflecting the work that has been accomplished related to the provider implementation support activity. At a minimum, the deliverable must include:

- *Provider Re-enrollment* – This document must identify the provider re-enrollment tasks or subtasks that have been conducted and will contain, at a minimum, the following information:
  - o Description of the type and specific events conducted
  - o Names of Providers re-enrolled
  - o Names and NPI for each provider
  - o Names of those providers without an NPI
  - o Description of materials developed and used
  - o Contractor comments regarding re-enrollment task or subtask

  *Bidder's Note: As part of this contract, the MMIS Contractor will be responsible for re-enrolling all providers with the North Dakota Medicaid program 6 months prior to the system's "Go Live" date.

- *Provider MMIS Log-On Administration* – This document must identify the providers who have been assigned a unique provider Log-In ID for accessing the replacement MMIS and will contain, at a minimum, the following information:
  - o Names of providers who have been assigned a unique provider Log-In ID
  - o Dates provider Log-In ID's were assigned
  - o Description of communication materials provided

- *Provider Communications* – This document must identify the communication efforts and materials that were used to complete the task or subtask identified to support the provider implementation support activities. Each report for this Section will contain a sub-total for each stakeholder group and an overall grand total. This Section of the report will contain, at a minimum, the following information:
  - o Number of communication events conducted
  - o Number and type of communication materials developed
  - o Number of communication events scheduled statement of work

6. **Pilot Test Plans and Schedule** – This activity / deliverable involves a small-scale implementation of the solution to various business functions, in order to determine the effectiveness of the solution before it is implemented system-wide. A schedule of such pilot testing activities must be included, as well as a description of contingency plans that will be used if "less than desirable" outcomes are produced.

7. **Pilot Test Results** – This deliverable presents the results of all pilot testing activities, including any re-tests that occurred on tests with previous poor outcomes.

8.5   SYSTEM OPERATIONS PROCESS

8.5.1   IMPLEMENTATION ACTIVITIES

8.5.1.1   OBJECTIVES

Implementation includes making all final corrections, upgrades, and changes to the system to meet deficiencies identified in the testing process. For the MMIS component, implementation means being able to accept healthcare claims from all provider types other than pharmacy (in

any required medium), being able to accept all transaction formats required under HIPAA, being able to accept any remaining proprietary forms and formats that have been designated by DHS, and being able to produce required data and reports for State users. As the lead systems contractor, the MMIS Contractor must assure the State that all interfaces are working and the required information for all processing claims and reporting is accessible. The multiple components of this procurement, as well as the potential for multiple contractors, increase the risk for failure at the implementation stage.

The MMIS Contractor will also take the lead in preparing the MMIS-related components to collectively meet CMS MMIS Certification requirements. This responsibility includes working with the individual contractors to demonstrate that all certification requirements can be met. DHS will also require that the contractors prepare for and (as necessary) participate in the certification of the MMIS, including preparing certification manuals, ensuring that first-run reports are collected and maintained for the certification review, ensuring that all certification requirements are met to allow certification back to the first day of operations, and identifying all other systems that are involved in achieving the Certified MMIS. This CMS Certification support shall be considered part of the Contractor's System Warranty / Maintenance responsibilities. After "Go Live", the MMIS Contractor is responsible for three (3) key tasks, while the POS and DSS/DW Contractors are responsible for the first two (2) key tasks:

- System Warranty / Maintenance responsibilities for one (1) year
- Knowledge Transfer / Training responsibilities for six (6) months
- Support for CMS Certification process through the point of certification

DHS staff must be given sufficient time to review all system, user and security documentation for completeness prior to implementation. The system response time and all user and automated interfaces must be clearly assessed and operational. A complete file transfer plan must be developed and executed. This plan must identify:

- The name of each file, table, or database

- Destination of transferred data

- Transfer start and completion times

- Location and phone numbers of person(s) responsible to execute the transfer

- A complete fall back plan if the file transfer does not go as planned

8.5.1.2   DELIVERABLES

At a minimum, the following deliverables will be included:

1.   **State Staff Training Plan** – The State Staff Training Plan identifies all the activities leading up to, and including, the Knowledge Transfer / Training of DHS management and user staff, at all levels, in the proper use of the MMIS, POS, and DSS/DW. Minimum requirements for this deliverable are:
     - Description of training materials
     - Description of training facilities (for example, use of screens)
     - Training schedule
     - Plans for remedial training

- Methodology to ensure continued training during the Operations Task for new staff or staff changing positions (for example, use of videotapes).

2. **Provider Transactions Training Plan** – The Provider Training plan identifies all the activities leading up to, and including, the training of all provider types in proper billing procedures, and understanding of electronic and paper remittance advice (RA) documents.   Minimum requirements for the Provider Training Plan are:
   - Description of training materials;
   - Description of on-line, real-time training on electronic communications and claims and other document submission;
   - Examples of training agendas and test transactions used to train providers;
   - Training schedule for all provider types across the State;
   - Training schedule or examples of on-line training materials available on-line or in hard-copy to out-of state providers in neighboring states;
   - Providing Medicaid and HIPAA-experienced training staff throughout the contract period;
   - Locations for training, and plans for providing desktop training at those locations; and
   - Plans for remedial and ongoing training during operations.

3. **Report Distribution Schedule** – This deliverable presents the reports management plan, to include the following for all regularly scheduled reports:

   - Responsible person for the report
   - Distribution list for the report
   - Frequency of update
   - HIPAA issues (if any)
   - Business definitions of data included in the report

   Report Distribution listings for current systems should be reviewed and, where applicable, must be reviewed and revised as part of the Implementation Activities. Revisions to the Report Distribution lists must be based on any new report access features available through software upgrades. The Report Distribution listings will also be used to track distribution and access to updated user manuals.

   Revisions to the Updated Report Distribution Lists must also reflect input from other State users regarding report data available to them from DHS systems. It is expected that these users will have received and reviewed test reports from the implemented systems for review prior to providing their input on updates to the Report Distribution lists.

4.   **Software Release Plan** – This deliverable presents the Contractor's plans and schedules for releasing new versions of software programs and/or applications that support the implemented system. Examples of items to be addressed by this plan include, but are not limited to the following:

- Proprietary drug rebate application implemented by the POS Contractor
- Proprietary provider claims submission software provided to DHS as an optional service by the MMIS Contractor
- Proprietary scanning or OCR technology provided to DHS as an optional service by the MMIS Contractor

5.   **Operational Readiness Test Results** – The Contractor will submit a report that details the results of the operational readiness assessments and certifies that the system and any subsystems, functions, processes, Contractor/State operational procedures, staffing, telecommunications, and all other associated support is in place and ready for operation.

6.   **Emergency Change and Back-out Plan** – This deliverable presents the procedures necessary when emergency changes need to be made to the system. It also identifies what policies, procedures, and safeguards are followed when a previously implemented change needs to be removed from the system environment because the change did not produce the anticipated outcome.

7.   **Final Facility and Data Security Manual** – This deliverable documents the policies, procedures, and safeguards in place for maintaining a physically secure office site, in addition to the Contractor's plan for ensuring that all data (particularly PHI) is secure. This document includes policies and procedures that will be followed and any additional documentation that DHS and ITD require to document adherence to information security standards.

8.   **Final Implementation Checklist** – This deliverable provides the list of tasks, procedures, documentation, and other relevant activities to be completed during the final installation of the fully-tested, operational version of each transferred system. As necessary, the Contractor includes brief descriptions and/or cross-references to other documentation in the checklist.

9.   **Final Documentation and Manuals** – Prior to the operational start date of the new systems, the Contractor will provide final versions of all systems documentation, user and policy manuals, operational procedures, and other relevant documentation.

10.   **Certification Checklist** – MMIS Certification encompasses the production and delivery of final systems documentation, preparation for, and obtaining CMS Certification of the replacement MMIS. At a minimum, this MMIS Contractor deliverable must include:

- *Certification Approach* – Preparation for certification shall include developing and assembling documents that will be used to support the certification process and review. This deliverable must describe the approach the Contractor will take to achieve certification by addressing the Contractor responsibilities that are outlined below.

- o Create a checklist based on review of the State Medicaid Manual, which identifies specific requirements that must be met.
- o Review of other reference documents or contacts with other State staff recently involved in certification review.
- o Identify and review other project deliverables that will be used in certification.
- o Identification of other documents that will be required for certification that will need to be assembled or created.
- o Archive first-run test claims and reports until receipt of certification.
- o Resolve any deficiencies identified during certification review.
- o Process to be used to assemble, update and library requirement deliverables.

- • *Certification Checklist Criteria* – The certification checklist shall contain, but is not limited to:
  - o A crosswalk of Federal requirements to certification Deliverables (system documentation, reports, walk-through books) and explanation of form and content of the deliverables.
  - o Delineation of responsibilities between DHS and the Contractor in completing certification.

11.   **Certification Review Package and Manuals** –This deliverable requires CMS Certification for final acceptance. The Certification Review Package, the final product of documentation requirements identified in the Certification Checklist and Readiness process, will be used to obtain certification of the replacement MMIS. The Review Package will include the components described below.

- • *Review Package* – This Section will describe the documents the Contractor will prepare in support of the onsite review. This package will be submitted to DHS with a written statement of intent to claim enhanced Federal Financial Participation. DHS will be responsible for submitting the approved review package to CMS. This package will include, at a minimum:
  - o Confirmation that system operations meet requirements and performance standards as specified in the State Medicaid Manual Part 11, Chapter 3.
  - o Copy of system acceptance letter to the Contractor from DHS.
  - o Full system certification documentation including:
    - ▪ System Documentation
    - ▪ Source Code
    - ▪ Code Library
    - ▪ Data Dictionary
    - ▪ User Manuals
    - ▪ Operating Procedures
    - ▪ MITA Assessment
    - ▪ System Test Plan
    - ▪ System Test Results
    - ▪ Acceptance Test Plan (available from DHS)
    - ▪ Acceptance Test Results (available from DHS)
    - ▪ Substantive and representative samples of reports
  - o Documentation for onsite review:
    - ▪ First-run Federally-required MMIS reports
    - ▪ Documentation, which may be requested by CMS following the Preliminary Review
  - o Updated report distribution list and schedule

      o   Cross-reference of MMIS-required data elements and State-required data elements

12.   **<u>Schedule for Updates to Data Warehouse</u>** – This deliverable presents a schedule for all updates made to the DSS / Data Warehouse from other source systems. This document must also present a method for tracking data presented back to any "staging database" in use externally or internally. From that point, ITD would be responsible for tracking data to the underlying source. There will be some overlap at the data mart level.

13.   **<u>Systems Support Plan</u>** – The Systems Support Plan encompasses planning for, managing, and executing the operations and maintenance of the new system by the Contractor. It shall include routine system support tasks as well as how to manage enhancements to the system. At a minimum, the deliverable must include:

- *Scope* – This Section will identify the scope of the Systems Support Plan that will be developed by the Contractor to identify resource and administrative requirements for on-going support of the system. This will expand the outline that was included in the Implementation Approach deliverable and is related to the Configuration Management Plan.

- *Production Operation Support* – This Section will address production systems support requirements, including the managerial and technical services required to manage and operate the replacement system. This includes, but is not limited to, the following:
  o   Batch cycle scheduling specification, including job turnaround time monitoring
  o   Database administration
  o   Coordination and consultation with applications software and testing teams
  o   Database standards identification and compliance monitoring
  o   Database maintenance, reorganization and recovery
  o   Data queries and corrections
  o   Database performance analysis and improvement
  o   Database resource utilization and capacity planning
  o   Performance tuning
  o   Problem identification
  o   Software release and emergency implementation
  o   Software quality assurance evaluation
  o   System resource forecasting
  o   Performance monitoring
  o   Software migration
  o   MMIS security implementation and monitoring
  o   Mainframe liaison support with DHS
  o   Maintaining required interfaces, including file format and regular exchange of data according to requirements defined by DHS

- *System Maintenance Resource Requirements* – This section will address system maintenance resource requirements resulting from a determination by DHS or the Contractor that a deficiency exists in the system or that improved efficiency can be achieved through software modifications; including, but not limited to:

- o Activities necessary to correct a deficiency within the operational system, including deficiencies found after implementation of modifications incorporated into the system
- o Activities necessary to ensure that all data, files, program, and documentation are current, and errors are found and corrected
- o File maintenance activities for updates to tables and databases
- o Changes to operations parameters concerning the frequency, quality, format, sorting media and distribution of reports
- o Changes to edit disposition parameters for established edit or audit criteria
- o Addition of new values or changes to existing values in all system tables

- *System Enhancement Resource Requirements* – This Section will address system enhancement resource requirements resulting when DHS or the Contractor determines that new functionality or significant modifications of existing system functionality will be completed. This includes, but is not limited, to:
  - o Activities necessary for the system to continue to meet the requirements of DHS
  - o Activities necessary for the MMIS to continue to meet CMS Certification requirements existing at the time of Contract award and ongoing standards
  - o Implementation of capabilities neither specified in the RFP nor agreed to during the design and development tasks
  - o Implementation of audits and edits not defined in the RFP, current operating system and acceptance by DHS
  - o Changes to established report, screen, or tape formats, new data elements, or report items
  - o Acceptance of a new input form

- *Activity Tracking and Reporting* – This Section will present the Contractor's plan for providing or using DHS's automated on-line software management system for tracking and reporting all system maintenance and modification projects with full accessibility by DHS. This plan will identify of a defined set of software development and management indicators; including, but not limited to:
  - o Project description and priority
  - o Dates requested, estimated and required
  - o Requestor
  - o Assigned resources
  - o Estimated hours to complete
  - o Project status including hours worked and estimated
  - o Methods used to evaluate these data
  - o Description of standard reports to be viewed on line.
  - o Options for producing reports of varying content and format

- *System Maintenance and Enhancement Processing* – This Section will present the Contractor's plan for processing system maintenance and enhancement tasks; including, but not limited to:
  - o Notification of DHS that a system problem has been identified or a change is needed in order to improve system operations or accuracy
  - o Receiving system change requests from DHS
  - o Logging change requests and status into the project tracking and reporting system
  - o Development of requirements specification documents
  - o Establishing task priorities

- o Development of test plans and procedures for acceptance by DHS
- o Performing tests and submitting test results
- o Submission of updated systems documentation for approval
- o Implementation of system changes and validation

- *Technical and Management Reviews* – This Section will describe the Contractor's plan for conducting technical and management reviews involving appropriate Contractor and DHS staff. These reviews will be held routinely to address system objectives relating to software installation and project status.

- *Joint Technical Reviews* – This Section will address the plan for technical reviews involving staff with technical knowledge of software products to be reviewed. These reviews will focus on in-process and final software products. The reviews will have the following objectives:
  - o Review evolving software products to verify the proposed technical solution and obtain feedback on open issues
  - o Review project status, risks, and schedule issues
  - o Develop risk mitigation strategies
  - o Identify risks and issues to be raised to joint management reviews
  - o Ensure on-going communication between DHS and Contractor technical staff

- *Joint Management Reviews* – This Section will address the plan for joint management reviews involving staff with authority to make cost and schedule decisions. These reviews will have the following objectives:
  - o Review project tracking reporting to assess project status, directions being taken, technical agreements, and emerging issues
  - o Resolve issues that could not be resolved at joint technical reviews
  - o Arrive at agreed upon mitigation strategies for near and long term risks that could not be resolved at joint technical reviews
  - o Identify and resolve management-level issues and risks not raised at joint technical reviews
  - o Obtain commitments and approvals needed for timely accomplishment of tasks and projects

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9.0 ONGOING BUSINESS PROCESS REQUIREMENTS

9.1 DATA WAREHOUSE BUSINESS PROCESS REQUIREMENTS

9.1.1 STATE RESPONSIBILITIES

State responsibilities for the DSS/DW include, but are not limited to:

1. The State will define overall MMIS and POS data elements required for the Data Warehouse and approve parameters of standard reports.

2. The State will define parameters for ad hoc reports and request the reports on-line or provide specifications to the Contractor for more complex report requests.

3. The State will prioritize requests for ad hoc reports and file extractions.

4. The State will monitor production and review ad hoc reports.

5. The State will monitor the DSS/DW Contractor's performance.

6. The State will submit appropriate non-Medicaid information, as deemed necessary, to be merged with MMIS and POS history files.

7. The State will define review criteria necessary for analysis of provider billing practices.

8. The State will perform analytical simulation of policy change impacts, utilizing system capabilities provided by the Contractor.

9. The State will define requirements for an electronic library of standard and ad hoc queries / reports that will be maintained by the Contractor.

9.1.2 CONTRACTOR RESPONSIBILITIES

Contractor responsibilities for the DSS/DW include, but are not limited to:

1. The Contractor provides and maintains complete DSS/DW user documentation on the LAN in MS Word format.

2. The Contractor must provide on-line help including on-line data element and field look-up accessible to all users.

3. The Contractor must respond to DHS requests for information concerning the operation of the DSS/DW and production of ad hoc reports.

4. The Contractor must develop and obtain DHS approval for criteria and procedures to purge saved extract files and purge the saved extract file data according to the approved purge process.

5. The Contractor must provide one (1) year of System Warranty service after the "Go Live" date.

6. As part of DDI, the Contractor must train users in the development of specifications, research problems, review of production output and report formats, and to prepare specifications and produce reports of a more complex nature.

7. The Contractor provides ad hoc reports, as requested.

8. The Contractor incorporates industry best practices into the analysis of provider billing practices and provides data back to the State.

9. The Contractor programs, maintains, and produces standard reports on the analysis of program expenditures (including projections).

10. The Contractor programs, maintains, and produces standard reports on the analysis of Quality of Care measures (e.g., admissions, re-admissions, complications, etc.)

11. The Contractor programs, maintains, and produces standard reports on budget forecasting, as required.

12. The Contractor provides capabilities and technical support to perform analytical simulation of policy change impacts.

13. The Contractor will develop and maintain an electronic library for standard and ad hoc queries / reports.

14. The Contractor will oversee the query / report job queue and schedule production runs for such queries / reports according to the system requirements established in RFP Section 7.4.

15. The Contractor will provide ongoing "help desk" support for users of the DSS/DW.

16. In an ongoing basis, the Contractor will maintain system documentation prepares as part of Start-up Activities.

17. The Contractor will provide ongoing training for users of the DSS/DW.

18. The Contractor will document the cause of any data errors or inconsistencies that are creating significant data cleansing work effort during the weekly data update cycle. This documentation will be provided to appropriate State users to reduce or eliminate such errors or inconsistencies within the MMIS and POS, thereby improving the speed of the data load process for subsequent data update cycles.

9.1.3   PERFORMANCE STANDARDS

Performance standards for the DSS/DW include, but are not limited to:

1. Complete Data Warehouse updates from MMIS and POS data within twenty-four (24) hours of completion of the payment cycle. Any extraordinary updates will be performed in a timely and accurate manner at time intervals determined by DHS.

2. Resolve all Data Warehouse load errors within one (1) business day of identification of the error.

3. Complete updates from non-MMIS or POS data sources within the Department-specified timeframe from the point of receipt of the valid data.

4. Resolve any DSS/DW functionality errors within five (5) business days of identification of the error.

5. Complete complex ad hoc requests within two (2) business days of receipt of the request, unless an alternate timeframe is approved by DHS.

6. Produce required standard weekly reports and cycle processing reports by noon of the next State of North Dakota business day after the scheduled run.

7. Produce required standard monthly reports by noon of the fifth State of North Dakota business day after the end of the month.

8. Produce required standard quarterly reports by noon of the fifth State of North Dakota business day after the end of the quarter.

9. Produce required standard annual reports by noon of the tenth State of North Dakota business day following the end of the year (whether Federal fiscal year, State fiscal year, waiver year, or other annual period).

10. Produce ad-hoc and on-request reports on the date specified in the report request.

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10.0 FORMAT & CONTENT OF BID PROPOSALS

These instructions prescribe the format and content of the Bid Proposal and are designed to facilitate the submission of a Bid Proposal that is easy to understand and evaluate. Failure to adhere to the Bid Proposal format may result in the disqualification of the Bid Proposal.

10.1 INSTRUCTIONS

1.) A Bid Proposal is constituted of two distinct parts: (1) the Technical Proposal and (2) the Cost Proposal. Each Bid Proposal must be sealed in a box (or boxes), with the Cost Proposal and Company Financial Information portions each sealed in separate, labeled envelopes inside the same box(es). If multiple boxes for each Bid Proposal are used, the boxes must be numbered in the following fashion: 1 of 4, 2 of 4, etc. Boxes must be labeled with the following information:

- Bidder's Name and Address
- Department's Address and Procurement Officer (Identified by Section 2)
- RFP Title (North Dakota Medicaid Systems Replacement Project) and RFP Reference Number (325-05-10-016)
- RFP Component for which the Bid Proposal is being submitted for consideration (e.g., MMIS Replacement, POS Replacement, DSS Replacement)

Bidders submitting Bid Proposals for more than one of the three separate contract awards (MMIS, POS, and DSS/DW) will submit separate boxes for each Bid Proposal.

2.) All Bid Proposal materials must be printed on 8.5" x 11" paper (two-sided). The Technical Proposal materials must be presented in a 3-ring / "loose-leaf" binder, spiral binder, comb binder, or similar binder that is separate from the sealed Cost Proposal materials. The Cost Proposal materials must be submitted in a separate small 3-ring / "loose-leaf" binder, spiral or comb binder, "sliding bar" report cover, or similar binding that allows for easy removal of documents.

3.) If the bidder designates any information in its Bid Proposal as confidential, the bidder must submit an additional one (1) "non-proprietary copy" of Bid Proposal materials from which any confidential / proprietary information has been excised or redacted. The confidential material must be excised in such a way as to allow the public to determine the general nature of the material removed and to retain as much of the Bid Proposal contents as possible. Bidders cannot designate their entire proposal as confidential or proprietary. Non-proprietary versions of Bid Proposals must provide a sufficient level of information to understand the full scope of services to be provided.

The laws governing open records can be found in N.D.C.C. 44-04-18 at:

http://www.state.nd.us/lr/cencode/t44c04.pdf

4.) For the MMIS component, bidders will submit one (1) original, nine (9) copies, and (if applicable) one (1) non-proprietary copy of the Technical Proposal. MMIS bidders will submit one (1) original, three (3) copies, and (if applicable) one (1) non-proprietary copy of the Cost Proposal. The original and each copy must be in their own separate binder (or set of binders).

For the POS and DSS/DW components, bidders will submit one (1) original, five (5) copies, and (if applicable) one (1) non-proprietary copy of the Technical Proposal. POS and DSS/DW bidders will submit one (1) original, three (3) copies, and (if applicable) one (1) non-proprietary copy of the Cost Proposal. The original and each copy must be in their own separate binder (or set of binders).

As explained in the first instruction above, bidders submitting Bid Proposals for more than one (1) of the three (3) separate contract awards would therefore submit one (1) original, and the appropriate number of copies of the Technical Proposal and Cost Proposal for each separate RFP Component contract under consideration. All materials must be submitted in a timely manner to the Procurement Officer. The binder(s) containing the original Bid Proposal materials must be labeled "Original", the binder(s) containing a copy of the Bid Proposal materials must be labeled "Copy", and the binder(s) containing the non-proprietary copy of the Bid Proposal materials must be labeled "Non-proprietary Copy". Example Bid Proposal submissions by bidders are provided in the Table 20 below.

5.) Technical and Cost Proposals must also be submitted on CD-ROM (2 CD-ROM copies per Bid Proposal). One CD-ROM will contain a full electronic copy of the Technical Proposal and a full electronic copy of its corresponding "non-proprietary" version. The other CD-ROM, which must be sealed with the Cost Proposal materials, will contain a full electronic copy of the Cost Proposal and a full electronic copy of its corresponding "non-proprietary" version. Electronic files must be in ".pdf" format or ".doc" format (Microsoft Word 2000 or newer) and individually identified in the file name by Component Name, Bid Proposal part, and version [e.g., MMIS Technical Proposal (Full Proposal), or POS Cost Proposal (Non-proprietary)].

6.) As much as possible, Technical Proposal sections should be limited to discussion of elements relevant to the proposed solution for North Dakota. The "Services Overview" and "Corporate Organization, Experience, and Qualifications" sections of the Technical Proposal allow bidders to expound in greater detail about past or current projects.

Table 20: Example Bid Proposal Submissions by Bidder A and Bidder B

	Bidder A (Bidding on MMIS and POS)		Bidder B (Bidding on DSS Only)	
	# of Copies	Box Location	# of Copies	Box Location
MMIS Component	1 Original, 9 Copies, and 1 Non-proprietary Copy of Technical Proposal 1 Original, 3 Copies, and 1 Non-proprietary Copy of Cost Proposal (Separated from Technical Proposals and in Sealed Envelopes)	Box 1 of 3	No Bid	N/A

	Bidder A (Bidding on MMIS and POS)		Bidder B (Bidding on DSS Only)	
	# of Copies	**Box Location**	**# of Copies**	**Box Location**
POS Component	1 CD-ROM containing 1 full version of the Technical Proposal and 1 full non-proprietary version of the Technical Proposal 1 CD-ROM, sealed with the Cost Proposal materials, containing 1 full version of the Cost Proposal and 1 full non-proprietary version of the Cost Proposal 1 Original, 5 Copies, and 1 Non-proprietary Copy of Technical Proposal 1 Original, 3 Copies, and 1 Non-proprietary Copy of Cost Proposal ((Separated from Technical Proposals and in Sealed Envelopes) 1 CD-ROM containing 1 full version of the Technical Proposal and 1 full non-proprietary version of the Technical Proposal 1 CD-ROM, sealed with the Cost Proposal materials, containing 1 full version of the Cost Proposal and 1 full non-proprietary version of the Cost Proposal	Box 2 of 2	No Bid	N/A
DSS/DW Component	No Bid	N/A	1 Original, 5 Copies, and 1 Non-proprietary Copy of Technical Proposal 1 Original, 3 Copies, and 1 Non-proprietary Copy of Cost Proposal (Separated from Technical Proposals and in Sealed Envelopes) 1 CD-ROM containing 1 full version of the Technical Proposal and 1 full non-proprietary version of the Technical Proposal 1 CD-ROM, sealed with the Cost Proposal materials, containing 1 full version of the Cost Proposal and 1 full non-proprietary version of the Cost Proposal	Box 1 of 1

10.2 TECHNICAL PROPOSAL CONTENTS

The Technical Proposal must consist of the following sections separated by "Tabs". Documents and responses shall be presented in the order given below:

10.2.1 TABLE OF CONTENTS (TAB 1)

A Table of Contents of the Technical Proposal must be inserted at Tab 1. The Table of Contents will identify all Sections (identified here in Section 10.2 as "Tabs"), all Subsections contained therein, and the corresponding page numbers. The Table of Contents must include all Sections and subsections present under Tabs 1 through 11. The Table of Contents found at the beginning of this RFP provides a representative example of what is expected for the Technical Proposal Table of Contents.

10.2.2 TRANSMITTAL LETTER (TAB 2)

An individual authorized to legally bind the bidder must produce and sign a Transmittal Letter on official company letterhead. A photocopy of the Transmittal Letter must be included in each copy version of the Technical Proposal. The Transmittal Letter is evaluated as part of the screening for Bid Proposal Mandatory submittal requirements and must include:

1.) The bidder's mailing address.

2.) Electronic mail address, fax number, and telephone number for both the authorized signer and the point of contact designated by the bidder.

3.) A statement indicating that the bidder is a corporation or other legal entity. All subcontractors must be identified, and a statement included that indicates the exact amount of work to be done by the prime contractor [not less than sixty percent (60%) of total project hours] and each subcontractor, as measured by percentage of total contract price. The technical proposal must not include actual price information.

4.) A statement confirming that the prime contractor is registered to do business in North Dakota and providing assurances that any subcontractor proposed is also licensed to work in North Dakota.

5.) A statement identifying the bidder's Federal Tax Identification Number.

6.) A statement that the bidder will comply with all Contract Terms and Conditions as indicated by Section 3 of this RFP.

7.) A statement that no attempt has been made or will be made by the bidder to induce any other person or firm to submit or not to submit a proposal.

8.) A statement of affirmative action that the bidder does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, or handicap.

9.) A statement that no cost or pricing information has been included in this letter or the Technical Proposal.

10.) A statement identifying all amendments to this RFP issued by the State and reviewed by the bidder. If no amendments have been issued, a statement to that effect must be included.

11.) A statement that the bidder certifies in connection with this procurement that:

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

  b.) Unless otherwise required by law, the prices quoted have not been knowingly disclosed by the bidder prior to award, directly or indirectly, to any other bidder or to any competitor.

12.) A statement that the person signing this proposal certifies that he/she is the person in the bidder's organization responsible for, or authorized to make, decisions regarding the prices quoted and that he/she has not participated, and will not participate, in any action contrary to item 11 above.

13.) If the use of subcontractor(s) is proposed, a statement from each subcontractor must be appended to the transmittal letter signed by an individual authorized to legally bind the subcontractor stating:

  a.) The general scope of work to be performed by the subcontractor;

  b.) The subcontractor's willingness to perform the work indicated; and

  c.) The subcontractor's assertion that it does not discriminate in employment practices with regard to race, color, religion, age (except as provided by law), sex marital status, political affiliation, national origin, or handicap.

14.) Any request for confidential treatment of information must also be identified in the Transmittal Letter, in addition to the specific statutory basis supporting the request and an explanation why disclosure of the information is not in the best interest of the public. The Transmittal Letter must also contain the name, address and telephone number of the individual authorized to respond to the Department about the confidential nature of the information.

Transmittal Letters must be numbered in sequence with the remainder of the Technical Proposal.

10.2.3   REQUIREMENTS CHECKLISTS AND CROSS-REFERENCES (TAB 3)

10.2.3.1   BID PROPOSAL MANDATORY REQUIREMENTS CHECKLIST

Bidders will complete a checklist of Mandatory Requirements that includes the basic set of mandatory submittal requirements. Upon receipt of Bid Proposals, DHS will use this checklist to confirm that bidders have produced and submitted Bid Proposals according to DHS specifications. The form for the Bidder Checklist is provided in this RFP as Attachment E.

10.2.3.2 GENERAL REQUIREMENTS CROSS-REFERENCE

DHS requests that bidders develop a General Requirements Cross-reference (related to RFP Section 6) for each Technical Proposal under consideration, based upon the sample provided by Attachment D. In Column A, bidders will list requirements by reference number (e.g., 1.1.1.1.1 #1) in a manner that identifies the Section number from the RFP as well as the Requirement number from that RFP section. In Column B, bidders will list the location within the Technical Proposal where the bidder's response to this requirement can be found (e.g., Section 9, Page 56). Section 10.2.6 below further explains how General Requirements will be addressed within the text of the Technical Proposal.

10.2.3.3 GENERAL SYSTEM REQUIREMENTS CROSS-REFERENCE

DHS requests that bidders develop a General System Requirements Cross-reference (related to RFP Section 7.1) for each Technical Proposal under consideration, based upon the sample provided by Attachment D. In Column A, bidders will list requirements by reference number (e.g., 1.1.1.1.1 #1) in a manner that identifies the Section number from the RFP as well as the Requirement number from that RFP section. In Column B, bidders will list the location within the Technical Proposal where the bidder's response to this requirement can be found (e.g., Section 9, Page 56). Section 10.2.6 below further explains how System / Business Requirements will be addressed within the text of the Technical Proposal.

10.2.3.4 SYSTEM / BUSINESS REQUIREMENTS CROSS-REFERENCE

DHS requests that bidders develop a System / Business Requirements Cross-reference for each Technical Proposal under consideration, based upon the sample provided by Attachment D. In Column A, bidders will list requirements by reference number (e.g., 1.1.1.1.1 #1) in a manner that identifies the Section number from the RFP as well as the Requirement number from that RFP section. In Column B, bidders will list the location within the Technical Proposal where the bidder's response to this requirement can be found (e.g., Section 9, Page 56). Section 10.2.8 below further explains how System / Business Requirements will be addressed within the text of the Technical Proposal.

10.2.4 EXECUTIVE SUMMARY, INTRODUCTION, AND PROJECT UNDERSTANDING (TAB 4)

The bidder must submit an Executive Summary, Introduction, and Project Understanding write-up that provides the Evaluation Committees and State Management with a collective understanding of the contents of the entire Bid Proposal. The Executive Summary, Introduction, and Project Understanding should briefly summarize the strengths of the bidder and the key features of its proposed approach to meet the requirements of the RFP component (i.e., MMIS, POS, or DSS/DW) toward which the individual Bid Proposal is targeted. This section must also include a summary of the bidder's Project Management Plans for all phases of the resulting contract.

Due to the potential for multiple contractors as a result of this procurement, DHS requests that bidders provide a written description of their understanding of the North Dakota Medicaid Systems Replacement Project. In addition, it is expected that bidders will identify the risks inherent in the overall North Dakota Medicaid Systems implementation and identify the strategies that the bidder will use to mitigate each risk.

10.2.5   SERVICES OVERVIEW (TAB 5)

In the Services Overview section, DHS expects bidders to provide a comprehensive overview of the services that they are proposing to provide to the State. For bidders who have submitted Bid Proposals for multiple RFP components, the Services Overview section also provides an opportunity to discuss how the collective set of services integrate with one another. Bidders may also reference other "added value" services that are relevant to the Scope of Services for the submitted Bid Proposal(s).

10.2.6   GENERAL REQUIREMENTS (TAB 6)

In the General Requirements section, bidders will explain their approach to all General Requirements and General System Requirements identified in Sections 6 and 7.1. As much as possible, bidder responses to General Requirements must be presented in an order matching the order in which they appear in this RFP.

For the General Requirements section of the Technical Proposal, DHS expects bidders to list the requirement numbers for addressed requirements above the paragraph or set of paragraphs that addresses them.

*Bidder's Note: The RFP presents requirements for Key Personnel in the General Requirements. In Bid Proposals, however, the bidder's response to Key Personnel and project staffing requirements must be addressed in the Project Management Planning response (Tab 9).

10.2.7   START-UP ACTIVITIES (TAB 7)

In the Start-up Activities Section, bidders will explain their approach to the project Start-up requirements listed in Section 8. Bidders will describe their approach to the specific Start-up Activities and deliverables within the Management, System Supply, System Development, and System Operations Processes.

10.2.8   SYSTEM / BUSINESS REQUIREMENTS (TAB 8)

The bidder must address each contract function (e.g., the Drug Rebate function of the POS contract) identified by the RFP component under consideration (from Sections 7.2, 7.3, and 7.4 of the RFP). Bidders will also explain in detail how they plan to approach each contractor responsibility / operational requirement for the contract function. This section must provide a comprehensive integrated narrative that describes how the Contractor will meet the

requirements (i.e., provide a description of the bidder's process(es), control procedures, and quality assurance procedures for performing each function). In addition, the bidder may provide process flow diagrams to supplement the narrative.

*Bidder's Note: For the System / Business Requirements sections of the Technical Proposal, DHS expects bidders to list the requirement numbers for addressed requirements above the paragraph or set of paragraphs that addresses them.

DHS expects that bidders will format the System / Business Requirements section of the Technical Proposal in a manner similar to the following outline:

SECTION OUTLINE NUMBERING	CONTENTS
8	RFP Component System Requirements Introduction
8.1	Name of Business Area 1 (e.g., Provider Services)
8.2	Name of Business Area 2 (e.g., Recipient Services)
8.2.1	Name of Function 1 in Business Area 2 (e.g., Eligibility)
8.2.2	Name of Function 2 in Business Area 2 (e.g., Third Party Liability)
8.2.x	Etc.
8.3	Name of Business Area 3
8.4	Name of Business Area 4
8.5	Name of Business Area 5
8.6	Name of Business Area 6
8.7 - 8.X	Name of Business Area 7, etc.

Bidders are free to enumerate subsections below each contract function as they see fit. Bidders are also given wide latitude in the degree of detail they offer or the extent to which they reveal plans, designs, examples, processes, and procedures. Bid Proposals must be fully responsive to the service requirements. Merely repeating the requirement statement will be considered non-responsive and disqualify the bidder. Bid Proposals must identify any deviations from the requirements of this RFP or requirements that the bidder cannot satisfy.

*Bidder's Note: The requirements provided by this RFP present specifications for DHS's desired systems solutions for MMIS, POS, and DSS/DW. Bidders are expected to price the solution, as requested. In the event that a bidder has a more efficient and/or effective alternative solution to any elemental requirement described in this RFP, the bidder must provide appropriate text in the Technical Proposal to describe alternative solutions AND provide appropriate text in the Cost Proposal describing potential savings.

10.2.9 PROJECT MANAGEMENT PLANNING (TAB 9)

The Project Management Planning section is broken down into two subsections: 1.) Project Staffing and 2.) Draft Work Plans for Contract Phases. These subsections will contain the information described below.

10.2.9.1 PROJECT STAFFING

10.2.9.1.1   Resumes

The bidder must provide resumes for all identified Key Personnel, including the bidder's Project Manager, who will be involved in providing the services contemplated by this RFP. Resumes must also be included for any Key Personnel that have been designated from subcontractor staff. The following information must be included in the resumes:

- Full name
- Position within Key Personnel designations
- Education and Relevant Licensure / Certifications
- Years of experience and employment history (particularly as it relates to the scope of services specified for the RFP components in Section 6)
- Minimum of three (3) professional references from outside the staff member's company

All staff identified as "Key Personnel" must be employees of the bidder or subcontractor, or must have provided a letter of commitment to join the bidder or subcontractor's organization, at the time of Bid Proposal submittal.

10.2.9.1.2   Organization and Staffing Charts

The Project Organization and Staffing section must include, for each phase of the project, the organization charts of proposed personnel. Proposals will specify the number of full-time equivalent workers (FTEs) who will be working on each project phase and describe the proposed Contractor organizational structure. Contractor organization charts will have staff positions considered as effective during the entire duration of the project (unless otherwise approved by DHS) and will include:

a.) All proposed individuals for whom resumes are included, identifying their major areas of responsibility during each phase and the percent of their time to be dedicated to the North Dakota Medicaid Systems Replacement Project. All subcontractor personnel must be clearly indicated.

b.) The Project Organization and Staffing section will include charts for the installation and operations phases. Separate charts must be included for each task of the installation phase (planning, transfer and modification, system testing, implementation, etc.). These charts must include the number of qualified personnel, by FTE, for each organizational unit.

A narrative explanation of the various charts and of the responsibilities of Key Personnel must be included. Job descriptions for the staff positions identified on the organization charts must also be included. Bidders must also include on-site / off-site estimates for all staff proposed.

10.2.9.1.3   Subcontractors

The bidder shall disclose the planned use of corporate subcontractors (i.e., another company) or individual subcontractors (i.e., a contracted staff member) to perform the services described in this RFP. This includes:

- The name and address of each subcontractor,
- The subcontractor's qualifications,
- The work the subcontractor will be performing, and
- The estimated dollar amount of each subcontract.

The prime contractor for each contract must perform at least 60% of the work awarded as a result of this RFP. "Special Services" project staff members are excluded from subcontractor percentage calculations. This type of staff includes physicians, attorneys, and similar Professional staff that are hired on a retainer or "as needed" basis.

10.2.9.2   DRAFT PROJECT WORK PLAN(S) FOR CONTRACT PHASES

DHS requires that all bidders produce a Draft Project Work Plan for DDI Phase activities. For the DSS/DW Contractor, a separate Draft Project Work Plan must also be prepared for the Operations Phase. In addition to task lists and corresponding start and end dates, the Draft Project Work Plans for each Contract Phase will include supplemental information identifying Key Personnel resource allocations within contract phases.

As a supplement to the Draft Project Work Plan, bidders must also include detail on which work plan tasks will be conducted on-site and/or off-site. Section 6.3.1 designates the contract functions that must be performed at the local Bismarck facility.

10.2.10 CORPORATE ORGANIZATION, EXPERIENCE, & QUALIFICATIONS (TAB 10)

The bidder must provide a corporate organization chart of the firm that is submitting the proposal. If the firm is a subsidiary of a parent company, the organization chart must be that of the subsidiary firm. The chart must display the firm's structure and the organizational placement of the oversight for the North Dakota Medicaid Systems Replacement Project. The bidder must identify the name of the person who will be responsible for signing the contract and indicate the signing person's relationship with the firm. In this section, bidders must also:

- Disclose the legal structure of your organization and the state in which the organization is registered

- Provide evidence of a North Dakota business license and any necessary applicable professional license required by law

- Describe the history of the organization

- Provide a table of the structure of the organization, including the names and credentials of the owners and executives

- Describe the executive, management and technical staff assigned to this project. Include the number of staff, their roles on this project, their expertise and experience in providing the services described in the RFP, and their tenure with the organization

- Identify any established partnership relationships with the community

- Identify other projects in which the bidder is currently providing or has provided services similar to the services described in this RFP. Identify if the prior projects were completed on time and within budget

- Describe all other contracts or projects currently undertaken by the bidder; include relevant resource loading information (e.g., number of FTE and percentage of company's current non-administrative FTE devoted to the project)

- Describe all other related contracts for which the bidder has submitted a bid proposal but contract award has not been announced. In this description, the bidder must include the scheduled award date and contract start/end dates.

10.2.10.1 CONTRACTOR EXPERIENCE LEVELS

Bidders will provide discussion on all relevant Corporate Experience, including all Medicaid contracts, within the last five (5) years. As appropriate, bidders must also list prime contractors or subcontractors to the bidder. Bidders will include all projects that demonstrate, at a minimum:

1.) Relevant governmental experience with MMIS, medical claims systems, pharmacy Point-of-Sale systems, Data Warehouses, or Decision Support Systems (indicate clearly which projects demonstrate experience with takeover, operation, enhancement, and/or turnover)

2.) Relevant non-governmental experience with medical claims systems, pharmacy Point-of-Sale systems, Data Warehouses, or Decision Support Systems (indicate clearly which projects demonstrate experience with takeover, operation, enhancement, and/or turnover)

3.) Experience with the system (MMIS, POS, or DSS/DW) that is being proposed by the vendor. Specifically, the vendors must include representative projects that clearly illustrate their design, development, and implementation experience with the system that is being proposed as part of their solution

4.) Other experience with large-scale, data processing system takeover and operation (other than those covered above)

5.) Other experience with governmental healthcare programs

For the projects referenced above, the bidder must provide Project Summaries that contain all information specified in Section 6.1.3. Project Summary tables are **limited to one (1) project per page**.

10.2.10.2 CORPORATE LETTERS OF REFERENCE

The bidder must provide Corporate Letters of Reference from three (3) previous clients knowledgeable of the bidder's performance in providing services similar to the services described in this RFP and a contact person and telephone number for each reference. If subcontractors are used, three (3) Corporate Letters of Reference for the subcontractor(s) must also be included.

10.2.10.3 DISCLOSURE OF FELONY CONVICTIONS

The bidder must state whether it or any owners, officers, or primary partners have ever been convicted of a felony. Failure to disclose such matters may result in rejection of the Bid Proposal or in termination of any subsequent contract. This is a continuing disclosure requirement. Any such matter commencing after submission of a Bid Proposal, and with respect to the successful bidder after the execution of a contract, must be disclosed in a timely manner in a written statement to the Department.

10.2.11 CERTIFICATIONS AND GUARANTEES BY THE BIDDER (TAB 11)

10.2.11.1 AUTHORIZATION TO RELEASE INFORMATION

The bidder must sign and submit with the Bid Proposal a document in which the bidder authorizes the release of information to the Department.

10.2.11.2 CERTIFICATION OF INDEPENDENCE AND NO CONFLICT OF INTEREST

The bidder must sign and submit with the Bid Proposal a document in which the bidder must certify that the Bid Proposal was developed independently. The bidder must also certify that no relationship exists or will exist during the contract period between the bidder and the Department that interferes with fair competition or is a conflict of interest. The Department reserves the right to reject a Bid Proposal or cancel the award if, in its sole discretion, any relationship exists that could interfere with fair competition or conflict with the interests of the Department.

10.2.11.3 CERTIFICATION OF AVAILABLE RESOURCES

The bidder must sign and submit with the Bid Proposal a document in which the bidder must certify that the bidder organization has sufficient personnel resources available to provide the services for all Bid Proposals submitted.

10.2.11.4 ACCEPTANCE OF TERMS AND CONDITIONS

The bidder must specifically stipulate that the submitted Bid Proposal acknowledges the acceptance of all terms and conditions stated in the RFP. If the bidder objects to any term or condition, a specific reference to the RFP page and section must be made. Objections or responses that materially alter the RFP shall be deemed non-responsive and disqualify the bidder.

10.2.11.5 FIRM BID PROPOSAL TERMS

The bidder must guarantee in writing the availability of the services offered and that all Bid Proposal terms, including the price that is specified by the Cost Proposal, will remain firm for at least **120 CALENDAR DAYS** after the deadline specified for submission of proposals. Guarantees of Firm Bid Proposal Terms must not make reference to any dollar amounts contained in the Cost Proposal.

10.3   COST PROPOSAL CONTENTS

The Cost Proposal must include the following:

- Table of Contents
- Pricing Schedules
- Company Financials Content

10.3.1   TABLE OF CONTENTS (TAB 1)

A Table of Contents of the Cost Proposal must be inserted at Tab 1. The Table of Contents will identify all Sections (identified herein by Tabs), Subsection contained therein, and corresponding page numbers. The Table of Contents must include all Sections and Subsections present under Tabs 1 through 4. The Table of Contents found at the beginning of this RFP provides a representative example of what is expected for the Cost Proposal Table of Contents.

10.3.2   PRICING SCHEDULES (TAB 2)

See Pricing Schedules provided in Attachment G for specific format and content instructions.

*Bidder's Note: The requirements provided by this RFP present specifications for DHS's desired systems solutions for MMIS, POS, and DSS/DW. Bidders are expected to price the solution, as requested. In the event that a bidder has a more efficient and/or effective alternative solution to any elemental requirement described in this RFP, the bidder must provide appropriate text in the Technical Proposal to describe alternative solutions AND provide appropriate text in the Cost Proposal describing potential savings.

10.3.3 COMPANY FINANCIALS CONTENT (TAB 3)

The bidder must submit the following documents to be used in the evaluation of financial viability:

- Audited or reviewed financial statements (annual reports) for the last three (3) years

- A minimum of three (3) financial references (e.g., letters from creditors, letters from banking institutions, Dunn & Bradstreet supplier reports)

- A description of other contracts or projects currently undertaken by the bidder, including relevant resource loading information (e.g., number of FTE and percentage of company's current non-administrative FTE devoted to the project)

- A summary of any pending or threatened litigation, administrative or regulatory proceedings or similar matters that could affect the ability of the bidder to perform the required services

- A disclosure of any contracts during the preceding three (3) year period, in which the bidder or any subcontractor identified in the Bid Proposal has defaulted. List all such contracts and provide a brief description of the incident, the name of the contract, a contact person and telephone number for the other party to the contract

- A disclosure of any contracts during the preceding three (3) year period, in which the bidder or any subcontractor identified in the Bid Proposal has terminated a contract prior to its stated term or has defaulted and/or had a contract terminated by the other party prior to its stated term. List all such contracts and provide a brief description of the incident, the name of the contract, a contact person and telephone number for the other party to the contract

This information will be used on a pass/fail basis as part of a screening for financial viability, as described further in Section 11.5.2.

10.3.4 PERFORMANCE BOND COMMITMENT (TAB 4)

Bidders must obtain a letter of commitment for a performance bond from a bonding company and submit it in Tab 4 of the Cost Proposal. The amount of the performance bond must be equal to ten percent (10%) of the total dollar value of the bidder's Cost Proposal for the full term of the contract.

The actual performance bond must be obtained from a bonding company acceptable to the State and must be provided to the State within **ten (10) calendar days** after the date of the Notice of Intent to Award. A bidder's failure to provide the performance bond within the required time will cause the State to reject the proposal.

11.0 EVALUATION OF BID PROPOSALS

11.1 INTRODUCTION TO EVALUATION PROCESS

This section describes the evaluation process that will be used to determine which Bid Proposal provides the greatest benefits to DHS. The evaluation process is designed to award the contract not necessarily to the bidder of least cost, but rather to the bidder with the best combination of attributes to perform the required services.

The evaluation process will ensure the selection of the best overall solution for the North Dakota Medicaid program. The evaluation process will include the following components:

- Establish Evaluation Committee
- Evaluate Bid Proposal Mandatory Requirements from Checklist
- Evaluate and Score Technical Proposals
- Evaluate and Score Cost Proposals, including Screening for Company Financial Viability
- Proposal Ranking and Evaluation Committee Recommendation
- DHS Contract Award Decision by the Executive Steering Committee

The information that follows describes the components of, the activities conducted in, and the resultant product of the evaluation process.

11.2 EVALUATION COMMITTEES

The Department intends to conduct a comprehensive, fair, and impartial evaluation of all Bid Proposals received in response to the three (3) Systems Component awards designated by this RFP. In making its award determinations, the Department will be represented by a set of Evaluation Committees. Subject Matter Experts from State staff have been assigned to the individual RFP System Components (i.e., MMIS, POS, and DSS/DW), as identified by the requirements in Section 7.

11.3 MANDATORY REQUIREMENTS FOR PROPOSALS

As part of its initial screening, all Bid Proposals submitted in response to this RFP will be assessed by DHS to assure that the mandatory submittal requirements for proposals have been satisfied. Any one mandatory requirement that is not met may cause a Bid Proposal to be declared non-responsive. Non-responsive proposals will be returned to the bidder. As mentioned in Section 7, the Bid Proposal Mandatory Requirements Checklist is detailed in Attachment E to this RFP.

11.4 SCORING OF BIDDER TECHNICAL PROPOSALS

11.4.1 INDEPENDENT EVALUATION OF TECHNICAL PROPOSALS

The individual Evaluation Committee members of the appropriate Evaluation Committee will independently evaluate each Bid Proposal that passes the mandatory submittal criteria. Committee members will score each Bid Proposal using criteria established by DHS and according to the factors that are outlined below. The Committee will meet at the completion of their independent evaluation process to address any technical questions raised by their respective reviews and discuss the relative merits of each bidder's Bid Proposal. At the conclusion of this discussion, the Committee members may independently re-evaluate and re-score any section of any Bid Proposal. After the first round of scoring, Oral Presentations will be held with a DHS-designated set of qualified finalists. Following Oral Presentations, the Evaluation Committee may independently re-evaluate and re-score any section of any Bid Proposal. After the final re-score, the Committee will convene to average the bidder's scores (from all independent Evaluation Committee members) for each section of the bidder's Technical Proposal in order to facilitate a composite and final Technical Proposal score for each bidder.

11.4.2 EVALUATION CRITERIA AND ASSIGNED POINT TOTALS

The evaluation of each Technical Proposal will have seven (7) major criteria. The maximum score for Technical Proposals varies by RFP Component. The total scoring for the Technical Proposal portion of each RFP Component is divided as follows:

Table 21: Assigned Point Totals for Evaluation Criteria for each System Procurement

	MMIS	POS	DSS / DW
Executive Summary, Introduction, and Project Understanding	50	25	25
Services Overview	50	25	25
General Requirements	100	50	50
Start-up Activities	100	50	50
Operational Requirements	600	300	300
Management Plan	150	75	175
Corporate Experience / Qualifications	150	75	75
Tech Proposal Total	1200	600	700
Cost Proposal Total	400	200	300
GRAND TOTAL	1600	800	1000

11.4.3   DESCRIPTION OF EVALUATION CRITERIA

The following paragraphs provide a general description of the factors covered by the detailed evaluation criteria.

11.4.3.1   EXECUTIVE SUMMARY, INTRODUCTION, AND PROJECT UNDERSTANDING

For this section, the Committee will review the proposal's executive summary, introduction, project understanding, overall quality of the proposal (including appendices), and the general qualifications of the bidder. It will also include a review of subcontracting arrangements and how these may affect the overall contract. Requirements to be evaluated under this heading are outlined in Section 10 of this RFP.

The Committee will also evaluate the bidder's understanding of the future North Dakota Medicaid program and the systems that support it, including both Contractor direct responsibilities and responsibilities of DHS and any other agencies that are involved in

administration of the North Dakota medical assistance programs. The RFP requirements to be evaluated are outlined in Section 10.

11.4.3.2   SERVICES OVERVIEW

For this section, the Committee will evaluate the proposed services and solutions to meet the business needs and technical needs of DHS. For the MMIS Contractor, this section will also be evaluated for quality in the bidder's overview of the necessary steps to implement and certify the replacement MMIS on-time. This material will be evaluated for coherence and understanding and reasonableness of approach.

11.4.3.3   GENERAL REQUIREMENTS

For the General Requirements section, the Committee will evaluate how well the bidder explains their approach to all General Requirements identified in either Section 6 or Section 7.1 (General System Requirements).

11.4.3.4   START-UP ACTIVITIES

For the Start-up Activities section, the Committee will evaluate the bidder's explanation of their approach to the general project Start-up Activities and deliverables requirements listed in Section 8.

11.4.3.5   SYSTEM / BUSINESS REQUIREMENTS

The Committee will assess the bidder's approach to meeting all the functional, operational, and technological requirements of the RFP. For systems solutions, DHS requires that the proposed replacement system is currently operational or is in the development stages for an existing client. DHS may accept a modular solution for non-MMIS solutions if it provides better flexibility, integrity, and congruity of processes. The bidder's response will be evaluated based upon the functional description of the bidder's solution and how the system meets or exceeds the requirements listed in this RFP.

11.4.3.6   PROJECT MANAGEMENT PLANNING

The approach to project management and problem resolution are critical success factors in the management of a large Medicaid operation. The Committee will assess the bidder's approach to project management, and the tools and structure that will control the project. They will evaluate the bidder's work plan and approach to the DDI Phase and, in the case of the DSS/DW contract, the bidder's work plan for the Operations Phase. The bidder's organization of the project teams during these phases and the planned North Dakota facility will also be appraised in this Section. The entire approach to developing work plans, continued tracking and monitoring, and the approach to adherence to the approved work plans will be important items for the Committee.

The bidder's approach and commitment to quality control in all phases of the contract will also be evaluated. The contents to be evaluated are shown in Section 10 of this RFP.

The Committee will review resumes of all Key Personnel proposed by the bidder and may verify references. Reference checking may not be limited to those references supplied by the bidder. Evaluation of Key Personnel presenting at Oral Presentations will also be incorporated into this section's evaluation. Section 6 outlines the requirements for Key Personnel.

11.4.3.7 CORPORATE ORGANIZATION, EXPERIENCE, AND QUALIFICATIONS

The bidder's (and subcontractor's) corporate background, corporate organization, and relevant corporate experience are significant factors in the evaluation process. As part of the Cost Proposal evaluation, a separate Committee will review the bidder's financial stability to ensure that the State of North Dakota will be fully covered against any financial difficulties that the company may experience during any period of the contract. The experience and reputation of the bidder in managing large projects of this nature and how the bidder interacts with its clients for status reporting and other contract issues is important. Experience in Medicaid, large healthcare delivery systems, managed care operations, and recent technological advancements in the arena of healthcare systems will carry significant weight in the evaluation of submitted Bid Proposals.

11.5 SCORING OF BIDDER COST PROPOSALS

A separate committee will review and score the Cost Proposals from all bidders meeting the mandatory requirements. This committee will note any cost limitations imposed by the bidders that could prevent the State from achieving the objectives of the procurement and report these limitations to the Procurement Officer for a decision on rejection of the proposal.

11.5.1 ASSIGNMENT OF POINTS

The maximum score for the Cost Proposal varies by RFP Component. Maximum point totals for each system component's Cost Proposal have been identified above in Section 11.4.2.

11.5.1.1 POINT ALLOCATION FOR MMIS AND POS COST PROPOSALS

For the MMIS and POS components, Cost Proposal points are allocated across two Cost Proposal sub-factors that are identified by the submitted Pricing Schedules. The proposed Total Implementation Cost will account for eighty-five percent (85%) of the available Cost Proposal points. The hourly rate offered by the bidder for Change Service Requests (CSRs) will account for the remaining fifteen percent (15%). Therefore, the breakdown of Cost Proposal points for these two contracts is:

Table 22: Breakdown of MMIS and POS Cost Proposal Points

	MMIS	**POS**
Implementation Cost	340	170
CSR Rate	60	30

11.5.1.2   POINT ALLOCATION FOR DSS/DW COST PROPOSAL

Cost Proposal points for the DSS/DW component are allocated across three Cost Proposal sub-factors that are identified by the submitted Pricing Schedules, as follows:

- The proposed Total Implementation Cost will account for twenty percent (20%) of the available Cost Proposal points,

- The NPV in U.S. Dollars for proposed Operations Costs over both the base and option years of the contract will account for seventy percent (70%) of the available Cost Proposal points, and

- The hourly rate offered by the bidder for Change Service Requests (CSRs) will account for ten percent (10%) of the available Cost Proposal points. Therefore, the breakdown of Cost Proposal points for the DSS/DW contract is:

Table 23: Breakdown of DSS/DW Cost Proposal Points

	DSS/DW
Implementation Cost	60
NPV of Operations Cost	210
CSR Rate	30

11.5.1.3   CALCULATION OF SCORES

The lowest price received by any bidder for each of the Cost Proposal sub-factors will receive the maximum points designated for that portion of the Cost Proposal points for that contract. Therefore, using the MMIS example provided above, the lowest Total Implementation Cost for the MMIS contract will receive the full 60 points for that sub-factor. The lowest hourly rate for the CSR Rate will receive the full 30 points for that sub-factor.

The lowest NPV of Operations Cost will receive the full 210 points for that sub-factor. The Cost Proposal Evaluation Committee will use the proposed total Operations Phase costs for each year, divided by 12 months, as the base of a calculation for a monthly Net Present Value (NPV) of the Operational Phase costs over the two (2) year base contract for DSS/DW services. Monthly NPVs for each Fiscal Year will be added together to produce a total NPV for the bidder's proposed Operations Phase costs. It is the total NPV of Operations Phase costs that will be evaluated as seventy percent (70%) of the available Cost Proposal points.

In order to calculate every other bidder's score (other than the bidder who received maximum points) for each Cost Proposal sub-factor, the other bidders' cost (or NPV cost) will be divided into the corresponding value of the lowest bidder and then multiplied by the maximum points designated for that sub-factor. The formula for each sub-factor is expressed as follows:

> Bidder's Score = (Lowest Cost / Bidder Cost) x Maximum Points

In order to calculate the total Cost Proposal score, the Cost Proposal Evaluation Committee will add the Implementation Cost subtotal, the Operations Cost score subtotal, and the CSR Rate Cost score subtotal.

11.5.2 SCREENING FOR FINANCIAL VIABILITY

After the Oral Presentations and the Bidder's Technical and Cost Proposal scores are combined, the Bid Proposal that receives the most points for each component will be reviewed for the bidder's financial stability and viability to sustain its operations and to assume the North Dakota contract(s). This will include a review of the financial information requested in Section 10.3.3. The Bidder's financials will be evaluated on a pass/fail basis.

11.6 TECHNICAL AND COST PROPOSALS COMBINED

Technical and Cost Proposal scores will be combined to establish a final score for each bidder. Proposals will be ranked according to total score in order to facilitate a recommendation from the Evaluation Committee. As evidenced by the point totals designated above, not all RFP system components have the same point ratio between Technical and Cost Proposals.

11.7 ORAL PRESENTATIONS AND BEST AND FINAL OFFERS

The State is likely to request Oral Presentations and a subsequent "Best and Final Offer" from those bidders that have demonstrated to the Evaluation Committee their ability to satisfy the requirements of the RFP. The Evaluation Committee, through the Procurement Officer, will notify each bidder of their selection as a finalist and arrange for an Oral Presentation of their respective systems or services. Oral Presentations will take place at a State office location to be determined and bidders are expected to have all designated "Key Personnel" on hand. The order, schedule, and agenda for the presentations are at the sole discretion of the Department. The presentation may include slides, graphics, and other media selected by the bidder to

illustrate the Bid Proposal. The presentation must not materially change the information contained in the Bid Proposal.

Upon completion of Oral Presentations, individual Evaluation Committee members may re-score bidder's Technical Proposal score based on any clarifications received during that bidder's Oral Presentation.

At the end of each Oral Presentation, bidders will receive any debriefing instructions regarding the Best and Final Offer (BAFO) process. Bidders will be given five (5) business days after their Oral Presentation to develop and submit their BAFO. BAFOs must be submitted via delivery service (e.g., UPS, FedEx, U.S. Postal Service Priority Mail) by **3:00 p.m. Central Time**, on the day specified by Table 1 in Section 2.4. The BAFO must be in writing, accompanied by a transmittal letter binding the bidder to the financial terms described therein. BAFOs are to be sent to the Procurement Officer of this RFP at the same address identified in Section 2.

11.8 RECOMMENDATION FROM THE EVALUATION COMMITTEE TO THE EXECUTIVE STEERING COMMITTEE

Following the Cost Proposal Evaluation process, the Evaluation Committee will forward their results to the Executive Steering Committee for a final decision and contract(s) award, if appropriate. The Executive Steering Committee's decision is final. DHS reserves the right to take any additional steps deemed necessary in determining the final awards, which may include negotiations with the selected bidder(s).

11.9 NOTICE OF INTENT TO AWARD

A Notice of Intent to Award acknowledging the apparent successful bidder for each contract will be sent by mail to all bidders who have submitted a timely Bid Proposal. The Notice of Intent to Award is subject to execution of a written contract and Federal approval. As a result, the notice does not constitute the formation of a contract between the Department and the apparent successful bidder.

11.10 ACCEPTANCE PERIOD

Negotiation and execution of the contract(s) shall be completed no later than **December 27, 2005**. If the apparent successful bidder fails to negotiate and execute a contract, the Department (in its sole discretion) may revoke the award and award the contract to the next highest ranked bidder or withdraw the RFP.

The Department further reserves the right to cancel the award at any time prior to execution of a written contract or receiving Federal approval.

11.11 FEDERAL APPROVALS

The contract award is subject to Federal approval. DHS will make every effort to obtain and expedite Federal approval. DHS reserves the right to not award a contract if Federal approval is not obtained or does not receive enhanced FFP.

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12.0 ATTACHMENTS

This Section of the RFP presents all supplements that have been referenced as attached material by the main body of the RFP. This includes both clarifying documentation for the RFP and State requested forms for a responsive Bid Proposal.

Attachments included in this Section are:

- *Attachment A:* Glossary of Terms and Acronyms
- *Attachment B:* Sample Purchase of Service Agreement
- *Attachment C:* Contract Bond Form
- *Attachment D:* Sample Requirements Cross-reference
- *Attachment E:* Mandatory Bid Proposal Requirements Checklist
- *Attachment F:* DDI Deliverable Responsibilities
- *Attachment G:* Pricing Schedules
- *Attachment H:* Program Interfaces Description
- *Attachment I:* Current Hardware List
- *Attachment J:* Program Statistics
- *Attachment K:* Recipient Eligibility in MMIS
- *Attachment L:* MITA Business Process Model Crosswalk

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12.1   ATTACHMENT A: GLOSSARY OF TERMS AND ACRONYMS

ACRONYM OR TERM	DEFINITION
ACID	Atomicity, Consistency, Isolation, and Durability
ADA	American Dental Association (as in ADA claims)
ADAP	AIDS Drug Assistance Program
AMA	American Medical Association
ANSI	American National Standards Institute
APC	Ambulatory Payment Classification
APG	Ambulatory Patient Groups
API	Application Programming Interface
ASA	American Society of Anesthesiologists
ASC	Ambulatory Surgical Center
ASP	Average Sales Price
ASSIST	Assessment Case Management System
ATM	Asynchronous Transfer Mode
AVR or AVRS	Automated Voice Response System
AWP	Average Wholesale Price. Part of a calculation for one of the State's four pharmacy reimbursement methods.
BAFO	Best and Final Offer
Basic Care	Residential coverage for aged, blind, and disabled SSI recipients in North Dakota
BCCP	Business Continuity and Contingency Plan
BCBSND	Blue Cross Blue Shield of North Dakota
BENDEX	Beneficiary & Earnings Data Exchange System
BLOBS	Binary Large Objects
Buy-In	See Medicare Buy-In
CCI	Correct Coding Initiative
CD	Compact Disc
CD ROM	Compact Disc Read-Only Memory
CDT	Current Dental Terminology
CFR	Code of Federal Regulations
CFS	Children and Family Services
CHAMPUS	Civilian Health and Medical Programs of the Uniformed Services (Now TRI-CARE)
Checkwrite	Weekly payment cycle conducted by the Department
CICS	Customer Information Control System
CLIA	Clinical Laboratory Improvement Amendments
CLOBS	Character Large Objects
CMS	Centers for Medicare and Medicaid Services (formerly HCFA)
CMS-1500	Centers for Medicare and Medicaid Services, Form 1500. The CMS-1500 is the basic form prescribed by CMS for claims from physicians and suppliers, except for ambulance services.
CMS 64 Report	The CMS 64 Report provides the State's Medicaid Financial Statistics Tables to the Federal Government.
CMSO	Center for Medicaid and State Operations

ACRONYM OR TERM	DEFINITION
CNRA	Council on Naturopathic Registration and Accreditation
COB	Coordination of Benefits
COLD	Computer Output to Laser Disc
COLT	Computer Output Laser Technology
CON	Certificate of Need
Contract Officer	The individual assigned by DHS to provide: 1.) Final approval on Contractor deliverables 2.) Signing authority to enter into contract with the Contractor 3.) Signing authority to modify the contract with the Contractor 4.) Signoff on substitution of subcontractors 5.) Signoff on substitution of Key Personnel
COTS	Commercial Off-the-Shelf
CPT-4	Current Procedural Terminology, Version 4
Crossover Claims	Claims for recipients with both Medicare and Medicaid coverage.
CSHS	Children's Special Health Services - specialty care in North Dakota for children to treat an eligible diagnosed condition
CSP	Coordinated Services Program - A special program administered by DHS for Medicaid recipients who have "over-utilized" Medicaid services. These individuals are assigned to a select group of "Lock-In" providers to control claims.
CSR	Change Service Request
CSV	Comma Separated Value
CY	Calendar Year
DD	Developmentally Disabled or Developmental Disability
DDE	Direct Data Entry
DDI Phase	Design, Development, and Implementation Phase of Contract
DDS	Disability Determination Services
DEA	Drug Enforcement Agency
DED	Data Element Dictionary
DEERS	Defense Enrollment Eligibility Reporting System
DESI	Drug Efficacy Study Implementation
DHS	North Dakota Department of Human Services
DME	Durable Medical Equipment
DMZ	Demilitarized Zone - a computer or small subnetwork that sits between a trusted internal network, such as a corporate private LAN, and an untrusted external network, such as the public Internet
DOB	Date of Birth
DOD	Department of Defense
DOH	North Dakota Department of Health
DoIT	North Dakota DHS Division of Information Technology
DOS	Date of Service
DOS	Disk Operating System
DPI	North Dakota's Department of Public Instruction
DRG	Diagnosis Related Groups
DSD	Detailed System Design
DSH	Disproportionate Share Hospital

ACRONYM OR TERM	DEFINITION
DSM	Diagnostic and Statistical Manual of Mental Disorders
DSS	Decision Support System
DUR	Drug Utilization Review or Drug Use Review. *See also ProDUR and RetroDUR.*
DW	Data Warehouse
EA	Enterprise Architecture
EAI	Enterprise Application Integration
EAC	Estimated Acquisition Cost
ECM	Enterprise Content Management
EDI	Electronic Data Interchange
EDMS	Electronic Document Management Systems
EDS	Electronic Data Systems
EFT	Electronic Funds Transfer
EMC	Electronic Media Claim
EOB	Explanation of Benefit. *See also REOMB.*
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment (*Health Tracks* in North Dakota)
EQRO	External Quality Review Organization
ESB	Enterprise Service Bus
FDA	Food and Drug Administration
FDB	First DataBank
FEIN	Federal Employer Identification Number
FFP	Federal Financial Participation
FFS	Fee For Service
FFY	Federal Fiscal Year
FMAP	Federal Medicaid Assistance Payment
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Centers
FTE	Full-Time Equivalent
FUL	Federal Upper Limits
GCN	Generic Code Number
GIF	Graphics Interchange Format
GIS	Geographic Information Systems
GPI	Generic Product Indicator
GSD	General Systems Design
GTE	GTE (General Telephone and Electric) Data Services, Inc.
GUI	Graphical User Interface
HCBS	Home and Community Based Services waivers. North Dakota has six HCBS waivers, which are for: the Aged and Disabled, Developmentally Disabled, and Traumatic Brain Injury.
HCFA-1500	See CMS-1500.
HCIdea	Health Care Identifier that cross-references all DEA numbers for a provider.
HCPCS	Healthcare Common Procedure Coding System

ACRONYM OR TERM	DEFINITION
HEDIS®	Health Plan Employer Data and Information Set. HEDIS is a set of standardized performance measures designed to ensure that purchasers and members have the information they need to reliably compare the performance of managed health care plans.
HHS	Department of Health and Human Services (Federal)
HID	Health Information Designs – Performs RetroDUR for North Dakota
HIPAA	Health Insurance Portability and Accountability Act of 1996.
HIPP	Health Insurance Premium Payment
HL7	Health Level Seven - Standards developing organizations (SDO) operating in the healthcare arena – standards for clinical and administrative data
HPSA	Health Professional Shortage Area
HRSA	Health Resource Services Administration
HSC	Human Service Center
HTML	Hypertext Markup Language
ICD-9-CM	International Classification of Diseases 9th Edition Clinical Modification
ICF	Intermediate Care Facilities
ICF/MR	Intermediate Care Facility for the Mentally Retarded
ICN	Internal Control Number. The internal control number is used to uniquely identify claims documents.
ID	Identification (number)
IDEA	Individual Disabilities Education Act
IEEE	Institute of Electrical and Electronics Engineers, Inc.
IEP	Individual Education Program
IHS	Indian Health Services
IP	Internet Protocol (as in TCP/IP)
IRS	Internal Revenue Service
ISLA	Individual Supported Living Arrangement
ISP	Individual Service Plan
IT	Information Technology
ITD	North Dakota Information Technology Department
ITF	Integrated Test Facility
IV&V	Independent Verification and Validation
J2EE	Java 2 Platform, Enterprise Edition
JAD	Joint Application Development
JDBC	Java Database Connectivity
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
JPEG	Joint Photographic Experts Group
LAN	Local Area Network
LOS	Length of Stay
LTC	Long Term Care
LTCF	Long Term Care Facility
MAC	Maximum Allowable Cost; e.g., Federal MAC or State MAC
MAR or MARS	Management and Administrative Reporting (MAR) Subsystem

ACRONYM OR TERM	DEFINITION
MCO	Managed Care Organization. North Dakota has one MCO, administered by Noridian Mutual Health Insurance Company.
MD	Doctor of Medicine
MDS	Minimum Data Set
Medically Needy	The Medically Needy program provides medical assistance to individuals who meet the categorical but not the financial criteria for Medicaid eligibility. Medically Needy eligibles may be responsible for a portion of their medical expenses. This is referred to as "recipient liability".
Medicare Buy-In	Premium Payments made by DHS to CMS on behalf of North Dakota Medicaid members that are determined to be Medicare eligible.
Medicare Part A	Medicare hospital insurance that pays for inpatient hospital stays, care in a skilled nursing facility, hospice care and some home healthcare.
Medicare Part B	Medicare medical insurance that helps pay for doctors' services, outpatient hospital care, durable medical equipment, and some medical services that are not covered by Part A.
Medicare Part D	Medicare's prescription drug benefit
MER	Medical Evidence of Record
MITA	Medicaid Information Technology Architecture
MMIS	Medicaid Management Information System
MOM	Message-Oriented Middleware
MPP	Massively Parallel Processing
MR	Mentally Retarded (developmentally disabled)
MSIS	Medicaid Statistical Information System
NABP	National Association of Boards of Pharmacy
NCPDP	National Council for Prescription Drug Programs
NCQA	National Committee for Quality Assurance
NCVHS	National Committee on Vital and Health Statistics
NDC	National Drug Code
NDM	Network Data Mover
Nebo Systems	Provider Enrollment accesses this site for UPIN look-up
NF	Nursing Facility (See also SNF)
NHII	National Health Information Infrastructure
NPI	National Provider Identifier number
NPPES	National Plan and Provider Enumeration System
NPS	National Provider System
NPV	Net Present Value
NSF	National Standard Format
NUBC	National Uniform Billing Committee
NUCC	National Uniform Claims Committee
OB/GYN	Obstetrician/Gynecologist
OCR	Optical Character Recognition
ODBC	Open Database Connectivity

ACRONYM OR TERM	DEFINITION
OIG	Office of the Inspector General - the Federal authority for identifying and investigating instances of fraud and abuse for State Medicaid programs and all Federal programs.
OLTP	On-line Transaction Processing
OMB	Office of Management and Budget
On-line	Accessible via a computer system or computer network
OP	Outpatient
Operations Phase	If applicable, the Operations Phase of the contract refers to the contract phase in which the Contractors awarded contracts by this RFP will assume and maintain live operation of a Medicaid function from a current contractor or the State. In the event that a current contractor is awarded a contract whose function they are already providing, the Operations Phase then refers to the point where newly implemented enhancements, services, or features begin operation.
OSCAR	On-line Survey Certification and Reporting
P&T	Pharmacy and Therapeutics
PA	Prior Authorization
Pay and Chase	Pay and Chase is the term used by North Dakota Medicaid to identify the portion of funds paid to a provider for member services that are recoverable from liable third parties.
PC	Personal Computer
PC-ACE	The software that Noridian Mutual Insurance Company (Noridian) supplies to their providers to submit claims. It is a PC-based software system that creates and transmits 837 Professional and Institutional claims transactions to Noridian. Noridian validates the transaction, and if there are no HIPAA validation errors, transmits the file to the MMIS.
PCCM	Primary Care Case Management
PCP	Primary Care Provider
PDF	Portable Document Format
PDL	Preferred Drug List
PDMP	Prescription Drug Monitoring Program
PHI	Protected Health Information
POS	Point-of-Sale
PPS	Prospective Payment System
PQAS	Prior Quarter Adjustment Summaries (Drug Rebate)
PRO	Peer Review Organization
Procurement Officer	The individual assigned by DHS to manage the procurement of this contract.
ProDUR	Prospective Drug Utilization Review
Project Directors	The individuals assigned by DHS to manage this project after contract award.
Project Manager	The individuals assigned by the Contractor and the State to manage their respective activities for this project after contract award.
PSA	Prostate Specific Antigen

ACRONYM OR TERM	DEFINITION
QA/UR	Quality Assurance/Utilization Review
QMB	Qualified Medicare Beneficiary
QSP	Qualified Service Provider
RA	Remittance Advice
RBRVS	Resource-Based Relative Value Scale
RDBMS	Relational Database Management System
RL	Recipient Liability; Relevant for medically needy individuals who have a specific amount of income that must be spent down in order to qualify. This becomes the recipient's share of cost.
REOMB	Recipient Explanation Of Medical Benefit. See also EOB.
RetroDUR	Retrospective Drug Utilization Review
RFP	Request for Proposal
RHC	Rural Health Clinic
ROAP	Regional Office Automation Program
ROSI	Reconciliation of State Invoice
RPC	Remote Procedure Call
RR	Recipient Responsibility – the Recipient's share of cost in the Basic Care program
RSD	Requirements Specifications Document
RUG	Resource Utilization Group
RVS	Relative Value Scale (or Schedule)
RVU	Relative Value Unit
Rx	Medical Prescription
SAMS	Information system used by the Aging Services Division
SCHIP	State Children's Health Insurance Program ("*Healthy Steps*" in North Dakota)
SDX	State Data Exchange
SFY	State Fiscal Year
SKFI	Scan and Key from Image
SLMB	Specified Low-income Medicare Beneficiary
SMP	Symmetric Multi-Processing
SNF	Skilled Nursing Facility
SOA	Service-Oriented Architecture
SOAP	Simple Object Access Protocol
SPED	Service Payments for the Elderly and Disabled – in-home and community based services for older or physically disabled persons in North Dakota
SPOC	Single Plan Of Care
SQL	Structured (or System) Query Language
SSA	Social Security Administration
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
SSN	Social Security Number
SUR or SURS	Surveillance and Utilization Review (SUR) Subsystem
TAD	Turnaround Document. The paper TAD is used to bill for non-medical services rendered by Qualified Services Providers (QSP), Basic Care, and DD (non- ICF/MR) providers.

ACRONYM OR TERM	DEFINITION
TANF	Temporary Assistance to Needy Families
TBD	To Be Determined
TBI	Traumatic Brain Injury
TCM	Targeted Case Management
TCP	Transmission Control Protocol (as in TCP/IP)
TECS	Technical Eligibility Computer Systems
TIN	Tax Identification Number
Title XIX	Social Security Act, Title XIX (Title 19). This Act established Medicaid medical assistance programs.
Title XVIII	Social Security Act, Title XVIII (Title 18). Title 18 of the Act, which is entitled Health Insurance for the Aged and Disabled, established Medicare health insurance.
Title XXI	Social Security Act, Title XXI (Title 21). This act provides funds to States, enabling them to initiate and expand the provision of child health assistance to uninsured, low-income children.
TP	Transaction Processing
TPA	Trading Partner Agreement
TPL	Third Party Liability
UAT	User Acceptance Test
UB-92	Universal Billing, Form 92.
UPIN	Universal Provider Identification Number
UPL	Upper Payment Limit
UR	Utilization Review
URA	Unit Rebate Amount (Drug Rebate)
Usual & Customary	One of Four Reimbursement Methods for Pharmacy. This refers to the amount that a provider typically bills for a particular drug.
V&V	Verification and Validation (See also IV&V)
VERSA	Disability Determination Services (DDS) payment system
VISION	Automated eligibility system, housing a portion of North Dakota's Medicaid eligibility information
VPN	Virtual Private Network
VR	Vocational Rehabilitation
VRIS	Vocational Rehabilitation Information System
VSAM	Virtual Storage Access Method
W3C	World Wide Web Consortium
WAC	Wholesaler Acquisition Cost
Waiver Programs	See HCBS.
WAN	Wide Area Network
WAP	Wireless Application Protocol
WML	Wireless Markup Language
Women's Way	North Dakota's program for women who are not Medicaid eligible and who have been diagnosed with breast or cervical cancer.
Work Plan	The Work Plan for response to this RFP includes Tasks and Subtasks, Duration, Resources, Milestones/Deliverables, and Target Dates for Milestones/Deliverables.
WSI	Workforce Safety and Insurance (formerly Worker's Compensation)

ACRONYM OR TERM	DEFINITION
X12N 270/271	ANSI ASC X12 270/271 Transaction. Refers to HIPAA Healthcare Eligibility Benefit Inquiry and Response Transactions.
X12N 275	ANSI ASC X12 275 Transaction. Refers to HIPAA Claims Attachment Transaction (yet to be finalized and incorporated).
X12N 276/277	ANSI ASC X12 276/277 Transaction. Refers to HIPAA Healthcare Claims Status Request and Response Transactions.
X12N 278	ANSI ASC X12 278 Transaction. Refers to HIPAA Referral Certification and Prior Authorization Requests Transaction.
X12N 820	ANSI ASC X12 820 Transaction. Refers to HIPAA Premium Payment Transaction.
X12N 834	ANSI ASC X12 834 Transaction. Refers to HIPAA MCO and SCHIP Enrollment and Disenrollment Transaction.
X12N 835	ANSI ASC X12 835 Transaction. HIPAA Claims Payment and Remittance Advice Transaction.
X12N 837	ANSI ASC X12 837 Transaction. Refers to HIPAA Healthcare Claim or Encounter Transaction.
X12N 841	ANSI ASC X12 841 Transaction. Refers to HIPAA related code lists. Provides standardized data requirements and content for the purpose of loading a database with the code sets adopted under HIPAA.
X12N 997	ANSI ASC X12 997 Transaction. Refers to the HIPAA Functional Acknowledgement Transaction.
XML	eXtensible Markup Language
YCC	North Dakota's Youth Correctional Center
YTD	Year to Date

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12.2   ATTACHMENT B: SAMPLE PURCHASE OF SERVICE AGREEMENT

The following pages present a sample *Purchase of Service Agreement* that would be modified per the scope of this RFP and signed by DHS and the Contractor prior to commencement of work.

CONTRACT #

PURCHASE OF SERVICE AGREEMENT

WHEREAS, the State of North Dakota, acting through its North Dakota Department of Human Services, Division of Information Technology (State), has determined the services referred to in the paragraph below entitled "Scope of Service" should be purchased; and

WHEREAS, _____, (Vendor) proposes to provide those services;

NOW, THEREFORE, the State and Vendor enter into the following:

A G R E E M E N T

I.   TERM OF THE AGREEMENT

The term of this agreement shall be from the ___day of _____ 200___ through the ___day of _____ 200__. However, this agreement may be terminated with or without cause by either party giving the other party thirty (30) days prior written notice.

II.   SCOPE OF SERVICE

The Vendor agrees to provide:

III.   COMPENSATION

The State, upon written request of the Vendor, agrees to pay the Vendor $_____ for completing the scope of service. Total payment under the terms of this agreement shall not exceed $_____. **Final payment requests shall be submitted to the State no later than thirty (30) days after the expiration of this agreement.**

IV.   VENDOR'S UNDERSTANDING OF TERM OF FUNDING

The Vendor understands that this agreement is a one-time agreement, and acknowledges that it has been furnished no assurances that this agreement may be extended for periods beyond its termination date.

V.   VENDOR ASSURANCES

This agreement shall be construed according to the laws of the State of North Dakota. In connection with the furnishing of supplies or performance of work under this agreement, persons who contract with or receive funds to provide services to the North Dakota Department of Human Services are obligated and agree to comply with all local, state and federal laws, regulations and executive orders related to the performance of this agreement including but not limited to the following: Fair Labor Standards Act, Equal Pay Act of 1963, Titles VI and VII of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of

1973, the Age Discrimination Act of 1975, the Age Discrimination in Employment Act of 1967, the Americans with Disabilities Act of 1990, the North Dakota Human Rights Act, and the Drug-free Workplace Act of 1988. Questions regarding the provision of services according to these Acts may be directed to Krista L. Andrews, Contract Officer, North Dakota Department of Human Services, Judicial Wing, State Capitol, 600 E. Boulevard, Bismarck, ND 58505 (701-328-2311 or 701-328-3975 TDD).

The Vendor certifies by signing this agreement that neither the Vendor, Subcontractor, nor their principals, are presently debarred, declared ineligible or voluntarily excluded from participation in transactions with the State or Federal Government by any Department or Agency of the Federal Government.

Vendor shall be an approved vendor with the Office of Management and Budget within the State of North Dakota as required by NDCC § 54-44.4-09.

VI.   AUTHORITY TO CONTRACT

The Vendor shall not have the authority to contract for or on behalf of or incur obligations on behalf of the State. However, the Vendor may subcontract with qualified Vendors of services provided that any such subcontract shall acknowledge the binding nature of this agreement, and incorporate this agreement, together with its attachments as appropriate. The Vendor agrees to be solely responsible for the performance of any subcontractor.

VII.   INDEPENDENT ENTITY

The Vendor shall perform as an independent entity under this agreement. The Vendor, its employees, agents, or representatives are not employees of the State for all purposes, including but not limited to, the application of the Social Security Act, the Fair Labor Standards Act, the Federal Insurance Contribution Act, the Federal Unemployment Act, the North Dakota Unemployment Compensation Law, and the North Dakota Workers' Compensation Act. No part of this agreement shall be construed to represent the creation of an employer/employee relationship. The Vendor will retain sole and absolute discretion in the judgment of the manner and means of carrying out the Vendor's activities and responsibilities under this agreement.

VIII.   NONPERFORMANCE

Failure by the Vendor to perform the terms of this agreement shall constitute a breach of contract, and shall result in the immediate termination of the agreement. In the event of a termination for breach by the Vendor, the State may retain, as liquidated damages, any payment to be made under this agreement which remains unpaid at the time of the breach, and may also recover from the Vendor, those amounts already paid for individual items of work which are incomplete at the time of the breach.

However, should a breach by the Vendor be caused by circumstances, beyond the control of the Vendor, and no fault of its own, so as to render the agreement impossible of performance by the Vendor, then the agreement shall be terminated. In the event of a breach, by the Vendor, in such circumstances, the State may set off, against any liability or obligations owed to the Vendor, under this agreement or otherwise, any amounts paid for individual items of work which are incomplete at the time of the breach, but shall not be entitled to liquidated damages.

The State shall give written notice, to the Vendor, of the termination, which notice shall specify the effective date thereof.

IX.   TERMINATION OF AGREEMENT FOR INADEQUACY OF FUNDS

It is agreed that in the event appropriations to the Department of Human Services are not obtained and continued at a level sufficient to allow for payments to the Vendor, for the services identified in Paragraph II, the obligations of each party hereunder may be terminated at the option of the State, provided that any such termination shall be without prejudice to any obligations or liabilities of either party already accrued prior to such termination.

X.   INDEMNITY

Vendor agrees to defend, indemnify, and hold harmless the State of North Dakota, its agencies, officers and employees (North Dakota), from any and all claims of any nature, including all costs, expenses, and attorneys' fees, which may in any manner result from or arise out of this agreement, except for claims resulting from or arising out of North Dakota's sole negligence. The legal defense provided by Vendor to North Dakota under this provision must be free of any conflicts of interest, even if retention of separate legal counsel for North Dakota is necessary. Vendor also agrees to defend, indemnify, and hold North Dakota harmless for all costs, expenses, and attorneys' fees incurred in establishing and litigating the indemnification coverage provided herein. This obligation shall continue after termination of this agreement.

XI.   INSURANCE

A. **Required Coverages**. Vendor shall secure and keep in force during the term of this agreement, from insurance companies authorized to do business in North Dakota, the following insurance coverages covering the Vendor for any and all claims of any nature which may in any manner arise out of or result from this agreement:

1) Commercial general liability, including contractual coverage, with minimum liability limits of $250,000 per person and $1,000,000 per occurrence.

2) Professional errors and omissions including a three (3) year "tail coverage endorsement," with minimum liability limits of $1,000,000 per occurrence and in the aggregate. In the alternative to obtaining the tail coverage endorsement, Vendor agrees to continue the insurance in place a minimum of three (3) years following completion of the work specified in this agreement.

3) Automobile liability, with minimum liability limits of $250,000 per person and $500,000 per occurrence.

4) Workers' compensation coverage meeting all North Dakota statutory requirements.

B. **General Insurance Requirements**. The insurance coverages listed above must meet the following additional requirements:

1) Any deductible or self-insured retention amount or other similar obligation under the policies shall be the sole responsibility of the Vendor. The amount of any deductible or self-retention is subject to approval by the State.

2) This insurance may be in policy or policies of insurance, primary and excess, including the so-called umbrella or catastrophe form, and must be placed with insurers rated "A" or better by A.M. Best Company, Inc., provided any excess policy follows form for coverage. The policies shall be in form and terms approved by the State. "Follows form" means the excess policy must be written with the

same terms and conditions as the policy to which it is excess.

3) North Dakota will be defended, indemnified, and held harmless to the full extent of any coverage actually secured by the Vendor in excess of the minimum requirements set forth above. The duty to indemnify North Dakota under this agreement shall be not be limited by the insurance required in this agreement.

4) North Dakota shall be endorsed on the commercial general liability policy, including any excess policies (to the extent applicable), as additional insureds. North Dakota shall have all the rights and coverages as Vendor under said policies. The additional insured endorsement for the commercial general liability policy shall be written on a form equivalent to the ISO 1985 CG 20 10 form, or such other form as approved by North Dakota, and shall not limit or delete North Dakota's coverage in any way based upon North Dakota's acts or omissions.

5) The insurance required in this agreement, through a policy to endorsement, shall include:

   a) a "Waiver of Subrogation" waiving any right of recovery the insurance company may have against North Dakota;

   b) a provision that the policy and endorsements may not be canceled or modified without thirty (30) days' prior written notice to the undersigned State representative;

   c) a provision that any attorney who represents North Dakota under this policy must first qualify as and be appointed by the North Dakota Attorney General as a Special Assistant Attorney General as required by N.D.C.C. § 54-12-08;

   d) a provision that Vendor's insurance coverage shall be primary (i.e., pay first) as respects any insurance, self-insurance or self-retention maintained by North Dakota and that any insurance, self-insurance or self-retention maintained by North Dakota shall be excess of the Vendor's insurance and shall not contribute with it;

   e) cross-liability/severability of interest coverage for all policies and endorsements.

6) The legal defense provided to North Dakota under the policy and any endorsements must be free of any conflicts of interest, even if retention of separate legal counsel for North Dakota is necessary.

7) Vendor shall furnish a certificate of insurance and, if requested, a copy of the insurance policy and all its endorsements, including the additional insured endorsement, to the undersigned State representative prior to commencement of this agreement.

8) Failure to provide insurance as required in this section is a material breach of contract entitling State to terminate this contract at any time effective upon delivery of notice to the Vendor.

XII.   ACCESS TO BOOKS AND RECORDS

The State, federal government, and their duly authorized representatives shall have access to the books, documents, papers, and records of the Vendor which are pertinent to the services provided under this agreement for the purpose of making an audit, examination, or making excerpts and transcripts. This documentation shall be available for a period of three (3) years from the date of submission of the final expenditures report.

XIII.   NOTICE

Any notice required or permitted to be given pursuant to this agreement may be personally served on either party by the party giving such notice, or may be served by certified mail, return receipt requested, addressed to the executive office of the party upon whom service is made.

XIV.   INTEGRATION, MERGER, AND MODIFICATION

This Contract, including the following attachments, constitutes the entire agreement between the parties. There are no understandings, agreements, or representations, oral or written, not specified within this Contract. This contract may not be modified, supplemented or amended, in any manner, except by written agreement signed by both parties. The attachments are:

a)   STATE's Request for Proposal ("RFP") number _____, dated _____ ____, 200__;

b)   STATE's amended Request for Proposal ("RFP") number _____, dated _____ ____, 200__;

c)   STATE's response to bidder's questions dated _____, 200__;

d)   Scope of services;

e)   <other items specific to your project>

f)   CONTRACTOR's proposal dated _____. 200__.

This contract may not be modified, supplemented or amended, in any manner, except by written agreement signed by both parties.

XV.   CONFLICT IN DOCUMENTS

Notwithstanding anything herein to the contrary, in the event of any inconsistency or conflict among the documents making up this Contract, the documents must control in this order of precedence: First – the terms of this Contract, as may be amended; Second - the State's Request for Proposal number ___ dated _____, ____, 200__; and Third - the CONTRACTOR's Proposal.

XVI.   COLLATERAL CONTRACTS

Where there exists any inconsistency between this agreement and other provisions of collateral contractual agreements which are made a part of this agreement by reference or otherwise, the provisions of this agreement shall control.

XVII.   APPLICABLE LAW

This agreement shall be governed by and construed in accordance with the laws of the State of North Dakota.

XVIII.   ASSIGNMENT

Neither Party shall assign this agreement and rights without the written approval of the other Party. Such approval shall not be unreasonably withheld. This agreement shall be equally binding on the respective Parties, their successors and assigns.

XIX.   CONFIDENTIAL INFORMATION

The Vendor agrees not to use or disclose any information it receives from the State under this agreement that is confidential or exempt from mandatory public disclosure except as necessary to carry out the purposes of this agreement or as authorized in advance by the State. The State agrees not to disclose any information it receives from the Vendor which the Vendor has previously identified as confidential and which the State determines in its sole discretion is protected from mandatory public disclosure under a specific exception to the North Dakota open records law, North Dakota Century Code § 44-04-18. The duty of the State and the Vendor to maintain confidentiality of information under this section continues beyond the term of this agreement, including any extensions or renewals.

XX.   OWNERSHIP OF WORK PRODUCT

All work product, equipment or materials created or purchased under this agreement belong to the State and must be delivered to State at State's request upon termination of this agreement. Vendor agrees that all materials prepared under this agreement are "works for hire" within the meaning of copyright laws of the United States and assigns to the State all rights and interests Vendor may have in the materials it prepares under this agreement, including any right to derivative use of the material. Vendor shall execute all necessary documents to enable the State to protect its rights under this section. Use of work product or materials for purposes other than the scope of this agreement must be approved in writing by the State.

XXI.   COMPLIANCE WITH PUBLIC RECORDS LAWS

Vendor understands that, except for disclosures prohibited in Section XVII, the Vendor must disclose to the public upon request any records it receives from Vendor. Vendor further understands that any records which are obtained or generated by the Vendor under this agreement, except for records that are confidential under Section XVII, may, under certain circumstances, be open to the public upon request under the North Dakota open records law. Vendor agrees to contact the State immediately upon receiving a request for information under the open records law and to comply with the State's instructions on how to respond to the request.

XXII.   ATTORNEY FEES

In the event a lawsuit is instituted by the Vendor to obtain performance due to any kind under this agreement, and the Vendor is the prevailing party, State shall, except when prohibited by N.D.C.C. § 28-26-04, pay the State's reasonable attorney fees and costs in connection with the lawsuit.

XXIII.   ALTERNATIVE DISPUTE RESOLUTION – JURY TRIAL

The State does not agree to any form of binding arbitration, mediation, or other forms of mandatory alternative dispute resolution.   The parties have the right to enforce their rights and remedies in judicial proceedings. The State does not waive any right to a jury trial.

VENDOR

By_____
  DATE

Its_____
  (TITLE)

_____

Vendor's Federal Identification Number

STATE OF NORTH DAKOTA

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES

By_____ _____
  CAROL K. OLSON DATE
  EXECUTIVE DIRECTOR

By_____ _____
  JENNIFER WITHAM, DIRECTOR DATE
  DIVISION OF INFORMATION TECHNOLOGY

By_____ _____
  KRISTA L. ANDREWS DATE
  CONTRACT OFFICER

12.3 ATTACHMENT C: CONTRACT BOND FORM

The State's Contract Bond Form is found on the following pages.

CONTRACT BOND
Central Services Division
A division of Office of Management and Budget
SFN 51815

State Procurement Office
14th Floor Capitol Tower
600 East Boulevard Ave Dept 012
Bismarck ND 58505-0310
(701) 328-2683

Contract Number _____ (See instructions on next page to complete this form.)

Know all men by these present, that we _____

as principal, and _____

as surety, are held and firmly bound unto the State of North Dakota in the penal sum of _____ for the use of said State of North Dakota and also for the use of any person having any lawful claim against the principal or any subcontractor on account of labor or supplies of materials as set forth in the conditions hereof; for the payment of which well and truly to be made we jointly and severally bind ourselves, and each of our heirs, executors, administrators and successors, firmly by these presents.

THE CONDITION OF THE OBLIGATION IS SUCH THAT, WHEREAS, said principal has entered into written contract with the Office of Management and Budget for the State of North Dakota:

in _____ County, North Dakota, which said contract and incorporated plans and specifications are by this reference mad a part hereof as fully and with the same force and effect as if set forth in full herein:

NOW THEREFORE, if the Principal shall: (1) Perform all the terms, covenants and conditions of said contract; (2)Protect the State of North against any loss or damage from any cause arising out of said contract; (3) Pay or cause to be paid all bills and claims against the Principal or any subcontractor on account of labor or services performed and all materials, equipment or supplies furnished, whether directly or indirectly arising out of the performance of said contract; (4)Pay all insurance premiums and all items for which payment under the terms of the contract is to be made or guaranteed by the Principal; (5) Have made or will make prior to the commencement of any work by himself or any subcontractor under such contract, the full and true report to the Workers' Compensation Bureau of the payroll expenditures for the employees to be engaged in such work, and that he has paid, or will pay, the premium thereon prior to the commencement of such work; (6) Pay or cause to be paid all contributions due to the Unemployment Compensation Division; (7) Pay or cause to be paid any and all taxes that may be accessed or levied to be a charge against such contractor or any subcontractor under such contract by the State of North Dakota or any of its subdivisions; then this obligation shall be null and void; otherwise to remain in full force and effect. And the said Surety hereby stipulates and agrees that any change, extension, alteration, deduction, or addition, with or without notice to the Surety, in or to the terms of said contract or the plans or the specifications accompanying the same provided for therein, shall not in any way affect the obligation and liability of said Surety on this bond.

SIGNED AND SEALED THIS _____ DAY OF_____, 20_____.

(Seal of Principal)

Principal:
By:
Title:

Important Notice:
If an individual doing business under a firm name, so state, giving both names, and the individual signing shall designate himself as sole owner.
If partnership, so state, and at least one member of such partnership must sign

(Seal of Surety)

Surety:
By:
Title:

If a Corporation, the full corporate name must be used and the execution must be by an officer of the corporation

Any other person executing for the principal or surety must attach a power of attorney

Countersigned (North Dakota Resident Agency of Surety):
Mailing Address:

Section 26.1-03-01 of the North Dakota Century Code provides that "an insurance company transacting an insurance business in this State may not expose itself to loss on any one risk or hazard to an amount exceeding ten percent of its paid-up capital and surplus if a stock company, or ten percent of its surplus if a mutual company, unless the excess is reinsured." If excess reinsurance agreements are required on this bond, an affidavit executed by an officer of the surety shall be attached, stating that such reinsurance agreements have been entered into and are in effect at the time the bond is executed, giving the name and address of all companies with whom such agreements have been made, and that copies of such reinsurance agreements will be furnished to the North Dakota State Insurance Commissioner upon request.

Instructions: (1) Dates used in the completion of this bond form should be the actual dates, without regard for the effective dates of the contract, to which the bond applies. Dates must be in chronological sequence, i.e., date of signature on the basic bond form must be the same or prior to the dates indicated in the acknowledgement portion, and dates used in the acknowledgment of surety portion must be the same as or subsequent to the date used in other portions of the bond form. (2) Persons signing the bond as a 'principal' must be an officer of the firm unless a notarized authorization for such signing is also submitted with the bond form. (3) Dates of Power of Attorney forms, when used, must be dated the same as the date of the certification to which it pertains. If the person(s) signing and executing this contract bond do not comply strictly with these instructions, then the contract bond form will be sent back to the appropriate person(s) for any necessary corrections.

ACKNOWLEGEMENT OF PRINCIPAL

STATE OF_____COUNTY OF_____

ON THIS _____ DAY OF _____, 20 _____ BEFORE ME A NOTARY PUBLIC IN THE STATE OF

_____ PERSONALLY APPEARED _____ KNOWN TO ME TO BE

_____ OF THE PRINICPAL DESCRIBED IN THE WITHIN INSTRUMENT AND WHO EXECUTED

THE SAME FOR AND ON BEHALF OF SAID PRINCIPAL.

Notary Public must legibly stamp, type of print name in addition to signature:	
NOTARY PUBLIC, STATE OF:	**(Notary Seal)**
My commission expires:	

ACKNOWLEDGEMENT OF SURETY
STATE OF_____COUNTY OF_____

ON THIS _____ DAY OF _____, 20 _____ BEFORE ME A NOTARY PUBLIC IN THE STATE OF

_____ PERSONALLY APPEARED _____ KNOWN TO ME TO BE

_____ OF THE SURETY DESCRIBED IN THE WITHIN INSTRUMENT AND WHO

EXECUTED THE SAME FOR AND ON BEHALF OF SAID SURETY.

Notary Public must legibly stamp, type of print name in addition to signature:	
NOTARY PUBLIC, STATE OF:	**(Notary Seal)**
My commission expires:	

ATTORNEY GENERAL – APPROVED AS TO FORM:

	Attorney General:
This _____Day of _____20____	**By Assistant:**

NORTH DAKOTA STATE PROCUREMENT OFFICE APPROVAL

	Authorized Agent:
This _____Day of _____20____	

12.4 ATTACHMENT D: SAMPLE REQUIREMENTS CROSS-REFERENCE

The following table provides a sample of the necessary cross-reference for General Requirements, General System Requirements, and System / Operational Requirements.

RFP SECTION AND REQUIREMENT #	LOCATION OF RESPONSE IN BID PROPOSAL
Section 7.2.2.1.1, Requirement #1	Section 8.2, Page 130
Section 7.2.4.1.1, Requirement #7	Section 8.4, Page 185
Etc.	Etc.

The bidder is expected to produce a similar table with the same column headings.

12.5   ATTACHMENT E: MANDATORY BID PROPOSAL REQUIREMENTS CHECKLIST

On the following pages, DHS has provided the template for the Bid Proposal Mandatory Requirements Checklist that is to be submitted with the Technical Proposal portion of Bid Proposals. Bidders are expected to confirm compliance by typing or printing "Yes" in the "Bidder Check" column. Upon receipt of Bid Proposals, DHS will confirm compliance by entering "Yes" in the "DHS Check" column.

MANDATORY REQT #	REQUIREMENT	BIDDER CHECK	DHS CHECK
BIDDER NAME:			
	GENERAL SUBMITTAL REQUIREMENTS		
1	Is bidder an approved vendor on the State Procurement Office's bidder's list (per Section 1.5.4)		
2	Did the Bidder submit a Letter of Intent to Bid by 3:00 p.m., Central Time, on June 22, 2005?		
3	Are all Bid Proposal materials being submitted to the Procurement Officer on or before specified submission deadline of September 1, 2005 at 3:00 p.m., Central Time?		
4	Does each Bid Proposal consist of two distinct parts (i.e., *Technical Proposal and Cost Proposal)*?		
5	Is each Bid Proposal sealed in a box (or boxes), with the *Cost Proposal* portion sealed in separate, labeled envelopes inside the same box(es)?		
6	Are packing boxes numbered in the following fashion: 1 of 4, 2 of 4, etc., for each Bid Proposal that consists of multiple boxes?		
7	Are all boxes containing bids labeled with the following information?: • Bidder's Name and Address • Procurement Officer and Department's Address (Identified by Section 2.1) • RFP Title (North Dakota Medicaid Systems Replacement Project) and RFP Reference Number (325-05-10-016) • RFP Component for which the Bid Proposal is being submitted for consideration (i.e., MMIS Contract, POS Contract, or DSS/DW Contract)		
8	Are separate boxes utilized for each Bid Proposal, if submitting Bid Proposals for more than one of the three separate contract awards?		
9	Are all Bid Proposal materials printed on 8.5" x 11" paper (two-sided)?		
10	Are materials for each *Technical Proposal* presented in a 3-ring binder, spiral binder, comb binder, or similar binder separate from the sealed *Cost Proposal* materials?		
11	Are materials for each *Cost Proposal* presented in a small 3-ring binder, spiral or comb binders, "sliding bar" report cover, or similar binding that allows for easy removal of documents? *(NOTE: This will be determined when Cost Proposals are opened after Technical Proposals have been evaluated.)*		
12	Has one (1) "non-proprietary" copy of Bid Proposal materials been submitted if any Bid Proposal information is designated as confidential? *(Note: Bidders cannot designate their entire proposal as confidential or proprietary.)*		
13	Does each Bid Proposal package include an original proposal, the specified number of copies, and 1 non-proprietary copy (if applicable) for the Technical Proposal in a separate binder (or set of binders)? Are the original, copies, and non-proprietary copy correctly marked?		

BIDDER NAME:			
MANDATORY REQT #	**REQUIREMENT**	**BIDDER CHECK**	**DHS CHECK**
14	Does each Cost Proposal package include an original proposal, the specified number of copies, and 1 non-proprietary copy (if applicable) for the Cost Proposal (in one or more separate, sealed Envelopes)? Are the original, copies, and non-proprietary copy correctly marked? *(NOTE: This will be determined when Cost Proposals are opened after Technical Proposals have been evaluated.)*		
15	Have Bid Proposals also been submitted on CD Rom (1 CD for Technical and 1 CD for cost) copies per Bid Proposal).		
16	Does each submitted CD-Rom contain one full version of each Bid Proposal part and one "non-proprietary" version of each Bid Proposal part?		
17	Are all electronic files in PDF format or Microsoft Word (2000 or newer) format?		
18	Are all electronic files individually identified by Component Name, Bid Proposal part, and version?		
	TECHNICAL PROPOSAL CONTENTS		
19	Does each *Technical Proposal* consist of the following sections separated by tabs with associated documents and responses presented in the following order?: • Table of Contents (Tab 1) • Transmittal Letter (Tab 2) • Requirements Checklists and Cross-References (Tab 3) • Executive Summary, Introduction, and Project Understanding (Tab 4) • Services Overview (Tab 5) • General Requirements (Tab 6) • Start-up Activities (Tab 7) • Operational Requirements (Tab 8) • Project Management Planning (Tab 9) • Corporate Organization, Experience, and Qualifications (Tab 10) • Certifications and Guarantees by the Bidder (Tab 11)		
20	Does the *Table of Contents* in Tab 1 of the *Technical Proposal* identify all Sections, Subsection(s), and corresponding page numbers?		
21	Does the *Transmittal Letter* in Tab 2 include the following?:		
	• A signature by an person authorized to legally bind the bidder		
	• Print on official business letterhead		
	• The bidder's mailing address		
	• Electronic mail address, fax number, and telephone number for both the authorized signer and the point of contact designated by the bidder		
	• A statement indicating that the bidder is a corporation or other legal entity. • Identification of all subcontractors • A statement indicating the exact amount of work to be done by the prime contractor [not less than sixty percent (60%)] and each subcontractor, as measured by percentage of total contract price.		

BIDDER NAME:			
MANDATORY REQT #	**REQUIREMENT**	**BIDDER CHECK**	**DHS CHECK**
	• A statement confirming that the bidder is registered to do business in North Dakota • The corporate charter number of the prime contractor • Assurances that any subcontractor proposed is also licensed to work in North Dakota		
	• A statement identifying the bidder's Federal Tax Identification Number		
	• A statement that the bidder will comply with all *Contract Terms and Conditions* as indicated by *Section 9* of this RFP		
	• A statement that no attempt has been made or will be made by the bidder to induce any other person or firm to submit or not to submit a proposal		
	• A statement of affirmative action that the bidder does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, or handicap		
	• A statement that no cost or pricing information has been included in the transmittal letter or the *Technical Proposal*		
	• A statement identifying all amendments to this RFP issued by the state and have been received by the bidder. (If no amendments have been received, a statement to that effect shall be included)		
	• A statement that the bidder certifies in connection with this procurement that: a) The prices proposed have been arrived at independently, without consultation, communication, or agreement, as to any matter relating to such prices with any other bidder or with any competitor for the purpose of restricting competition; and b) Unless otherwise required by law, the prices quoted have not been knowingly disclosed by the bidder prior to award, directly or indirectly, to any other bidder or to any competitor		
	• A statement that the person signing this proposal certifies that he/she is the person in the bidder's organization responsible for, or authorized to make, decisions regarding the prices quoted and that he/she has not participated, and will not participate, in any action contrary to item 11 above		
	• Is a statement from each proposed subcontractor appended to the transmittal letter signed by an individual authorized to legally bind the subcontractor stating: a.) The general scope of work to be performed by the subcontractor b.) The subcontractor's willingness to perform the work indicated c.) The subcontractor's assertion that it does not discriminate in employment practices with regard to race, color, religion, age (except as provided by law), sex marital status, political affiliation, national origin, or handicap		

BIDDER NAME:			
MANDATORY REQT #	**REQUIREMENT**	**BIDDER CHECK**	**DHS CHECK**
	• Identification of any request for confidential treatment of information, in addition to the specific statutory basis supporting the request and an explanation why disclosure of the information is not in the best interest of the public.		
	• The name, address and telephone number of the individual authorized to respond to the Department about the confidential nature of the information (if applicable)		
22	Is a completed copy of the *Mandatory Requirements Checklist* included in Tab 3?		
23	Is a *General Requirements Cross-reference* in Tab 3 included for each *Technical Proposal* under consideration, based upon the sample provided by Attachment D?		
24	Is a *System / Business Requirements Cross-reference* in Tab 3 included for each *Technical Proposal* under consideration, based upon the sample provided by Attachment D?		
25	Are requirements numbers listed above the paragraph or set of paragraphs for all addressed requirements in?		
26	Does information in Tab 11 all of the designated certifications and guarantees by the bidder?:		
	COST PROPOSAL CONTENTS		
27	Does the Cost Proposal include the following sections?: • Table of Contents • Bid Proposal Security • Pricing Schedules • Company Financials		
28	Does Tab 1 include a *Table of Contents* of the *Cost Proposal*? Does the *Table of Contents* identify all Sections, Subsections, and corresponding page numbers?		
29	Are pricing schedules, as specified in the RFP, included in Tab 2?		
30	Are company financials included in Tab 3?		
31	Does the *Company Financial Information* include audited financial statements (annual reports) for the last 3 years?		
32	Does the *Company Financial Information* include at least three (3) financial references (e.g., letters from creditors, letters from banking institutions, Dun & Bradstreet supplier reports, etc.)?		
33	Does the *Company Financial Information* include a description of other contracts or projects currently undertaken by the bidder?		
34	Does the *Company Financial Information* include a summary of any pending or threatened litigation, administrative or regulatory proceedings or similar matters that could affect the ability of the bidder to perform the required services?		

BIDDER NAME:			
MANDATORY REQT #	**REQUIREMENT**	**BIDDER CHECK**	**DHS CHECK**
35	Does the *Company Financial Information* include a disclosure of any contracts during the preceding three (3) year period, in which the bidder or any subcontractor identified in the Bid Proposal has defaulted. List all such contracts and provide a brief description of the incident, the name of the contract, a contact person and telephone number for the other party to the contract?		
36	Does the *Company Financial Information* include a disclosure of any contracts during the preceding three (3) year period, in which the bidder or any subcontractor identified in the Bid Proposal has terminated a contract prior to its stated term or has had a contract terminated by the other party prior to its stated term.?		
37	Has a Performance Bond Commitment Letter been included in Tab 4?		

12.6 ATTACHMENT F: DDI DELIVERABLE RESPONSIBILITIES

The table below illustrates the deliverables that each of the systems contractors are expected to produce during the DDI phase of their contract. The Department's expectations for content of each deliverable have been presented in Section 8 above.

Table 24: DDI Deliverable Responsibilities

DELIVERABLES	MMIS	POS	DSS/DW
RFP Section 8.2.1 - Project Management Activities			
Detailed Project Work Plan	▲	▲	▲
Project Control and Project Management Plan	▲	▲	▲
Configuration Management Plan	▲	▲	▲
Configuration Management Environment	▲	▲	▲
Quality Management Plan	▲	▲	▲
DDI Incident Reports	▲	▲	▲
Electronic Project Library	▲	▲	▲
RFP Section 8.3.1 - Planning Activities			
Documentation Standards Plan	▲	▲	▲
Project Staffing and Facility Plan	▲	▲	▲
System Technical Standards Plan	▲	▲	▲
Equipment / Technology Acquisition Plan	▲	▲	▲
Staff Training Plan	▲	▲	▲
Facility Security and Data Security Plan	▲	▲	▲
Business Continuity and Contingency Plan	▲	▲	▲
Transition Plan			▲
RFP Section 8.4.1 - Concept Verification and Validation (V & V) Activities			
Requirements Analysis Document	▲	▲	▲
Traceability Matrix	▲	▲	▲
Gap Analysis	▲	▲	▲
Build Strategy / Schedule	▲	▲	▲
MITA Assessment	▲	▲	▲
RFP Section 8.4.2 - Requirements Verification and Validation (V & V) Activities			
Data Model / Entity Relationship Diagram for the System	▲	▲	▲
Business Process Models for all Automated and Manual Functions	▲	▲	
Document Imaging Requirements	▲		
Implementation Plan (Version 1)	▲	▲	▲
Provider Communications Plan	▲	▲	
Workflow Process Management Requirements Gap Analysis	▲		
Final Formats for all Input and Output Files	▲	▲	▲
Interfaces and Data Acquisition	▲	▲	▲

DELIVERABLES	MMIS	POS	DSS/DW
System Architecture Document	▲	▲	▲
RFP Section 8.4.3 - System Design Activities			
Design Overview Document	▲	▲	▲
System Design Documents	▲	▲	▲
Data Dictionary	▲	▲	▲
Configuration Management Environment Software Load	▲		
Draft Operational Procedure Manuals	▲	▲	▲
Edit and Audit Rules	▲	▲	
Updates to Previous Deliverables	▲	▲	▲
RFP Section 8.4.4 - System Development Activities			
Comprehensive System Test Plan	▲	▲	▲
Completed Test Criteria	▲	▲	▲
Systems Documentation	▲	▲	▲
System User Manuals	▲	▲	▲
Draft and Final Operating Procedures	▲	▲	▲
RFP Section 8.4.5 - Data Conversion Activities			
Conversion Quality Assurance Plan	▲	▲	▲
Data Conversion Strategy	▲	▲	▲
Data Conversion Plan	▲	▲	▲
Conversion Mapping Document	▲	▲	▲
Comprehensive List of Input Files and Tables	▲	▲	▲
Conversion Test Results	▲	▲	▲
Error Correction Plan	▲	▲	▲
Contractor's Plan for HIPAA Compliance	▲	▲	▲
RFP Section 8.4.6 - Structured System Test Activities			
System Test Tracking Tool	▲	▲	▲
Testing Problem Tracking and Resolutions	▲	▲	▲
System Testing Test Strategy	▲	▲	▲
Detailed System Testing Test Plan	▲	▲	▲
Corrective Action Plan	▲	▲	▲
Structured System Test Results	▲	▲	▲
Updated User Documents	▲	▲	▲
Updated Operational Procedures Document	▲	▲	▲
Updated Business Continuity and Contingency Plan	▲	▲	▲
RFP Section 8.4.7 - Operational Readiness Test Activities			
Checklist Matrices	▲	▲	▲
Updated Operational Procedures Documents	▲	▲	▲
Operational Readiness Report	▲	▲	▲
RFP Section 8.4.8 - Pilot Test Activities			

DELIVERABLES	MMIS	POS	DSS/DW
Provider Implementation Support Materials	▲	▲	
Provider Training Plan, Materials, and Reports	▲	▲	
Draft Provider Handbooks	▲	▲	
Provider Implementation Support Plan	▲	▲	
Provider Implementation Support Report	▲	▲	
Pilot Test Plans and Schedule	▲	▲	▲
Pilot Test Results	▲	▲	▲
RFP Section 8.5.1 - Implementation Activities			
State Staff Training Plan	▲	▲	▲
Provider Transactions Training Plan	▲	▲	
Report Distribution Schedule	▲	▲	▲
Software Release Plan	▲	▲	▲
Operational Readiness Test Results	▲	▲	▲
Emergency Change and Back-out Plan	▲	▲	▲
Final Facility and Data Security Manual	▲	▲	▲
Final Implementation Checklist	▲	▲	▲
Final Documentation and Manuals	▲	▲	▲
Certification Checklist	▲		
Certification Review Package and Manuals	▲		
Schedule for Updates to Data Warehouse	▲	▲	▲
Systems Support Plan	▲	▲	▲

12.7 ATTACHMENT G: PRICING SCHEDULES

12.7.1 PRICING SCHEDULES 1A, 1B, AND 1C – COMPOSITE PRICING SCHEDULE FOR INDIVIDUAL BID PROPOSAL

For Pricing Schedules 1a, 1b, and 1c, provided on the following page(s), bidders will present their composite costs for services. In addition to these composite costs, all bidders will identify a composite rate for any additional "Change Service Request" (CSR) or "Time and Materials" work that may or may not be requested by DHS during the course of the awarded contract.

Pricing Schedules 1a and 1b are for the MMIS and POS components, where only the DDI Price is relevant. In addition to the DDI Price provided, DHS is requesting that bidders also provide an hourly rate that will be used for Change Service Requests that may occur during the contract for consideration during evaluation and contract award.

*Bidder's Note: Pricing Schedule 1a shows line items for Call Management, Workflow Management, and Document Receipt and Control. Only the MMIS Contractor is responsible for pricing these solutions.

Pricing Schedule 1c is for the DSS/DW component, where pricing will be given for both the Implementation Phase and Operations Phase of the anticipated contract under consideration. Proposed total Operations Phase costs for the fourteen (14) month base of the contract will be represented as shown, followed by a total price for each of the two (2) 2-year contract options.

For the DSS/DW evaluation, the Cost Proposal Evaluation Committee will use the proposed total Operations Phase costs for each Fiscal year to calculate a monthly Net Present Value (NPV) of the Operational Phase costs over the fourteen (14) month base contract and two (2) 2-year options for the respective services. Monthly NPVs for each Fiscal Year will be combined to produce a total NPV for the bidder's proposed Operations Phase costs. It is the total NPV of Operations Phase costs that will be evaluated as seventy percent (70%) of the available Cost Proposal points.

*Bidder's Note: Bidders need not use the Pricing Schedule template sheet provided (via "copy and paste" from the electronic document or via photocopy), but the format of the bidder's Pricing Schedule must be the same as the template provided.

NORTH DAKOTA MEDICAID SYSTEMS REPLACEMENT PROJECT

Summary Pricing Schedule 1a
MMIS System Component

COMPONENT NAME	MMIS		
Item #	**Line Item Description**		**Bid Price**
1	Production of DDI Deliverables (Including Salaries and Benefits)		$
2	Software Costs		$
3	Travel		$
4	Administrative Overhead		$
5	Items Priced Separately by the Bidder:		
	Knowledge Transfer / Training Activities		$
	System Warranty / Maintenance Activities		$
	Call Management (MMIS Only)		$
	Workflow Management, FileNet Customization		$
	Workflow Management, Vendor-proposed Workflow Management Solution		$
	Document Receipt and Control		$
	Other (To Be Itemized Separately by the Bidder)		$
6a	**DDI Total Fixed Price (Total of Items #1 through #5), with FileNet Customization**		**$**
6b	**DDI Total Fixed Price (Total of Items #1 through #5), with Vendor's WPM Solution**		**$**
7	**CSR Hourly Rate**	$ per Hr. =	**$**

NORTH DAKOTA MEDICAID SYSTEMS REPLACEMENT PROJECT

Summary Pricing Schedule 1b
POS System Component

COMPONENT NAME	POS	
Item #	**Line Item Description**	**Bid Price**
1	Production of DDI Deliverables (Including Salaries and Benefits)	$
2	Software Costs	$
3	Travel	$
4	Administrative Overhead	$
5	Items Priced Separately by the Bidder:	
	Knowledge Transfer / Training Activities	$
	System Warranty / Maintenance Activities	$
	Other (To Be Itemized Separately by the Bidder)	$
6	**DDI Total Fixed Price (Total of Items #1 through #5)**	$
7	**CSR Hourly Rate** $ per Hr. =	$

NORTH DAKOTA MEDICAID SYSTEMS REPLACEMENT PROJECT

Summary Pricing Schedule 1c
DSS/DW System Component

COMPONENT NAME	DSS/DW						

Item #	Line Item Description						Bid Price Totals
1	Production of DDI Deliverables (Including Salaries and Benefits)						$
2	Software						$
3	Travel						$
4	Administrative Overhead						$
5	Items Priced Separately by the Bidder:						
	Knowledge Transfer / Training Activities						$
	System Warranty / Maintenance Activities						$
	Other (To Be Itemized Separately by the Bidder)						$
6	**DDI Total Fixed Price (Total of Items #1 through #5)**						$
7	**CSR Hourly Rate**	$ per Hr.		=			$
		Base Contract		**1st 2-year Option**		**2nd 2-year Option**	
		FY 2007-08 (3 months)	**FY 2008-09**	**FY 2009-10**	**FY 2010-11**	**FY 2011-12**	**FY 2012-13**	

8	**Operations Price**	$	$	$	$	$	$	$

12.7.2   PRICING SCHEDULE 2 – DDI PRICING DETAIL

For Pricing Schedule 2, bidders will present a pricing detail of the fixed DDI cost represented as Item #6 in Pricing Schedules 1a, 1b, and 1c. DHS has provided line items with the names of the DDI activities. Note that line items also exist for the pricing of Knowledge Transfer / Training activities and System Warranty / Maintenance activities to be broken out and priced independent from other DDI activities.

Since the successful bidder will be paid "per deliverable" during the DDI Phase of the contract, it is expected that the successful bidder will propose "per deliverable" prices during contract negotiations. The total of all "per deliverable" prices that is determined during contract negotiations will "roll up" to their respective DDI activity. The total of all DDI activities will "roll up" into the DDI Total Fixed Price that is negotiated. "Per deliverable" prices negotiated during contract negotiations will already factor in all related costs and overhead (e.g., Salaries & Benefits, Software, Travel, Administrative Overhead, etc.).

The bidder can identify additional line item categories under the section of Pricing Schedule 2 that is labeled as "Other Costs".

*Bidder's Note: Bidders need not use the Pricing Schedule template sheet provided (via "copy and paste" from the electronic document or via photocopy), but the format of the bidder's Pricing Schedule must be the same as the template provided.

Pricing Schedule 2
DDI Pricing Detail

ITEM #	LINE ITEM DESCRIPTION	FIXED PRICE
1	**Project Management Activities (RFP Section 8.2.1)**	$
2	**Planning Activities (RFP Section 8.3.1)**	$
3	**Concept Verification and Validation Activities (RFP Section 8.4.1)**	$
4	**Requirements Verification and Validation Activities (RFP Section 8.4.2)**	$
5	**System Design Activities (RFP Section 8.4.3)**	$
6	**System Development Activities (RFP Section 8.4.4)**	$
7	**Data Conversion Activities (RFP Section 8.4.5)**	$
8	**Structured System Test Activities (RFP Section 8.4.6)**	$
9	**Operational Readiness Test Activities (RFP Section 8.4.7)**	$
10	**Pilot Test Activities (RFP Section 8.4.8)**	$
11	**Implementation Activities (RFP Section 8.5.1)**	$
12	**Knowledge Transfer / Training Activities**	$
13	**System Maintenance Activities**	$
14	**Other Costs (Itemized in the rows that follow)**	$
		$
		$
	GRAND TOTAL	$

12.7.3   PRICING SCHEDULE 3 – OPERATIONAL PHASE PRICING DETAIL

Pricing Schedule 3 is to be used only for the DSS/DW component.

Pricing Schedule 3 provides a template to show the breakdown of the bidder's proposed Operations Phase costs. The values represented in the row labeled "Grand Total" must be the same figures that are represented as Item #8 ("Operations Price") in Pricing Schedule 1c. DHS has provided some standard line item categories, but the bidder can identify additional line item categories under the section of Pricing Schedule 3 that is labeled "Other Costs". As mentioned in Section 11 above, the Cost Proposal Evaluation Committee will use the proposed total Operations Phase costs for each year to calculate a monthly Net Present Value (NPV) of the Operational Phase costs over the fourteen (14) month base contract and two (2) 2-year options for DSS/DW services. Monthly NPVs for each Fiscal Year will be combined to produce a total NPV for the bidder's proposed Operations Phase costs. For the DSS/DW component, it is the total NPV of Operations Phase costs that will be evaluated as seventy percent (70%) of the available Cost Proposal points.

*Bidder's Note: Bidders need not use the Pricing Schedule template provided (via "copy and paste" from the electronic document or via photocopy), but the format of the bidder's Pricing Schedule must be the same as the template provided.

Pricing Schedule 3
DSS/DW Operations Phase Pricing Detail

Item #	Line Item Description	Base Contract		1st 2-year Option		2nd 2-year Option		Total
		FY 2007-08 (3 months)	FY 2008-09	FY 2009-10	FY 2010-11	FY 2011-12	FY 2012-13	
1	Salaries and Benefits	$	$	$	$	$	$	$
2	Computer, Software, and Equipment Resources (i.e., items not provided by the State)	$	$	$	$	$	$	$
3	Travel	$	$	$	$	$	$	$
4	Administrative Overhead	$	$	$	$	$	$	$
5	Other Costs (Itemized in the following rows)	$	$	$	$	$	$	$
		$	$	$	$	$	$	$
		$	$	$	$	$	$	$
		$	$	$	$	$	$	$
		$	$	$	$	$	$	$
		$	$	$	$	$	$	$
	GRAND TOTAL	$	$	$	$	$	$	$

12.7.4   PRICING SCHEDULE 4 – PRICING OF OPTIONAL MMIS SYSTEM REQUIREMENTS

Pricing Schedule 4 provides a template for the pricing of the "Optional MMIS System Requirements" shown in RFP Section 7.5. Bidders for the MMIS Contract are expected to show a total cost for the optional services, as well as a description and itemized cost for the elemental components that build up into the proposed cost.

Pricing Schedule 4
Pricing of Optional MMIS System Requirements (RFP Section 7.5)

Item #	Line Item Description	Fixed Price
1	**Claims Submission Software**	$
		$
		$
2	**Automated Fingerprint Capture**	$
		$
		$
3	**Thermal Identification Cards**	$
		$
		$
	GRAND TOTAL	$

12.8   ATTACHMENT H: PROGRAM INTERFACES DESCRIPTION

In specifying interfaces between the replacement MMIS and other Department programs, DHS considers five (5) major processes for potential external program interfaces:

1.) Recipient Demographic and Eligibility Data

The MMIS must have basic data for any recipients it will process claims for. This is not necessarily the same data set required for a Medicaid eligible recipient, and eligibility is meant to indicate only the program that claims can be paid from, not the full set of data required to represent Title XIX eligibility. For example, a recipient receiving DD services may only need to have the fact that they have been approved by DD rather than extensive data required for Title XIX eligibility. DHS would also want the begin and end dates for services, and identifying data such as Name, Date of Birth, Social Security Number, Gender, Recipient I.D., and Addresses. This data will tell the MMIS that the recipient is eligible to have services paid for the indicated program.

2.) Provider Enrollment Data

If the provider base for the program is not contained within the set of providers enrolled in the MMIS, an interface of provider data may be useful. This would add providers that can be paid for services by the MMIS. Like recipient data, only a subset of provider data required for Title XIX providers may be necessary for some programs. Similarly, if certifications or approvals are required for Title XIX providers before they can be paid for services provided under certain programs, that certification could also be provided through an interface.

3.) Prior Authorizations

Prior authorizations provide the MMIS with information on which services and what amount of service should be paid. Without an authorized level of service, the MMIS will pay for any service billed and any amount of service provided to an eligible recipient by a qualified provider. Where service plans or authorizations exist in a system other than MMIS, an interface can import the authorizations to MMIS. This will reduce manual entry and support the direct electronic billing to the MMIS, if the provider has electronic billing capability. If the authorization exists and is accurate, the labor intensive processes of billing a program and having the claims re-entered in MMIS can be avoided. However, the fields required by the MMIS must be available in the external system for the interface to work most effectively. Where prior authorizations cannot be imported from another system, manual entry may be required to maintain expenditure controls.

4.) Claims Receipt and Processing

The MMIS must be able to receive claims, either directly from providers or through the program that is funding the services. If the claims are received and entered into an external system, an interface will allow the claims to be imported to the MMIS without additional manual entry.

5.) <u>Payment Data</u>

After claims have been paid, the funding program is notified of the expenditure amounts, check numbers, and other financial data. To the extent that this data can be received in an electronic file, data transfer is facilitated and errors in re-entering data are minimized.

12.8.1 <u>PROGRAM-SPECIFIC INTERFACES REQUIRED</u>

For our purposes, an interface is an exchange of electronic data between two systems. This can be accomplished through direct reads between systems, electronic file transfers, or other data transfer. These electronic transfers require formatting of data and development of transfer programs. Direct data entry into one system or another is not defined as a system interface, but is defined instead as standard data entry through a user interface. The proposed method of handling the five processes required for each external program interface is as follows:

Aging Services Division:

Recipient Demographic and Eligibility Data	Aging Services Division staff or County staff will enter eligible recipients directly into MMIS. No automated interface is required.
Provider Enrollment Data	Providers will be in the MMIS system. No interface is required. However, Aging Services Division and County staff should be able to search for providers who participate in that program on-line, by geographic area and specific types of services offered. They should also be able to print search results. MMIS will continue to provide all current reports on providers to the Aging Services Division.
Prior Authorizations	There is no comprehensive authorization file that can be interfaced with now, so authorizations would have to be entered directly by County or Aging Services Division staff. However, personal services must be authorized and the authorizations are stored in the Aging Services Division database. An interface with this file should be built, or the authorizations should be entered directly into MMIS. If the interface is used, it should be expanded in the future to accommodate all Aging Services. The interface must include all required fields for an Aging Services prior authorization in MMIS. Duplicate checks for authorizations added from Aging Services Division database to MMIS will be required, and exception processes defined for cases where potential duplicates are identified.
Claims Receipt and Processing	Claims will be submitted directly by providers through standard entry points. In addition, the MMIS will interface with SAMS to receive claims.
Payment Data	Payment data will be sent to SAMS from MMIS in an electronic file, with an automatic interface process. At a minimum, the file will include all data currently sent to the Aging Services Division on hardcopy reports.
Other	The Interactive Voice Response System will continue to be used and must be supported by the MMIS.

Vocational Rehabilitation (VR):

Recipient Demographic and Eligibility Data	Entered in MMIS through an interface with VRIS. Data required must be sufficient to support MMIS payment.
Provider Enrollment Data	Provider data will be entered directly into MMIS. No interface is required.
Prior Authorizations	The VR authorizations in VRIS are not recorded at the procedure code level of detail. Providers determine what procedures may be necessary for a given service episode. MMIS would require a translator that would recognize an authorization of "Office Visit" as authorizing a range of office visits and associated services.

Alternatively, if all claims come through VR as proposed, no authorization in MMIS will be required. MMIS can assume that any claim received from VRIS is authorized and should be paid. |
| **Claims Receipt and Processing** | VR staff will receive all claims, verify that the services are appropriate, and enter the approved claim in VRIS. MMIS will receive VR claims only through an automated interface with VRIS. |
| **Payment Data** | Payment data will be returned to VRIS via an electronic file. At a minimum, the file will contain all data fields now sent to VR on hardcopy reports. |
| **Other** | 1.) VR requires that MMIS recognize a hierarchy of funding sources and pay for services from VR funds, only if Medicaid or other funding for the service is unavailable.

2.) If MMIS prices and edits in MMIS are not available to VR, they feel they would not need to process through MMIS. However, the edits are extensive and would have to be programmed on a continuing basis. In addition, this alternative would not support using Medicaid funds when they are available for funding a service.   Finally, a separate solution would not support automated recoveries in MMIS or auditing across programs to ensure that duplicate claims are not paid by different programs. |

Single Plan of Care (SPOC):

Recipient Demographic and Eligibility Data	Eligibility data for SPOC is already in VISION. The children are Title XIX eligible. No interface is required.
Provider Enrollment Data	Providers would enroll in the Title XIX program. Certification to bill for wraparound services would be entered directly by CFS staff. The system must support the ability to enter a provider as a pending wraparound provider and also support searches that allow CFS to find and update the pending records with certification.
Prior Authorizations	Authorizations in the SPOC are not consistent with the data that will be required by MMIS. It may be possible to identify which services in the SPOC are to be paid by MMIS and subsequently use a translation for converting SPOC service values to procedure codes recognized by MMIS, but the outcome would be uncertain. This may be designated as a future enhancement.
Claims Receipt and Processing	Claims are billed directly to MMIS using standard entry points. Human Service Centers (HSCs) must be able to continue to submit claims through the ROAP system.
Payment Data	Payment data will be sent to the SPOC program for recording expenditures in their customized Microsoft Access database.

Children's Special Health Services (CSHS):

Recipient Demographic and Eligibility Data	Recipient data will be entered through an interface with the PowerBuilder System. The file sent to MMIS must include all data required to process claims in MMIS and all data required by CSHS to process payment data. The replacement MMIS system may have to accept data that is in the current system.
Provider Enrollment Data	Provider data for CSHS is in the MMIS. New providers will be enrolled through the MMIS provider enrollment process. No interface is necessary.
Prior Authorizations	Authorizations will be entered in MMIS through an interface with the PowerBuilder System. The files must include all data required to process claims in MMIS. A translator may be required to convert procedure codes used in the CSHS system to MMIS procedure codes. Duplicate checks for new authorizations will be required.
Claims Receipt and Processing	Claims can be submitted directly by providers through normal entry points or submitted to CSHS. CSHS will receive paper claims and send them to Medical Services for entry and processing.
Payment Data	MMIS will produce a payment record file to return to the PowerBuilder System. The file will, at a minimum, include the data sent by the current system to CSHS in hardcopy reports.
Other	Payment data will be sent to the PowerBuilder System to record expenditures. At a minimum, the data in the files will be the same as data sent by the current MMIS to CSHS in paper reports.

Developmental Disability (DD):

Recipient Demographic and Eligibility Data	Recipient records will be entered through an interface with the ASSIST System. If the recipient is not in VISION / TECS (i.e., not Medicaid eligible), the creation of an Individual Service Plan (ISP) in ASSIST would be used to create the individual record in MMIS <u>only if</u> reimbursement of State-funded service is authorized. The MMIS will perform duplicate checks on new records received from ASSIST to ensure that the recipient is not already known to the system. The files received must include all data required by MMIS to process DD claims.
Provider Enrollment Data	No interface is required to add providers from ASSIST to MMIS. Provider IDs may have to be manually populated in ASSIST to support authorizations, but DHS may be able to develop an interface that populates the ASSIST file with Medicaid Provider IDs.
Prior Authorizations	Prior Authorizations in MMIS will be created from interfaces with ASSIST. ASSIST Case Action Screening records will create long term care authorizations in MMIS. Services approved in ASSIST ISPs will create service authorizations in MMIS. Provider ID is not on the authorized services in ASSIST and may have to be added. "Service codes" in ASSIST will have to be translated into "procedure codes" for MMIS. Duplicate checks in MMIS for authorizations added through ASSIST will be required.
Claims Receipt and Processing	Providers will submit claims directly to the MMIS through normal entry points.
Payment Data	Payment data files will be sent to the ASSIST system to report expenditures. At a minimum, the data in the files will be the same as data sent to ASSIST by the current MMIS or in financial reports.
Other	Payment rates are maintained in Lotus Notes. These should be sent to MMIS via an interface to update the MMIS rates with changes. If this interface is not possible, rate updates will have to be entered manually. At a minimum, the data required will be the service, rate, begin date, and end date.

Disability Determination Services (DDS):

Recipient Eligibility	Recipient Data will be managed through an interface from VERSA to MMIS. The interface will require all recipient data required by MMIS to process claims. DDS providers should have on-line access to edit and update recipient data.
Provider Enrollment Data	No interface is required.
Prior Authorizations	Authorization for DDS will create prior authorizations in MMIS through an automatic interface. The data included in the interface must support claims processing in MMIS.
Claims Receipt and Processing	Claims will be received by DDS and sent to Medical Services for entry into MMIS. Providers may also submit claims directly to MMIS. MMIS must be able to recognize the claim as requiring DDS funding and process according to DDS program rules. No diagnosis code is required on these claims.
Payment Data	MMIS will return a payment file to DDS reporting all claims paid for that program. At a minimum, the file must include all data currently sent from the MMIS to DSS in paper format. MMIS will continue to produce reports produced for DDS by the current MMIS.
Other	DDS requires a hierarchy in payment logic that pays claims from DDS funds when authorized. Medicaid should not be billed to pay first in a DDS claim, and Medicaid dollars should not be used to pay for a service authorized by DDS.

12.8.2 RELATED REQUIREMENTS

In the course of reviewing interface requirements with North Dakota DHS and ITD staff, several general requirements were identified or re-enforced. Some of these include requirements that have already been identified, but receive additional emphasis from the integration requirements. These include:

Prior Authorization Edits:

The Prior Authorization processes must contain edits that will mirror claims processing. If a request receives authorization, DHS should be able to pay a resulting claim. That is, DHS doesn't want to tell a provider they can render a service and then be unable to pay it. This requires:

- Program specific edits for coverage and pricing - Services covered by one program may not be covered by another. The edits should be the same as those used for claims processing.

- Program specific audits for service limits - There may be service limits within a program that must be considered in approving a request.

- Cross program audits - If a service such as a surgery or diagnostic test has been approved under one program, DHS should not duplicate and pay for the same service under another program. A provider should not be paid by two programs for the same visit or procedure. There may be some services, such as diagnostic services, that can be considered potential duplicates within a specified time frame even though different providers request the service. For example, if a recipient has had an MRI of their heart within the month, DHS may want to know that as part of the approval process.

All of these points apply to claims as well as authorizations.

Approval of Exceptional Rates:

The Prior Authorization process should be able to approve rate overrides for services when the user has proper authority. This will accommodate exceptional rates required for services to high risk or exceptional recipients.

Workflow Locations For Staff Of Non-Medicaid Programs:

Some program staff work their own claims. For example, CSHS staff adjudicate their own claims and perform some review of services. All claims for a specific program should suspend to locations accessible to the specific program staff. That is, all CSHS claims would pend to locations CSHS1, CSHS2, or CSHS3, depending on the status of edits. CSHS staff would have access to those locations, but others (such as general Medical Services adjudicators) would not. This would give CSHS the ability to access their claims without searches or sorting.

Service Sets:

Authorizations may require a service set concept. An authorization for one service implies authorization for other services. That is, an office visit authorization implies a set of tests or x-rays. This would support programs like Vocational Rehabilitation, where the prior authorization is generic and the necessary procedures are determined by the provider.

View Edits On-line:

Users should be able to view edit and audit logic on-line.

View Rates On-line:

Users should be able to view rates and effective dates on-line. This applies to generic rates, provider specific rates, and exceptional rates approved by prior authorization. Exceptional rates would include a history of values approved for services that have no standard rates and require a determination of reimbursement levels on an individual basis. For example, In authorizing a bone marrow transplant, the user may want to view the most recent ten approvals to determine whether a specific request is reasonable.

View All Errors on Claims:

Claims adjudication should display all errors on a claim rather than aborting editing or auditing after a fatal error is encountered.

Funding Hierarchy:

Claims processing requires a hierarchy of funding sources. A claim should process the highest priority source that the recipient qualifies for first. If the claim denies for edits related to approvals or benefits for that program, it should process the claim for the next highest priority. The Remittance Advice would report all edit failures logged. This may be pretty difficult to implement on a general basis and may end up being optional.

Other Considerations:

From an enterprise perspective, integration of payment in the MMIS provides advantages to DHS that will justify the cost of these interfaces. Some of these advantages include:

• Audits across programs – The system will be able to identify duplicate prior authorization requests and billing across the programs served.

• Sharing of medical information – The system will be able to identify near duplicates in diagnostic tests and other services across programs. When programs enter or interface with Prior Authorization, the MMIS can provide an integration point that prevents unnecessary duplication of services. This could be overridden, as most possible duplicates should be. This would show up in the authorization stage and could be resolved before a service is provided or a claim submitted.

• Consistent pricing – The MMIS provides consistent pricing across programs where desirable.

• Maximization of external funding – The MMIS should be able to identify the best source of funds for a service and maximize external funding, including TPL for program participants with VISION / TECS records. If TPL can be recorded for non-Title XIX recipients, the maximization of TPL for those recipients would also be possible.

• Electronic Billing – If prior authorizations are integrated with MMIS, providers can bill for services to non-Title XIX recipients electronically. This should reduce staffing costs and improve timeliness of provider payments.

12.9   ATTACHMENT I: CURRENT HARDWARE LIST

The VISION, TECS, and MMIS systems all presently run on the State's z/OS Mainframe platform.

J2EE: WebSphere 5.1.x running on RedHat Enterprise 3.0; Intel-based hardware.

.NET: IIS6 running on Windows 2000 Server; Intel-based hardware. This will be migrating to Windows 2003 sometime within the next year.

Oracle: Solaris v8 running on Sun v880 hardware.

SQL Server: Windows 2000 Server on Intel-based hardware.

12.10 ATTACHMENT J: PROGRAM STATISTICS

Statistic	CY 2000 Actual	CY 2001 Actual	CY 2002 Actual	CY 2003 Actual	CY 2004 Actual
Total Pharmacy Services Claims	1,166,507	1,252,635	1,435,790	1,470,950	1,381,763
Total Pharmacy Services Expenditures (includes rebates)	$30,186,107	$35,162,327	$41,599,151	$40,759,110	$45,974,797
Total Other Medical Services Claims	1,185,294	1,185,832	1,389,933	1,321,767	1,597,405
Total Other Medical Services Expenditures	$357,355,852	$380,215,799	$413,925,773	$408,369,678	$454,407,313
Total MCO Encounters	4,512	4,993	1,351	11,113	9,092
Average Monthly Volume of Pharmacy Prior Authorizations	N/A	N/A	N/A	N/A	175
Average Monthly Volume of Other Medical Prior Authorizations	N/A	N/A	N/A	N/A	N/A
Average Monthly Caseload of Eligibles (SFY)	42,145	43,117	46,342	53,134	52,829
Average Monthly Enrollment in PCP	22,869	23,330	30,186	33,300	33,950
Average Monthly Enrollment in Managed Care Organization	679	487	474	757	813
Average Monthly Enrollment in SCHIP (Healthy Steps)	N/A	1,352	2,338	2,487	2,152
Average Monthly Provider Applications	101	147	153	124	165
Average Monthly Provider Services Call Volume	18,000	18,000	20,699	24,350	23,630
SURS Desk Audits Recoupment Dollars	$60.778	$72,928	$61,731	$314,165	$312,891
Average Volume of Eligibles with Third-Party Coverage	N/A	22,508	25,918	27,697	27,225
Annual Other Insurance on Paid Claims	N/A	N/A	N/A	$17,970,755	$22,298,192
Annual Current TPL Recovery Dollars	$ 3,043,589	$6,337,822	$6,351,986	$8,745,681	$13,300,259
Annual Estate Recovery	1,153,435	1,096,399	1,259,935	477,542	591,933

12.11 ATTACHMENT K: RECIPIENT ELIGIBILITY IN MMIS

As indicated in the Business Needs section, the MMIS will include a master index file that assigns an MMIS ID to all recipients added to the MMIS system. The first time that VISION / TECS adds a new recipient to MMIS, MMIS will assign a MMIS ID to the recipient from a sequential number generator and the cross-reference file will be populated with the Medicaid ID (from VISION / TECS). Graphically, this will appear as follows:

Figure 6: Architecture for Recipient Data
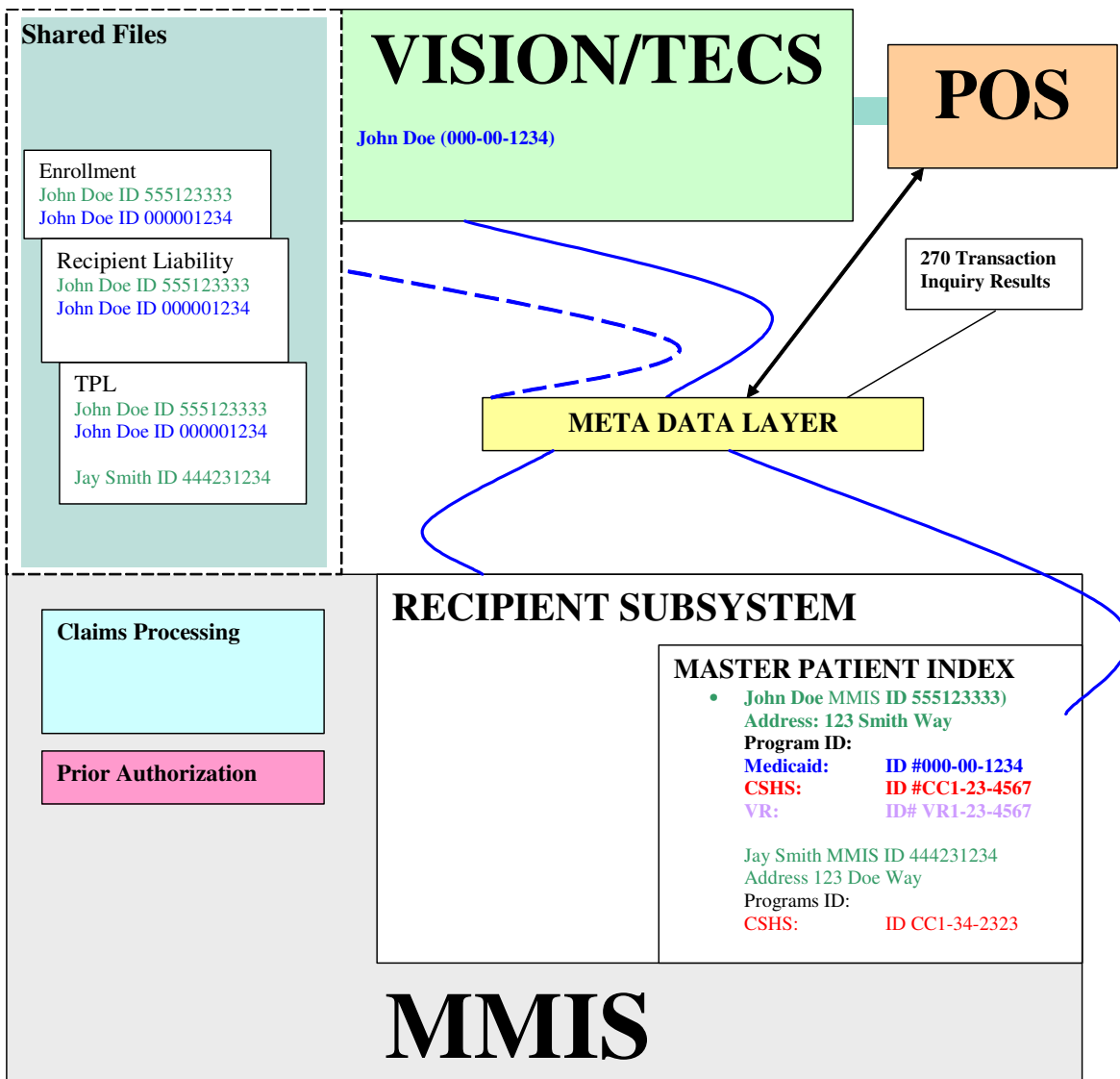
The ID index cross-reference is depicted within the MMIS because it will be controlled by the MMIS operations and will logically be within the MMIS. However, the actual index could reside in the metadata layer if that provides the best technical solution.

The shared tables would be accessed directly by either the VISION / TECS or the MMIS systems.

12.12 ATTACHMENT L: MITA BUSINESS PROCESS MODEL CROSSWALK

MITA BUSINESS PROCESS MODEL	CORRESPONDING NORTH DAKOTA RFP SECTION(S)
Member Management	*7.2.2 - Recipient Services*
Eligibility Determination	*Done at the County level
Enrollment	7.2.2.1 - Eligibility 7.2.9.3 - Process Enrollment
Member Information Management	7.2.2.2 - Third Party Liability 7.2.2.3 - Waivers and Special Programs 7.2.2.4 - EPSDT 7.2.2.5 - Recipient Liability/Copayment
Member Support	7.2.10 - Call Management
Provider Management	*7.2.1 - Provider Services* *7.2.10 - Call Management*
Contractor Management	
Health Services Contracting (PCCM, PCP, MCO, PBM, etc.)	7.2.9.1 - Maintain Managed Care Entities
Administrative Contracting (Enrollment, Brokers, QRO, FA, FI, etc.)	*N/A for this RFP
Contract Information Management	*State Responsibilities
Contractor Support	*State Responsibilities
Operations Management	
Payment Management	
Payment and Reporting	7.2.8 - Make Payment
Claims and Encounter Adjudication	7.2.3.2 - Edits and Audits 7.2.9.7 - Process Encounters 7.2.5.2 - Claims Processing and Adjudication 7.3.1.3 - Pharmacy Claims Processing and Adjudication 7.3.1.4 - Pharmacy Edits and Audits
Capitation and Premium Preparation	7.2.8 - Make Payment 7.2.9.5 - Support Managed Care Payments
Payment Information Management	7.2.5.2 - Claims Processing and Adjudication
Member Payment Management	7.2.2.5 - Recipient Liability/Copayment
Cost Recoveries	7.3.3.1 - Drug Rebate Invoicing 7.3.3.2 - Drug Rebate Tracking 7.3.3.3 - Drug Rebate Payment
Service Authorization	7.2.4 - Prior Authorization 7.2.9.4 - Process PCP Authorization 7.3.1.1 - Pharmacy Prior Authorization

MITA BUSINESS PROCESS MODEL	CORRESPONDING NORTH DAKOTA RFP SECTION(S)
Program Management	
Benefit Administration	7.2.3.1 - Rates and Fee Schedules 7.2.3.2 - Edits and Audits 7.2.3.2 - Data Maintenance and Updates 7.2.9.1 - Maintain Managed Care Rules 7.3.1.4 - Pharmacy Edits and Audits
Program Administration	*State Responsibilities
Budget	*State Responsibilities
Accounting	7.2.8.2 - Post Accounting Data
Program Quality Management	7.2.7 - Utilization Management 7.2.9.6 - Record and Enforce Penalties/Sanctions 7.3.2.1 - ProDUR 7.3.2.2 – RetroDUR
Program Information	7.2.3.2 - Edits and Audits 7.2.5.2 - Claims Administrative Reporting 7.2.6 - Administrative Reporting 7.2.8.3 - Financial Reporting 7.2.9.8 - Stop Loss/Risk Mitigation 7.2.9.9 - Managed Care Reporting 7.4.1.1 - Data 7.4.1.2 - Analytics 7.4.1.3 - Queries and Reporting
Care Management	
Manage Medicaid Population Health	*State Responsibilities
Establish Case	*State Responsibilities
Manage Case	*State Responsibilities
Manage Registry	*State Responsibilities
Program Integrity Management	
Identify Case	*State Responsibilities
Establish Case	*State Responsibilities
Manage Case	*State Responsibilities
Business Relationship Management	
Establish Business Relationship	*State Responsibilities
Manage Business Relationship	*State Responsibilities
Manage Business Relationship Communications	*State Responsibilities
Operations Support	
Privacy and Security Management	*State Responsibilities
Transaction Processing	7.2.5.1 - Claims 7.2.11 - Workflow Management 7.2.12 - Document Receipt and Control 7.3.1.2 - Pharmacy Claims Entry