

SECTION 3: SCOPE OF WORK

This section describes the requirements of the Oklahoma Medicaid Management Information System (MMIS) and the tasks required to design, develop, install, test, implement, operate, modify, maintain, and turnover an MMIS for the State of Oklahoma. Requirements are divided into the following ten (10) areas:

- o Data Processing Requirements,
- o General Operations Requirements,
- o MMIS Functional Requirements,
- o Project Administration and Controls,
- o Development and Implementation Task Requirements,
- o Operations Task Requirements,
- o Maintenance Task Requirements,
- o Modifications Task Requirements,
- o Turnover Task Requirements, and
- o Organization and Staff Requirements.

The MMIS Technical and Functional Capabilities section of the bidder's proposal must describe the way each requirement presented in this section will be met. Additional information about proposal submission requirements and the instructions for addressing the various types of requirements are contained in ITB Section 4. The evaluation methodology is described in more detail in ITB Section 5 of this ITB.

The contractor's approach to meeting these requirements and to performing these tasks must enable the MMIS to:

- o meet or exceed all requirements in 42 CFR 433, Subpart C and Part 11 of the State Medicaid Manual;
- o meet or exceed federal MMIS certification standards;
- o obtain recipient eligibility information from the Oklahoma Department of Human Services (DHS) Eligibility System (PS/2);
- o interface with and provide data to the OHCA Decision Support System/Data Warehouse (DSS/DW);
- o provide the information and processing capabilities necessary to support the Health Insurance Portability and Accountability Act of 1996 (HIPAA) including all accepting and sending all electronic data interchange (EDI) formats;
- o meet or exceed all functional requirements identified in the ITB; and
- o facilitate the implementation of future program initiatives.

In addition, the contractor must provide staffing and expertise required by OHCA to more efficiently operate Oklahoma Health Care Authority Programs as described in Subsection 3.6 of this ITB.

3.1 DATA PROCESSING REQUIREMENTS

The following subsections present data processing requirements which the contractor must meet during design, development, implementation, and operation of the Oklahoma MMIS and the optional DSS/DW.

3.1.1 SECURITY, CONFIDENTIALITY, AND AUDITING

The contractor must ensure that the system provides for safeguarding of data and for physical security of the contractor's processing facility(s). It shall incorporate features for maintaining program integrity so the fiscal capabilities of the system are not abused. Additionally, the system shall provide for access control to data and system software. Finally, adequate backup and recovery features are required to ensure that the service delivery function can continue in cases of system unavailability and that the system can be reconstructed in the case of a failure or disaster at the contractor's data processing facility.

The contractor shall ensure that the MMIS development and operations are in accordance with state and federal regulations and guidelines related to security, confidentiality, and auditing. Relevant publications include:

- o Automatic Data Processing Physical Security and Risk Management (FIPS PUB 31),
- o Computer Security Guidelines for Implementing the Privacy Act of 1974 (FIPS PUB 41),
- o Guidelines for Security of Computer Applications (FIPS PUB 73), and
- o Federal Regulations at 45 CFR 95.621.

In addition, the contractor must ensure that the MMIS operates in accordance with the final rules adopted under HIPAA for security and privacy.

The contractor shall further ensure that the system design facilitates auditing of computer files and paper records and that audit trails are provided throughout the system, including any conversion programs. Specific requirements related to security, confidentiality, and auditing are detailed in the following subsections.

3.1.1.1 On-Line and Application Security

The contractor shall design and implement various levels of security within the MMIS on-line applications, including, but not limited to, the following features:

- o unique log-ons for each user;
- o required passwords that will expire on a staggered schedule and that can be changed at any time by appropriate state or contractor management personnel;
- o restriction of application and/or function within application to specific workstations, workstation port, or application server;
- o restriction of application and/or function within application to specific log-ons;
- o audit trails, as described in ITB Subsection 3.1.1.5 below, of all update transactions by user log-on, date and time entered, and source of entry (workstation), including all attempted transactions;
- o access control to all data and to the applications software; the system shall employ a security system that restricts access to varying hierarchical levels of data and function; the security system must restrict access to data on a "need to know" basis and restrict functions based on an individual user profile, including inquiry only capabilities; global access to all functions must be restricted to specified staff;
- o the system shall provide for the same hierarchical password protection, as well as a system-inherent mechanism for recording any change to a software module or subsystem. The contractor shall propose procedures for safeguarding the state from unauthorized modifications to the MMIS. Finally, technical security shall be provided to prohibit unauthorized access to the communication network, and
- o all security features utilized throughout the MMIS and DSS/DW must be compliant with HIPAA security provisions.

3.1.1.2 Physical Security

Regardless of the equipment configuration, effective physical security measures must be implemented and maintained for all proposed MMIS equipment sites, processing areas (including the mailroom), and secured storage areas. At a minimum, the MMIS contractor must restrict perimeter access to equipment sites, processing areas, and storage areas through a card key or other comparable system, as well as provide accountability control to record access attempts, including attempts of unauthorized access. Physical security shall include additional features designed to safeguard processor site(s) through

required provision of fire retardant capabilities, as well as smoke and electrical alarms, monitored by security personnel.

The security plan will be implemented during the software development phase and adapted to use during MMIS implementation and operations.

3.1.1.3 Program Integrity

The contractor shall provide adequate system safeguards to deter potential program abuse. The first required feature is system identification of the source of any request to add, change, or delete system files. This feature, combined with required reporting capabilities, will provide state and contractor supervisory and management personnel with a mechanism for analyzing actions of an individual worker. Additionally the system shall randomly select claim records to support quality control and audit capabilities.

The integrity and confidentiality of recipient and all other data must be protected by safeguards to assure that information is not released without proper consent. Further, all individuals having access to the confidential data must agree in writing to abide by state and federal rules and policies related to confidentiality.

3.1.1.4 Backup and Recovery

It is critical that a plan including procedures, physical equipment, and facilities is in place to reconstruct the MMIS and data should a disaster strike any processor site. Regardless of the physical architecture of the MMIS, the contractor shall develop an adequate backup and recovery plan.

At a minimum, there are three types of situations which could arise, and which must be addressed by the contractor to ensure ongoing operations.

- o The first type is major disaster where the central computer installation and resident software are destroyed or damaged. The contractor must identify and provide alternative facilities and backup to ensure continuation of operations as a part of a comprehensive disaster recovery plan.
- o The second type of problem is system or application dependent resulting from network failure, software error, or operational errors where one or several days' processing is invalid, making data on the master file(s) also invalid. The contractor must provide a plan that addresses the restoration of program and data integrity.
- o The third type of situation is caused by system down time. The contractor must maximize system availability at the local level. Down time, caused by the failure of one or more components of the MMIS application software, must be resolved and the restoration of services implemented within four (4) hours of the failure.

Differences in the level of backup and recovery abilities exist for the DSS/DW, Eligibility Verification and Provider Inquiry System, and the PRO-DUR/ECM System. They are addressed as follows:

- o The contractor must provide back up for DSS/DW that will enable complete recovery of the hardware and software environment within five (5) calendar days.
- o The contractor must maximize the Eligibility Verification and Provider Inquiry System and PRO-DUR/ECM System availability within the State of Oklahoma. Down time, caused by the failure of one or more components of any of the application software, operating system, hardware and so forth, must be resolved and the restoration of services implemented within 30 minutes of the failure.

3.1.1.5 Audit and Control Requirements

Audit and control considerations are especially important where a large number of staff with diverse skill levels and responsibilities interface directly with the system. Audit and control features apply to all areas of a system and shall, therefore, be considered an integral part of the overall system architecture. The audit and control requirements for the MMIS are described below in terms of data control, error correction, and audit trails.

The MMIS shall contain a sufficient number of controls to maintain data and information integrity. MMIS must provide three types of controls:

- o **Preventive Controls:** Controls designed to prevent errors and unauthorized events from occurring,
- o **Detective Controls:** Controls designed to identify errors and unauthorized transactions which have occurred in the system, and
- o **Corrective Controls:** Controls to ensure that the problems identified by the detective control are corrected.

These controls shall be in place at all appropriate points of processing.

Audit trails shall be incorporated in the system to allow information on source documents to be traced through the processing stages to the point where the information is finally recorded. The ability to trace data from the final place of recording back to its source document shall also exist. These audit trails may be supported by listings, transactions reports, update reports, transaction logs, and error logs.

The contractor must ensure that the system facilitates auditing of individual claim records. This must be accomplished by creating audit trails throughout the system and conversion programs that identify and track changes to master file data and to all edits and audits encountered, resolved, or overridden.

Global overrides of edits and audits shall be permitted only by written prior approval of the state. Use of other overrides must be documented and approved in edit disposition manuals. Only authorized operators may override edits and audits. The contractor must create and maintain an audit trail of all override transactions which must identify overrides by log-on identification (ID), workstation ID, date, and time.

Changes to prices, reference files, recipient eligibility, TPL, and provider file data and financial transactions must be strictly controlled and appropriate audit trails maintained. These audit trails must contain the unique log-on ID (or batch update identifier), workstation ID, date, and time of the change. All updates to MMIS files and all error (rejected) update or replacement transactions must be reported to the state.

Each record changed must be updated with the date of the change and the identification of the person making the change. These dates and identifications must display on any on-line inquiry screens and reports showing file data. Log on ID must be used for document and change authentication.

3.1.1.6 Security Administration

Security features are only effective if utilized in conjunction with a prescribed security plan. It is the state's intention to monitor the contractor's security administration to ensure that the features built into the system are continuously effective. This security maintenance function will include periodic review of processing site(s) as well as periodic changes in passwords. In addition the contractor will be required to periodically, no less than annually, test backup and recovery plans through simulated disasters and lower level failures and provide training to state staff on security procedures.

3.1.2 HARDWARE AND SOFTWARE

The following identifies the hardware and software requirements.

3.1.2.1 Data Communications

The vendor shall provide single router point of entry for OHCA and “load balanced” service to the OHCA router. The vendor must provide a hot site LAN back up environment that includes connectivity between the contractor and the OHCA LAN/WAN infrastructure.

3.1.2.2 Eligibility Verification and Provider Inquiry System Software and Equipment

The contractor must provide the appropriate software and hardware to support the requirements of the eligibility verification and provider inquiry function. Direct input must be accepted from a variety of devices including PCs, touch-tone phones, and appropriate response for the access device must be provided. Also, the contractor should evaluate the potential for using the Internet and web-based applications as an alternative or additional methodology. If provider telephone equipment does not permit access to the audio response mechanism, the contractor may provide voice recognition equipment or use a human operator to answer these requests for recipient eligibility information. In addition the telephone system must be capable of recognizing both numeric and alphanumeric input.

3.1.2.3 Contractor Provider Relations Field Access

Contractor Provider Relations staff shall have access to an adequate number of portable PCs and remote access to enable them to access MMIS provider records and claims history during field visits for initial provider training.

3.1.2.5 Technical Baseline

The vendor shall comply with established OHCA product and technical baseline standards for the LAN, Internet, and desktop environment. OHCA will consult with the vendor about OHCA proposed upgrades and modifications to baseline standards.

OHCA must approve of contractor proposed upgrades and modifications to baseline standards. OHCA will make final decision on all proposed upgrades and modifications to baseline standards including the implementation schedule.

Current OHCA baseline standards are:

- o platform - Windows 9.X and Windows NT Service Pack 5, if Windows NT workstation is used must conform to Service Pack 5,
- o installation must proceed from a single executable without any manual configuration of registry settings,
- o application must log into windows API,
- o must provide control panel add/remove uninstall program, which must,
- o remove entirely except for shared components and data files, and
- o printing must access NT print services and network print shares.

3.1.2.8 Imaging

The contractor shall assume responsibility for maintaining current imaging files, including providing OHCA access and retrieval, or for any new imaging environment proposed to meet the functional requirements of this ITB, the contractor must converting historical images to the new environment and provide OHCA with access and retrieval capability.

3.1.3 SYSTEM RESPONSE TIME

The following subsection describes response time definitions and requirements.

3.1.3.1 System Response Time Definitions

Response time shall be measured during normal working hours, which are 7:00 a.m. to 6:00 p.m., Central Time, Monday through Friday, and on Saturdays 8:00 a.m. to 12:00 p.m., Central Time, except for state holidays; except the Eligibility Verification and Provider Inquiry System and the PRO-DUR/ECM System Response times which will be measured 7 days a week, 24 hours a day, except during agreed upon downtime. The response time definitions do not apply to the optional DSS/DW.

These definitions apply to networked workstations.

- o **Record Search Time** - The time elapsed after the search command is entered until the list of matching records begins to appear on the monitor.
- o **Record Retrieval Time** - The time elapsed after the retrieve command is entered until the record data begin to appear on the monitor.
- o **Screen Edit Time** - The time elapsed after the last field is filled on the screen with an enter command until all field entries are edited with the errors highlighted.
- o **New Screen Page Time** - The time elapsed from the time a new screen is requested until the data from that screen start to appear on the monitor.
- o **Print Initiation Time** - The elapsed time from the command to print a screen or report until it appears in the appropriate queue.
- o **Eligibility Verification and Provider Inquiry System Response Time** - The elapsed time from the establishment of a connection until an inquiry response begins to appear or be heard on the access device. Note the following exception, for inquiries through a switch vendor the elapsed time traveling through the switch vendors network will not be included.
- o **PRO-DUR/ECM Response Time** - The elapsed time from the receipt of the transaction by the contractor from the switch vendor until the contractor hands-off a response to the switch vendor.

3.1.3.2 System Response Time Requirements

The contractor shall ensure that response times listed below meet the following minimum standards. Times will be measured for adherence to the requirements every 15 minutes during randomly selected days several times per month, at the state's discretion, at a remote workstation. In addition, the contractor must provide a system to monitor and report on response times. The response time requirements do not apply to the optional DSS/DW.

- o **Record Search Time** - The response time must be within four (4) seconds for 95 percent of the record searches.
- o **Record Retrieval Time** - The response time must be within four (4) seconds for 95 percent of the records retrieved.
- o **Screen Edit Time** - The response time must be within two (2) seconds for 95 percent of the time.
- o **New Screen/Page Time** - The response time must be within two (2) second for 95 percent of the time.
- o **Print Initiation Time** - The response time must be within two (2) seconds for 95 percent of the time.
- o **Eligibility Verification and Provider Inquiry System Response Time** - The response time must be within four (4) seconds for 95 percent of the time.
- o **PRO-DUR/ECM Response Time** - The response time must be within four (4) seconds for 95 percent of the time.

3.1.4 SYSTEM ACCESS, DISPLAY AND NAVIGATION

The MMIS must incorporate user friendly systems navigation technology and a GUI that allows all MMIS users to move freely throughout the system using pull down menus, window tabs, and “point and click” navigation. In addition, the navigation process must be completed without having to enter identifying data multiple times. “Help” screens must be included and should be context-sensitive in order to provide for ease of use. The use of GUI access must be standardized throughout the MMIS. The system must contain a user friendly menuing system, understandable by-non-technical users, that provides access to all functional areas. This menuing system must be hierarchical and provide submenus for all functional areas of the MMIS. However, the menuing system must not restrict the ability of experienced users to directly access a screen, or the ability to access one screen from another without reverting to the menu structure. Menus should reflect the hierarchical or tree structure of the screens. Each menu item may indicate a list of screens or a list of submenus to indicate screen dependencies to the users. The system should remain available to the user from log on to system log off, without the need for intermediate system prompts. The display must provide for both upper and lower case alphabetic characters. These system access,

display and navigation requirements must be standard for all users of the MMIS, including users from other agencies and entities.

3.1.5 CONSISTENCY OF DATA IN THE SYSTEM

The state requires the contractor to provide a system that will assist the workers with their jobs and minimize confusion. Therefore, the state mandates the following standards must be used for all screens, windows, and reports.

- o All headings and footers must be standard.
- o Current date and time must be displayed.
- o All references to dates must be displayed consistently throughout the system. Century must be displayed and the date format must be mm/dd/yyyy. See ITB Subsection 3.1.6 for further century date requirements.
- o All data labels and definitions used must be consistent throughout the system and clearly defined in user manuals.
- o All MMIS generated messages must be clear and sufficiently descriptive to provide enough information for problem correction and be written in full English text. For example, Explanation of Benefits, HCPCS definitions, and diagnosis definitions should be written completely and in English.

3.1.6 CENTURY DATES

The MMIS shall be designed so stored dates identify the century.

3.1.7 SYSTEM INTERFACES

The MMIS shall accept and send data on-line and using removable electronic media from other state agencies and other external sources in the format required by the agency or device. Although the primary responsibility for management of the Oklahoma Medicaid program and the operation of the MMIS lies within OHCA, several divisions within other State agencies interface with the operation of the MMIS. The table below, *Table 3-1: MMIS Interfaces* lists these entities and indicates whether the nature of the interface is to input data to the MMIS or receive output (reports or tapes), or if the entity is involved in actual processing of MMIS data:

**Table 3-1:
MMIS INTERFACES**

Agency or System Interface	MMIS Process
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	<u>Input</u>	<u>Output</u>	<u>Processing</u>
Data Services Division (DHS)	X	X	X
Family Support Services (DHS)	X	X	
Audit and Review (OIG)		X	
Aging Services Division (DHS)	X	X	
Office of Finance (DHS)	X	X	
Office of Management Services –Research, Evaluation, and Statistics Unit		X	
Department of Rehabilitation Services	X	X	
Development Disability Services Division (DHS)	X	X	
Children and Youth Services (DHS)		X	
Oklahoma Juvenile Justice		X	
Department of Mental Health	X	X	
Department of Health	X	X	
University of Oklahoma College of Pharmacy	X	X	X
Oklahoma Foundation for Peer Review	X	X	

Information on interface requirements is included under the "Interface" subheadings in ITB Subsection 3.3, MMIS Functional Requirements as appropriate. The data element dictionary, record layouts, and operating environment for the interfaces can be made available.

3.1.8 SYSTEM FILES

All MMIS files, programs, and data must be available to the state or federal government upon request. The contractor must provide equipment and on-line inquiry access, to all files, programs, and data at the contractor's local facility to authorized state personnel. In addition to any files and/or extracts of files that are regularly scheduled to be delivered to the state, the contractor must provide a copy of any other file, along with documentation of its format, within five (5) working days of a written request from the state. Each file request shall identify the files and the version, the "as of" date, sequence,

media, and number of copies. The contractor shall receive no additional compensation for production and delivery of such files.

3.1.9 SOFTWARE AND HARDWARE COMPATIBILITY

All GUI front-end, database, middleware, and communications software must be written in languages approved by the state and compatible with the state computing environment. Alternate languages may be proposed with the understanding that they must be approved by the state. At the time of any turnover, the contractor must take any actions necessary, including software and data conversion, to enable the MMIS to be fully operational in the state computer environment.

The contractor's telecommunications network must be compatible with state standards for platforms and interconnections unless there are mutually agreed upon exceptions.

A listing of state approved languages and standards is available in the procurement library.

3.2 GENERAL OPERATIONS REQUIREMENTS

This subsection describes general requirements for contractor support of ongoing contractor and MMIS-related operational activities.

3.2.1 LOCATION OF CONTRACTOR OPERATIONS

The state will not provide any office space or facilities to the contractor. The contractor must identify where (location) each MMIS-related and contractor service function will be performed. The state requires that the contractor maintain a facility within a five (5) mile radius of OHCA offices throughout the term of the contract.

The following functions must be performed at the Oklahoma City area facility:

- o contract administration/state liaison (key personnel);
- o claim records receipt, prescreening, and putting claim records and other documents to microform;
- o data entry (hard-copy and electronic media claims [EMC] transactions) may occur at the contractor's Oklahoma site or another location at the approval of the state;
- o edit/audit claim records processing (suspense resolution);
- o system modifications (at a minimum, a Modification Task Manager and eight (8) programmer/analysts);

- o business operations (check requests to OHCA, Financial Services, accounts receivable handling, cash activity, check/RA mailing);
- o production of newsletters, manuals, and bulletins;
- o storage of paper claim records and other required documents at the contractor's staff site and not a remote storage location;
- o provider relations, enrollment and training; and
- o report printing on laser printers on paper size specified by the state.

The contractor may perform other MMIS functions, including computer processing, outside of the Oklahoma City, Oklahoma area but within the continental United States. The site of the Oklahoma office and all MMIS computer processing sites must be approved by the state.

3.2.2 MMIS EQUIPMENT AND OFFICE NEEDS

The contractor must provide all equipment and software necessary for it to successfully transfer, develop, test, operate, and maintain the MMIS. The contractor is responsible for site preparation for its Oklahoma project office. Also, the contractor must supply all hardware and software to connect to the State of Oklahoma WAN.

The State of Oklahoma has a well-developed hardware and software environment infrastructure, described in Subsection 3.1.2, and is not requesting that the contractor supply workstations or printers to the user community. The contractor will be required to supply the necessary MMIS software that will be required by the MMIS users beyond their standard configuration which is outlined in the Procurement Library. The state does require that the contractor supply the following in accordance to requirements specified:

- o at least one thousand (1,000) contiguous square feet of standard office space with one separate enclosed office within the space for exclusive use by OHCA staff;
- o standard office equipment, including personal computers, for ten (10) state staff at the contractor's Oklahoma project office during the Development and Implementation Task, and for two (2) state staff during the operations phase; two (2) printers, one being high speed; office furniture, telephone service, use of a photocopier and facsimile machine within the near vicinity of the OHCA space, and access to a meeting/conference room facility by appointment;
- o all required software and hardware to connect to the OHCA LAN for concurrent access of twenty (20) OHCA staff, using their state supplied workstations, to the contractor's MMIS system test region during the Development and Implementation Task and to the dedicated MMIS

integrated test facility during both Development and Implementation Task and the operations phase;

- o five (5) designated parking spaces must be provided for OHCA staff;
- o all telephones are part of the Contractor's phone system and must be connected to the Contractor's switchboard, with a separate Oklahoma pickup group. Voice mail must be provided. The contractor shall pay phone costs;
- o workstations must be configured as a Local Area Network connected to the State LAN/WAN infrastructure. The PCs must contain Pentium III or above, 64 K ram with appropriately sized hard drives to contain the following software configuration and expected data that will be accumulated during the course of their useful existence. The PCs must be additionally configured with CD/DVD drives and a system to backup their data content on a weekly basis. There must be sufficient electrical outlets to accommodate these and other general electrical requirements;
- o the Contractor will be responsible for installing and maintaining data lines for their PC network; and
- o all equipment supplied for MMIS-related activities must be configured in the most optimal manner and in conformance with the Information Services Division (ISD) standards. The ISD standards will be made available through the procurement library. Also, if during the Development and Implementation Task or the operations phase, it is determined that additional contractor maintained equipment or software is required to meet the stated MMIS performance requirements, the contractor will supply it at no additional cost to the state.

3.2.3 TELECOMMUNICATION ACCESS AND SUPPORT

The contractor shall provide access to MMIS files via telecommunications links. All equipment and network hardware and software required to interface with state systems must meet ISD telecommunications and interface standards. In addition, the contractor must provide general telecommunications technical support through a help desk, for such issues as trouble shooting, device resets, and network problems. The ISD standards will be made available through the procurement library.

3.2.4 SCREEN INITIATED ON-LINE DATA UPDATES

The contractor must provide on-line updates to files and tables. All on-line updates must have built-in edits and audit trails to ensure that data integrity is maintained throughout the MMIS. The MMIS must distinguish between inquiry and update from a screen/security standpoint. Users permitted inquiry privileges only will not be permitted to modify data. Drop down lists must be available to identify the options associated with all screen fields, and help screens must be available to facilitate completion of on-line

updating by staff. The MMIS and the optional DSS/DW, if selected by the State, at a minimum, must be available for state use on all state work days from 7:00 a.m. to 6:00 p.m., Central Time, Monday through Friday, on Saturdays between 8:00 a.m. to 12:00 p.m., Central Time, or, during overtime hours, as requested by the state.

3.2.5 SCREEN INITIATED ON-LINE INQUIRIES

The system must have on-line inquiry to all MMIS files. The MMIS must include the capability to query data on-line for provider, recipient (including PS/2), reference, claims, encounter records, and so forth using multiple parameters. For example, the contractor must provide the ability to query claim records information by provider identification, recipient identification, date of service, date of payment, procedure code, provider type, or any other element in the claim record, either in combination or separately. Inquiry screens must not allow the update of data on the screen. The use of the same screens for update and inquiry is permitted providing all data fields are protected from update when the screen is in inquiry mode. The security requirements identified in ITB Subsection 3.1 must be strictly adhered to for all inquiry only screens.

When users request printing of claim records or other data from on-line inquiry screens, the system shall be capable of identifying the number of pages that will be produced if the request is activated. This feature must prevent unintentional printing of data.

3.2.6 SYSTEM AND USER DOCUMENTATION

The contractor must develop, prepare, print, maintain, produce, and distribute MMIS System Documentation, MMIS User Manuals, and Oklahoma Health Care Authority Provider Manuals. The state will develop the policy and regulations section of Oklahoma Health Care Authority Provider Manuals. The contractor is responsible for drafting both provider specific billing instructions, as well as general billing instructions that are used by all provider types for the provider manuals and the Eligibility Verification and Provider Inquiry System.

MMIS User Manuals and Oklahoma Health Care Authority Provider Manuals will be prepared in draft form during the Development/Testing subtask and in final form during the Acceptance Testing subtask. During the Operations and Maintenance and Modifications Tasks, updates to MMIS System Documentation, MMIS User Manuals, and Oklahoma Health Care Authority Provider Manuals must be developed by the contractor. However, policy updates will remain the responsibility of the state. The contractor is responsible for preparing and printing **all** revisions, in final form, for all changes, corrections, or enhancements to the system and/or medical assistance program, prior to state sign off on the system change. The contractor will be responsible for the production and distribution of all MMIS User Manual and Oklahoma Health Care Authority Provider Manual updates. Distribution of MMIS User Manuals will be to designated state staff. Distribution of Oklahoma Health Care Authority Provider Manuals will be to all providers enrolled for Oklahoma medical assistance programs,

state staff, and any agency, organization, and/or person specified by OHCA. All manuals must be available in electronic format that is compatible with state standards.

The contractor is responsible for developing and providing to the state complete, accurate, and timely documentation of the MMIS. Four (4) copies of the MMIS System Documentation must be provided within thirty (30) days following state acceptance of the MMIS during the Implementation subtask. State acceptance will not be given and the final System Documentation cannot be delivered if portions of the MMIS are not functioning properly. During the Operations and Modifications Tasks, updates to the four (4) paper copies and an electronic copy, in a format that is compatible with state standards, of the MMIS System Documentation must be provided prior to state sign off on the system change.

MMIS User Manuals will also be provided in electronic form as a part of an on-line help facility which will provide complete and up-to-date information concerning access to all MMIS functions as well as system, navigation, printing, and reporting information.

3.2.7 SYSTEM CERTIFICATION

The MMIS which is implemented as a result of this procurement must meet all federal standards and possess all functional capabilities required by HCFA for certification, as described in Part 11 of the State Medicaid Manual and in 42 CFR 433, Subpart C. Costs, other than those for State staff, incurred to obtain federal certification are to be borne by the contractor.

3.2.7.1 Federally Required Functions

The MMIS must perform functions and possess capabilities required by HCFA at the time of certification.

3.2.7.2 Federally Required Data Elements

The MMIS must include all data elements identified in Part 11 of the State Medicaid Manual, and those data elements required at the time of certification.

3.2.7.3 System Performance

The system must meet all performance requirements and standards contained in this ITB. It must also be capable of producing samples, reports, and other documentation that may be required for HCFA review.

Performance requirements for some Operations Task responsibilities are identified in ITB Subsection 3.6. Failure to meet performance expectations could result in corrective action being initiated under the provisions of ITB Subsections 6.7 Liquidated Damages – Failure To Meet Performance Requirements.

3.2.8 ELECTRONIC MAIL/COURIER SERVICE

All contractor staff must have electronic mail (e-mail) capability for receiving email from OHCA staff and sending email to OHCA staff through the internet. The e-mail system must be capable of attaching and sending documents created using other software products, including OHCA's currently installed version of Microsoft Word 97 and any subsequent upgrades adopted by the state.

For communications that cannot be sent via electronic mail and report delivery and so forth, the contractor must provide courier service to and from the OHCA state facility twice each day. One courier service run must be in the morning and one in the afternoon. Delivery at the OHCA site must be made by the courier to each functional unit.

3.2.9 MMIS OPERATIONS

The contractor will be responsible for the operation of the MMIS. OHCA requires that the contractor provide suitably qualified personnel resources, facilities, and supplies necessary to support the production and operation of the MMIS and also meet the requirements and performance standards described in this ITB.

3.2.9.1 Production Operations Support

Production operations support includes the managerial and technical services required to manage and operate the MMIS. Specific requirements include scheduling and monitoring batch production runs, including actively participating in the scheduled production meetings; facilitating LAN and WAN connectivity for the MMIS; administering the data base; and performance tuning.

The state expects that the contractor shall provide all services associated with Production Operations Support including, but not limited to, the following activities:

- o batch cycle scheduling specifications, including job turn-around time monitoring and problem resolution;
- o data base administration;
- o problem identification and resolution;
- o software release and emergency implementation;
- o system resource forecasting;
- o response time monitoring and problem resolution;
- o software migration;
- o contractor's LAN support and administration;
- o MMIS security implementation and monitoring;
- o daily, weekly, and monthly production status reporting; and
- o mainframe liaison support with ISD.

The contractor shall provide Database Administration support including but not limited to the following activities:

- o data modeling and normalization;
- o logical database design;
- o physical database design;
- o database creation and update;
- 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; and
- o database resource utilization and capacity planning.

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3.2.9.2 Operational Trouble Reports

The contractor must provide operational trouble reports as soon as possible but no later than at the close of business of the day the problem is identified. Where the operational problem results in delays in report distribution or problems in on-line access on state business days, the contractor shall notify the state, during business hours, within fifteen (15) minutes of discovery of the problem, in order for state work activities to be rescheduled. For the Eligibility Verification and Provider Inquiry System and the PRODUR/ECM System, any un-anticipated downtime longer than fifteen minutes, the contractor must notify the designated on-call OHCA staff immediately. All notifications must be followed up in writing.

3.2.9.3 MMIS Contractor Requirements Relating To The DSS/DW

OHCA may acquire a DSS/DW from a vendor other than the MMIS vendor. Should this occur, the MMIS contractor is required to work effectively and efficiently with the DSS/DW vendor to ensure that the state can optimize this technology. Therefore, at a minimum, the MMIS contractor must:

- o work with the DSS/DW vendor to identify data needs, data sources, volume, data discrepancies, and transmission protocols;
- o supply updates of the MMIS data to the DSS/DW. Examples of the types of data to be provided are:
 - . Reference files, including procedure, diagnosis, and revenue codes;
 - . MMIS Medical Authorizations;
 - . Claims history files, including encounters;
 - . Provider files;
 - . Recipient eligibility files;
 - . Third Party Liability (TPL) files;
 - . Management and Administrative Reporting System (MARS) data; and
 - . Surveillance and Utilization Review (SUR) data.
- o initially supply the DSS/DW with a two year load of claims and encounter data and a complete set of all other files;
- o refresh all data and files on a weekly basis;
- o transmit data in ASCII, comma delimited format using Network Data Mover (NDM) except for the initial load (the initial load will be made utilizing tape cartridges or other agreed upon media);
- o provide the initial load of data the first month of the operation of the MMIS or the first month of the operation of the DSS/DW, whichever is later; and

- o monitor all data transmissions to ensure successful completion, work with the DSS/DW vendor to resolve transmission problems, and if transmission is still unsuccessful, notify the state liaison in a timely manner.

3.2.9.4 Staff Adjustment Process

For those units where staffing is priced at an hourly rate, the state reserves the right to increase, decrease, or totally eliminate the unit after providing the contractor with a thirty (30) day notice.

3.2.9.6 Facility Costs

The contractor shall be responsible for all costs related to securing and maintaining the operational facility, including, but not limited to, hardware and software maintenance, leasehold improvements, utilities, telephone, office equipment, supplies, janitorial services, storage, transportation, the shredding of confidential documents, and insurance.

3.3 MMIS FUNCTIONAL REQUIREMENTS

The Oklahoma MMIS must receive, enter, process, suspend, adjudicate to payment or denial, and report on claim records submitted by providers for services rendered to Medicaid and state medical assistance program eligible recipients. It must ensure the accuracy, reasonableness, and integrity of the claim records processing function and meet Oklahoma's information retrieval needs.

The MMIS functional requirements are presented here for the purpose of assisting bidders in gaining an understanding of Oklahoma's needs in obtaining a replacement MMIS.

This subsection presents descriptions of the requirements for each of the following MMIS functions:

- o Recipient Data Maintenance;
- o Recipient Identification Card;
- o Eligibility Verification and Provider Inquiry System;
- o Provider Data Maintenance;
- o Reference Data Maintenance;
- o Electronic Data Interchange(EDI) and Claim Capture;
- o Edit/Audit Processing;
- o Claims Pricing;
- o Enhanced Claims Editing
- o Adjustment Processing;
- o Claims Adjudication;
- o Claims Resolution;
- o Medical Authorization Processing;
- o Long Term Care Processing;

- o Pre-Admission Screening and Annual Resident Review (PASRR) and Medical Eligibility Determination and Tracking System (MEDATS)- (PASMED);
- o Managed Care;
- o Early and Periodic Screening, Diagnosis, and Treatment (EPSDT);
- o Third Party Liability Processing (TPL);
- o Case Management;
- o Financial Accounting and Reporting;
- o Retrospective Drug Utilization Review (DUR)
- o Prospective Drug Utilization Review (PRO-DUR)/Electronic Claims Management (ECM);
- o Drug Rebate Processing;
- o Security Management;
- o Customer Service;
- o Quality Assurance;
- o Internet;
- o Management Administrative Reporting (MAR);
- o Decision Support System/Data Warehouse (DSS/DW);
- o Surveillance and Utilization Review (SUR)/Fraud and Abuse;
- o SUR Case Tracking; and
- o Staff Performance Tracking.

For each of the above functions, an overview is presented first, followed by a description of requirements using the following subheadings:

- o Inputs,
- o Processing Requirements,
- o Outputs, and
- o Interfaces.

In addition to supporting the requirements listed below, the new MMIS must provide for the following capabilities across all functional areas of the system.

- o Maintain access to data through user friendly systems navigation technology and a graphical user Interface that allows users to move freely throughout the system using pull down menus and “point and click” navigation without having to enter identifying data multiple times.
- o Provide for contact sensitive help on screens for easy “point and click” access to valid values and code definitions by screen field.
- o Maintain flexibility in coding structures by use of parameter and table oriented design techniques.
- o Ensure that all data is available through the DSS/DW function.

- o Provide reports in data format for export and import purposes and through multiple media such as paper, CD-ROM and so forth.

3.3.1 RECIPIENT DATA MAINTENANCE

The primary purpose of the Recipient Data Maintenance function is to accept and maintain an accurate, current, and historical source of eligibility and demographic information on individuals eligible for medical assistance in Oklahoma. The maintenance of recipient data is required to support claim processing both batch and on-line, reporting functions, and eligibility verification. The current source of eligibility data for the MMIS is a daily file extract from PS/2. PS/2 maintains eligibility data for all medical assistance programs.

3.3.1.1 Inputs

The Recipient Data Maintenance function will accept input on all recipients of Oklahoma medical assistance programs from the state. Inputs to the Recipient Data Maintenance function include:

- o recipient data from the State's eligibility system ;
- o managed care enrollment information from the state's enrollment agent;
- o primary care provider (PCP) selections/assignments from health plans;
- o Beneficiary Data Exchange (BENDEX) tape; and
- o on-line updates of recipient data.

3.3.1.2 Processing

The MMIS Recipient Data Maintenance function must have the following processing capabilities:

3.3.1.2.1

Maintain the minimum data set prescribed by Part 11 of the State Medicaid Manual.

3.3.1.2.2

Accept on-line and process real-time on-line, update transactions of recipient data for all recipients from the State, the State's enrollment agent, and State users.

3.3.1.2.3

Provide a web-enabled application for collection of recipient PCP selections/assignments from managed care health plans via the internet and automatically update the recipient data base with the specific PCP selection/assignment.

3.3.1.2.4

Maintain an on-line audit trail of all updates to recipient data identifying source of the change, before and after images, and change dates.

3.3.1.2.5

Edit recipient update transactions received from the State's eligibility system for completeness and consistency, according to edit criteria established by the State.

3.3.1.2.6

Generate error reports of update transactions failing fatal and non-fatal editing.

3.3.1.2.7

Identify potential duplicate recipient records.

3.3.1.2.8

Maintain the current and all historical recipient identification numbers (case number) for a recipient, and provide a linkage to all claims for the recipient, regardless of the recipient identification number used to process the claim.

3.3.1.2.9

Maintain six (6) years of historical recipient information, including history of demographics, such as recipient address.

3.3.1.2.10

Provide access all current and historical recipient data, with inquiry capability by recipient ID number, name or partial name, Social Security number and the ability to use other factors such as sex and date of birth and/or county to limit the search by name and partial name. Partial name search must be provided through use of a proven algorithm, such as Soundex.

3.3.1.2.11

Maintain on-line access to all recipient data required to support claims processing, prior authorization processing, long term care processing, managed care processing,

waiver processing, eligibility verification processing, and other appropriate MMIS processes requiring specific recipient data.

3.3.1.2.12

Maintain flexibility in coding structures by use of parameter and table oriented design techniques, for data such as, medical eligibility coverage groups and program identifiers, to support changes to claims processing and reporting requirements.

3.3.1.2.13

Maintain on-line access to recipient profiles containing recipient health status information, recipient characteristics, and service utilization information including, but not limited to, once in a lifetime procedures, service frequency on limited services, nursing home therapeutic and hospital leave days, last compensable hospital stay, flag for exhausted TPL, flag for lock-in for surveillance and utilization review, last dental exam date, last bite wing x-ray date, and last prophylaxis date.

3.3.1.2.14

Provide for notes tracking by recipient to accommodate tracking of calls regarding claims, complaints, customer service, TPL and easy access to the call information by all users.

3.3.1.2.15

Provide for geographical mapping through latitude and longitude pinpoint of recipients through address.

3.3.1.3 Outputs

At a minimum, the proposed system must be capable of retrieving data necessary to generate the following outputs and support the following information needs. All data shall be available for retrieval through the DSS/DW function, paper, microform, and other media specified by the state.

3.3.1.3.1

The following types of reports must minimally be available:

- o reports to meet all federal and state reporting requirements,
- o active/inactive recipient summary listings,
- o possible duplicate recipient list,
- o recipients by county,
- o recipients recently deceased,
- o recipient ranking by dollars paid;

- o demographic reports and geographic maps of recipients by longitude/latitude;
- o recipient update transaction error reports, and
- o control and balance reports of transaction/file updates.

3.3.1.3.2

Provide on-line inquiry screens which will minimally accommodate the following, using a minimal number of screens:

- o recipient basic demographic data;
- o recipient mnemonic/phonetic/algorithm search;
- o recipient spenddown or cost sharing (premiums, copays);
- o recipient profile, characteristics, and service utilization;
- o recipient current and historical eligibility data;
- o recipient managed care information; and
- o recipient restriction data.

3.3.1.4 Interfaces

The Recipient Data Maintenance function must accommodate an external interface with the:

- o State's eligibility system,
- o State's enrollment agent,
- o internet,
- o State wide area network (WAN) for access by counties, and
- o VHA (Nurse Line Inquiry).

3.3.2 RECIPIENT IDENTIFICATION CARD

The purpose of the Recipient Identification Card function is to produce new and replacement identification cards for Oklahoma's medical assistance population based on recipient information provided in the Recipient Data Maintenance function.

3.3.2.1 Inputs

The MMIS Recipient Identification Card function must accept the following inputs:

- o the most current recipient data available, and
- o requests for issue of card replacements from the State's enrollment agent.

3.3.2.2 Processing

The MMIS Recipient Identification Card function must have the following processing capabilities:

3.3.2.2.1

Maintain all current and historical recipient identification card and recipient identification card issue information for all recipients, for the entire life of the contract.

3.3.2.2.2

Identify newly enrolled recipients that need a recipient identification card issued and generate and process card requests.

3.3.2.2.3

Accept and process requests for plastic, magnetic striped, recipient identification card replacements, deactivating any previously issued active recipient identification card for the same recipient.

3.3.2.2.4

Produce and distribute plastic, magnetic striped, recipient identification cards that meet all specifications of current recipient identification (ID) cards with the exception of color of the card. The card must conform to the American National Standards Institute (ANSI) Uniform Health Card ID Card Standards; contain the recipient's name, the twelve digit case number, the pre-assigned Banking ID number, and the card issue date on the front of the card; and contain fixed information and a magnetic stripe encoded with the recipient's case number, the Banking ID number, and the card issue date on the back of the card. The color of the recipient identification card must be conducive to photocopying the card and producing a readable copy.

3.3.2.2.5

Provide on-line access to all recipient identification card and recipient identification card issue data.

3.3.2.3 Outputs

The MMIS Recipient Identification Card function must provide:

- o reports to meet all federal and state reporting requirements,
- o control and balance reports,
- o ranking of recipients by the number of cards re-issued, with issue reason, and
- o number of cards re-issued by issue reason.

3.3.2.4 Interfaces

The Recipient Identification Card function must accommodate an external interface with the State's enrollment agent.

3.3.3 ELIGIBILITY VERIFICATION AND PROVIDER INQUIRY SYSTEM

The purpose of the Eligibility Verification and Provider Inquiry System is to provide an efficient and effective method for its provider community and other MMIS users to verify recipients' eligibility, third party insurance information, managed care provider information, spend down data and so forth. In addition this function is to allow providers to inquire and request information on prior authorization status and to request claims histories and remittance advices.

3.3.3.1 Inputs

The MMIS Eligibility Verification and Provider Inquiry System function must accept the following inputs:

- o the most current recipient data available,
- o the most current MMIS provider data available,
- o web-enabled access for inquiries from providers and authorized state personnel,
- o inquiries from providers and authorized state personnel via personal computers (PCs) and point-of-sale (POS) devices , and
- o telephone inquiries from providers and authorized state personnel.

3.3.3.2 Processing

The MMIS Eligibility Verification and Provider Inquiry System function must have the following processing capabilities:

3.3.3.2.1

Maintain a toll-free, dial-up, access, for enrolled medical providers, located within the state and out of state, through the use of their touch tone telephones, through the public switched telephone network, to the MMIS Eligibility Verification and Provider Inquiry System.

3.3.3.2.2

Maintain a dial-up access, for enrolled medical providers through use of PCs and their "switch vendors" (Envoy, National Data Corporation, and so forth) software, to the MMIS Eligibility Verification and Provider Inquiry System.

3.3.3.2.3

Maintain, for enrolled medical providers through use of PCs and their “switch vendors” (Envoy, National Data Corporation, and so forth) software, network, and “switch vendor” supplied link access to the MMIS Eligibility Verification and Provider Inquiry System.

3.3.3.2.4

Maintain a dial-up access, for enrolled medical providers through use of point-of sale devices through the public switched telephone network, to the MMIS Eligibility Verification and Provider Inquiry System.

3.3.3.2.5

Maintain an internet access, for enrolled medical providers through use of their PCs and their authorized internet access connection, to MMIS.

3.3.3.2.6

Maintain an interactive, Eligibility Verification and Provider Inquiry System session, through the use of an articulated automated voice response system.

3.3.3.2.7

Maintain an interactive, Eligibility Verification and Provider Inquiry System session, through the use of a web-enabled Eligibility Verification and Provider Inquiry System that accepts and sends HIPAA compliant EDI formats and meets HIPAA and other federal security and privacy requirements.

3.3.3.2.8

Maintain a recipient eligibility session, that minimally communicates the following:

- o Provides the appropriate safeguards, including:
 - . limiting access to eligibility information to enrolled medical providers and authorized state personnel only;
 - . protecting the confidentiality of all recipient information; and
 - . maintaining an audit trail of all inquiries and verification responses made, the information conveyed, and to whom the information was conveyed;
- o allows inquiry by case number, inquiry by full name and date of birth, inquiry by partial name and date of birth, and inquiry by social security number (SSN) and date of birth;

- o validates that an active card is presented based on the card issue date;
- o limits access to eligibility verification inquiry to inquiry for dates of service within the preceding thirteen months; and
- o limits access to perform the inquiry to enrolled providers and authorized state personnel.

3.3.3.2.9

Provide on-line access to all audit trail data on inquiries.

3.3.3.2.10

Process claims against the audit trail of eligibility inquiries and responses, guaranteeing the claim to process against the response of the inquiry.

3.3.3.2.11

Provide the capability for providers to request status of prior authorization required for a date or date range or by procedure code for a recipient through dial-up access, their PC, and “switch vendor” software and network, and through the internet to a web enabled application and for the MMIS Eligibility Verification and Provider Inquiry System to respond with the prior authorization information.

3.3.3.2.12

Provide the capability for providers to request remittance advices and claims histories through dial-up access, their PC, and “switch vendor” software and network and through the internet via a web enabled application and for the MMIS Eligibility Verification and Provider Inquiry System to respond with the remittance advice and/or claims history.

3.3.3.2.13

For all remittance advice and claim history requests that are requests for paper copies, charge the provider according to State allowed amounts per page.

3.3.3.2.14

Provide processes and data to meet eligibility verification requirements of Part 11 of the State Medicaid Manual.

3.3.3.4 Outputs

The MMIS Eligibility Verification and Provider Inquiry System function must provide the following outputs.

3.3.3.4.1

The primary output of the Eligibility Verification and Provider Inquiry System function is the recipient eligibility data provided to providers for confirming recipient eligibility for State Medical Assistance Program services.

3.3.3.4.2

Reports must minimally include:

- o reports to meet all federal and state reporting requirements,
- o operational reports about the number of inquiries received during the month, average waiting time for inquiries by hour segment, by day;
- o operational reports about the average response time of inquiries received during the week and month, average response time for inquiries by hour segment, by day, by week, by month;
- o records of what information was conveyed, and to whom, by week;
- o system downtime;
- o counts of inquiries by provider type and individual providers; and
- o appropriate reports to analyze and monitor usage of the Eligibility Verification and Provider Inquiry System function by access method, and to support measurement of performance expectations.

3.3.3.4 Interfaces

The Eligibility Verification and Provider Inquiry System function must accommodate an external interface with:

- o provider and provider “switch vendor” telephone systems,
- o provider “switch vendor’s telecommunication lines, and
- o the internet.

3.3.4 PROVIDER DATA MAINTENANCE

The Provider Data Maintenance function maintains comprehensive current and historical information about providers eligible to participate in Oklahoma's medical assistance program. Through the establishment of a single provider master file, provider demographic, certification, rate, and summary financial information is maintained to support accurate and timely claim records processing, enhanced management reporting, and utilization review reporting and surveillance activities. The Provider Maintenance function also maintains functions to support provider training activities.

The new MMIS must be capable of meeting the requirements of the National Provider Identification (NPI) standards of HIPAA. This includes identifying providers using the NPI and/or utilizing standards consistent with NPI and HIPAA requirements. This includes only one unique number for a provider, identifying all locations, provider types, specialties, authorization/certifications/licensing for services, and so forth for that provider as a logical record linked to the one provider number.

The Oklahoma MMIS Provider Data Maintenance function objectives are to:

- o encourage the participation of qualified providers by making enrollment and re-enrollment an efficient and accurate process;
- o ensure that providers are qualified to render specific services by screening applicants for state licensure and certification, and specialty and sub-specialty certification;
- o process provider applications and changes in a timely and accurate manner;
- o maintain control over all provider data; and
- o maintain all demographic and rate information to support claim records processing and reporting functions.

3.3.4.1 Inputs

The MMIS Provider Data Maintenance function must accept the following inputs:

- o provider enrollment and re-enrollment contracts;
- o licensure information, including electronic input from other State agencies, such as the Rehabilitation Accreditation Commission, Department of Health (DOH), Department of Corporations (DOC), Department of Mental Health (DMH), and Joint Commission on Accreditation of Healthcare Organizations (JCAHO);
- o residents names and prescriber numbers from the College of Pharmacy and names and prescriber numbers for any other practitioner that may prescribe drugs but is not a provider contracted to provide service;
- o provider update transactions;
- o Clinical Laboratory Improvement Act (CLIA) updates for providers from OSCAR;
- o electronic funds transfer (EFT) information for providers from the State Treasury Office (STO), Office of State Finance (OSF);
- o network provider information and PCP assignments from HMO's;
- o on-line provider update information from the State;
- o ownership information and ownership cross referencing; and
- o financial payment, adjustment, and accounts receivable data from the Financial Processing function.

3.3.4.2 Processing

The MMIS Provider Data Maintenance function must have the following processing capabilities.

3.3.4.2.1

Maintain flexibility in coding structures by use of parameter and table oriented design techniques, for data such as, medical eligibility coverage groups and program identifiers, to support changes to claims processing and reporting requirements.

3.3.4.2.2

Maintain access to data through user friendly systems navigation technology and a graphical user interface (GUI) that allows users to move freely throughout the system using pull down menus and “point and click” navigation without having to enter identifying data multiple times.

3.3.4.2.3

Provide for context-sensitive help on screens for easy, “point and click” access to valid values and code definitions by screen field.

3.3.4.2.4

Maintain an on-line audit trail of all updates to provider data identifying source of the change, before and after images, and change dates.

3.3.4.2.5

Distribute, receive, and process provider contracts, referring State specified contracts to OHCA for approval prior to file updates or additions.

3.3.4.2.6

Maintain on-line tracking of current and historical provider contracts from receipt to final disposition (approval/rejection) including tracking information such as date sent, date received, status to indicate activity.

3.3.4.2.7

Maintain files of hardcopies and/or images of all provider current and historical provider contracts and correspondence for seven years according to State criteria.

3.3.4.2.8

Automatically deactivate provider records with no activity in the last twelve (12) months.

3.3.4.2.9

Automatically terminate providers failing to re-enroll thirty days after the contract expires.

3.3.4.2.10

Automatically generate and distribute a letter to providers seventy-five (75) days before the contract expiration date and a follow-up letter forty-five (45) days before the contract expiration if no response for re-enrollment has been received.

3.3.4.2.11

Generate, distribute, receive, and process the State developed provider contract, for initial enrollment and on-going re-enrollment.

3.3.4.2.12

Provide the ability to process on-line on-demand requests for generation and distribution of a provider contract.

3.3.4.2.13

Accept and process adds and changes to the provider data set through on-line, real-time data entry.

3.3.4.2.14

Maintain an on-line audit trail of all changes made to the provider data set.

3.3.4.2.15

Periodically re-enroll all or certain State specified sub-groups of providers.

3.3.4.2.16

Edit all data-entered data for presence, format, and consistency with other data in the update transaction and on the provider master file.

3.3.4.2.17

Edit to prevent duplicate provider enrollment during an update transaction.

3.3.4.2.18

Identify and report, at least monthly, any suspected duplicate provider numbers, national provider identification (NPI), license or certification numbers, SSN, Federal Employer Identification Number (FEIN,) prescriber number, Drug Enforcement Agency (DEA) number, or CLIA numbers.

3.3.4.2.19

Accept, process, and maintain CLIA information for providers.

3.3.4.2.20

Utilize a Geographic Information System (GIS) using longitude and latitude, to identify recipient populations, service utilization, and corresponding provider coverage to support the provider recruitment, enrollment, and participation.

3.3.4.2.21

Cross-reference all provider numbers (including old and new numbers) which would identify the current active SSN or FEIN for that entity and provide the capability to access all the previous history, including claims, for any and all the provider numbers.

3.3.4.2.22

Maintain an on-line audit trail of provider names, provider numbers (including old and new numbers), locations, or status changes by program.

3.3.4.2.23

Maintain on-line access to a minimum of six (6) years of historical provider information, including provider rates and effective dates, provider program and status codes, and summary payment data.

3.3.4.2.24

Maintain on-line access to the provider data base with inquiry/update by provider name, phonetically similar name, partial name characters, provider number, specialty, sex, handicap access status, languages spoken, license number, prescriber number, Medicare number, SSN, FEIN, NPI, CLIA number, town, zip code, telephone number, and EFT status.

3.3.4.2.25

Maintain access to fifteen (15) years of archived provider history data.

3.3.4.2.26

Maintain an address provider name and a sort provider name, on the provider data set, each as a single field, forty-five (45) characters long utilizing universal abbreviations.

3.3.4.2.27

Identify by provider any applicable type codes, plan codes, location codes, practice type codes, category of service codes, affiliations (such as, clinic, group, health plan) and medical specialties and sub-specialties which are used for the state's medical assistance programs, and which affect provider billing, claim pricing, or other processing activities including reporting.

3.3.4.2.28

Provide for identification of sufficient numbers of provider type and specialty and sub-specialty codes to accommodate current and future needs of the state's medical assistance programs

3.3.4.2.29

Maintain effective and end dates for provider membership, enrollment status, electronic media claims (EMC) billing data, program, EFT status, restriction and on-review data, certification(s), specialty(s), sub-specialty(s), claim type(s), and other user-specified provider status codes and indicators.

3.3.4.2.30

Accept on-line, real-time updates of review or restriction indicators and effective and end dates for a provider to assist OHCA in monitoring a provider's medical practice.

3.3.4.2.31

Accept provider numbers for provider practice affiliations such as group practices, clinics, health plans, managed care plans, and so forth, and relate individual providers to the practice affiliation, as well as the practice affiliation to its individual member providers, with effective and end dates. A single practice affiliation, provider data set must be able to identify an unlimited number of individuals who are associated with the practice affiliation.

3.3.4.2.32

Identify, in the on-line provider data set, the name, address, and telephone number of the entity through which a provider bills, if a billing service is used.

3.3.4.2.33

Identify, in the on-line provider data set, providers that use automated submittal of claims, automated remittances, and/or electronic funds transfer in claims processing.

3.3.4.2.34

Maintain multiple, provider-specific reimbursement rates by program, including per diems, case mix, rates based on licensed levels of care, specific provider agreements, volume purchase contracts or other cost containment initiatives, with effective and end dates for a minimum of six (6) years, with on-line, real-time inquiry and update capability.

3.3.4.2.35

Maintain provider-specific rate files to accumulate facility-specific case mix, licensed level of care, or other rate data for on-line inquiry and update.

3.3.4.2.36

Identify multiple practice locations for a single provider and associate all relevant data items with the location, such as address and CLIA certification.

3.3.4.2.37

Maintain, in the on-line provider data set, multiple current and historical addresses and telephone numbers for a provider, including but not limited to:

- o pay to,
- o mail to, and
- o service location(s).

3.3.4.2.38

Maintain, in the on-line provider data set:

- o the number of beds by licensed level of care;
- o administrator name;
- o Department of Health certification;
- o ownership information and owners;
- o change in ownership information, such as, an indicator of responsibility of liabilities and receivables; and
- o other State-specified data elements for long-term care facilities.

3.3.4.2.39

Maintain, in the on-line provider data set, provider program eligibility and enrollment status codes with associated effective and end dates. The enrollment status codes must include but not be limited to:

- o contract pending,
- o enrolled,
- o specific provider arrangement,
- o change of ownership,
- o limited time-span enrollment,

- o out-of-state and border providers,
- o enrollment suspended, and
- o terminated - voluntary/involuntary.

3.3.4.2.40

Maintain specific codes for restricting the services for which providers may bill to those for which they have the proper certifications (for example, CLIA certification codes).

3.3.4.2.41

Maintain the flexibility to accommodate non-medical providers on the provider master file (for example, non-medical case managers, school districts), and maintain the necessary data on such providers.

3.3.4.2.42

Perform mass updates to provider rate information at State direction based on both automated and manually entered updates.

3.3.4.2.43

Accept retroactive rate adjustments to the provider file.

3.3.4.2.44

Maintain, in the on-line provider data set, summary-level accounts receivable and payable data and pending recoupment amounts which are automatically updated after each claims processing payment cycle by calendar week-to-date, month-to-date, year to date and State and federal fiscal year-to-date totals.

3.3.4.2.45

Maintain multiple provider types and specialties and sub-specialties with effective and end dates for each provider and with the flexibility to change provider type and specialty and sub-specialty.

3.3.4.2.46

Provide the capability to maintain prescriber numbers and names for practitioners not contracted to provide service but who do prescribe drugs to the medical assistance population.

3.3.4.2.47

Provide for an automated linking of the prescriber only history if the prescriber should become a contracted provider.

3.3.4.2.48

Maintain the capability to identify agency or department funding source based on provider type or specialty and sub-specialty.

3.3.4.2.49

Provide the capability to calculate and maintain separate 1099 and associated payment data by FEIN number for providers.

3.3.4.2.50

Generate a full file of providers, in an agreed upon State approved format and media, to be provided to the State on an agreed upon periodic basis.

3.3.4.2.51

Support the implementation of National Provider identification and HIPAA

3.3.4.2.52

Provide an on-line tracking of provider training information for each provider, including all history of when a provider was trained and by whom and on-going problems the provider is encountering.

3.3.4.2.53

Provide for the on-line entry of informational messages to be included on the remittance advice(s) based on provider category of service, provider type, or individual provider number, to assist with the overall training of providers.

3.3.4.2.54

Maintain the minimum data set prescribed by Part 11 of the State Medicaid Manual.

3.3.4.3 Outputs

The MMIS Provider Data Maintenance function must provide the following outputs:

3.3.4.3.1

All data shall be available for retrieval through the DSS/DW function.

3.3.4.3.2

All reports must be made available in data format for export and import purposes and through multiple media such as paper, cd-rom, and so forth.

3.3.4.3.3

The following types of reports must minimally be available:

- o reports to meet all federal and state reporting requirements;
- o report showing status of provider applications in process;
- o list of providers to be deactivated due to inactivity;
- o alphabetic and numeric provider listings that can be generated by selection parameters including program, provider type, category of service, specialty, sub-specialty, town, county, zipcode, and enrollment status;
- o audit trail reports of changes to provider file data including, before and after images of changed data, the clerk ID that changed the data, the date of the change;
- o PCP/CMs by county;
- o inter- related providers (affiliations) and number of recipients serviced in common;
- o information required for institutional rate setting;
- o provider accounts receivable and payable data, including claims;
- o reports giving an unduplicated count of provider additions, re-enrollments, active and inactive by enrollment status;
- o provider cross-reference listings for SSN, FEIN, State Tax ID, CLIA, zip code, town and license numbers;
- o report which displays growth in the number of active providers (including both billing and performing) by provider type and specialty and sub-specialty over time;
- o report identifying providers who have changed practice affiliations (for example, from one group practice to another) by provider type;

- o demographic reports and maps from the GIS, using longitude and latitude, for performing, billing, and/or enrolled provider, to assist in the provider recruitment process and provider relations;
- o provider 1099 statements; Internal Revenue Service (IRS) 1099 tape; the Oklahoma Tax Commission tape, as necessary; and associated payment reports;
- o W2 forms for personal care service providers; Social Security Administration (SSA) W2 tape; the Oklahoma Tax Commission tape, as necessary; and associated payment reports;
- o a listing of newly enrolled providers in need of training;
- o a list of the top fifty (50) most frequently received edits with instructions for resolution and upload this list to the State's internet site on a state specified frequency.
- o mailing labels for newly enrolled providers; and
- o reports for institutional rate setting.

3.3.4.3.4

Enrollment approval/denial or other correspondence letters.

3.3.4.3.5

All on-line provider screens must display basic identifying provider information including name and number on each screen. On-line screens must show:

- o basic information about a provider displayed on a single screen (for example, name, location, number, program, provider type, specialties, sub-specialties, certification dates, effective and end dates.);
- o information showing all rendering providers associated with a practice affiliation, such as a group, and all practice affiliations with whom a rendering provider is associated, for user defined time periods;
- o information showing provider eligibility history;
- o provider rate file data;
- o provider accounts receivable and payable data, including claims adjudicated but not yet paid;
- o additional provider information, such as provider addresses and summary calendar and fiscal year claims payment and recoupment data;

- o for institutional providers, the number of beds in the facility and reimbursement rates;
- o on-review data, and other special data (for example, lab certification data);

3.3.4.3.6

Provide an automated response to provider claims' status inquiries.

3.3.4.3.7

Provide capability to request the top fifty (50) most frequently occurring edits, through an on-line screen, by provider type and geographical location.

3.3.4.3.8

The MMIS must provide the capability to request mailing labels, through on-line screen, by category of service, provider type, provider specialty and/or geographical location.

3.3.4.3.9

A full provider file, provided to the State on an agreed upon periodic basis.

3.3.4.3.10

Group mailings and provider labels based on selection parameters including provider type, category of service, specialty, sub-specialty, town, county, zip code, and special program participation.

3.3.4.4 Interfaces

The Provider Data Maintenance function must accommodate an external interface with the State, to provide the provider file.

3.3.5 REFERENCE

The Reference Data Maintenance function maintains a consolidated source of reference information which is accessed by the MMIS during performance of other functions, including all claims processing functions, medical authorization and TPL processing. It also support MMIS reporting functions.

The state's goals in the maintenance of reference data are to:

- o provide coding and pricing verification for use during claims processing for all approved claim types and reimbursement methodologies;
- o support both on-line and automated update of reference table data; and

- o maintain flexibility in reference parameters and file capacity to make the MMIS capable of accommodating changes in Oklahoma's medical assistance programs.

3.3.5.1 Inputs

The MMIS Reference Data Maintenance function must accept the following inputs:

- o State updates for procedure [Health Care Financing Administration (HCFA) Common Procedure Coding System (HCPCS), Common Procedure Terminology (CPT), revenue center code] and rate;
- o HCPCS update tape from HCFA;
- o contracted service for tape for updating medical supplies catalogue number;
- o contracted service for tape for updating International Classification of Diseases (ICD) 10 data (or ICD 9 if 10 not implemented);
- o State-approved updates for drug and national drug code (NDC);
- o State approved updates for diagnosis, edit/audit criteria, and edit disposition files;
- o full National Drug Data File (NDDF) from a contracted service such as First Data Bank for drug codes, drug data, and drug pricing including wholesale acquisition cost (WAC) and average manufacturer price (AMP);
- o State-approved dispensing fees including variable dispense fees for compound drugs; and
- o updates from HCFA Drug Rebate tapes for drug rebate purposes.

3.3.5.2 Processing

The MMIS Reference Data Maintenance function must have the following processing capabilities:

3.3.5.2.1

Maintain an on-line audit trail of all manually entered updates to reference data identifying source of the change, before and after images, and change dates.

3.3.5.2.2

Maintain current and historical reference data, assuring that updates do not overlay or otherwise make historical information inaccessible.

3.3.5.2.3

Accept online and electronic/tape file updates, additions, and deletions to all reference files, with the capability to make changes to individual records or mass changes to groups or classes of records (for example, across provider type and specialty or ranges of procedure codes, across therapeutic class, generic class, hierarchical ingredient code list (HICL), and generic status).

3.3.5.2.4

Maintain password control, in varying levels of security, of staff making changes to reference data.

3.3.5.2.5

Maintain on-line access to all pharmacy related reference data.

3.3.5.2.6

Maintain a Drug data set of the eleven- (11-) digit NDC, which can accommodate updates from a contracted drug data and pricing service, the HCFA Drug Rebate file, any future State rebate program updates; and updates from State staff as needed. The Drug data set must contain, at a minimum:

- o unlimited date-specific pricing segments which include all prices by program control codes needed to adjudicate drug claims in accordance with State policy;
- o unlimited, multiple date-specific dispensing fees;
- o manufacturer and labeler codes;
- o State-specified restrictions on conditions to be met for a claim to be paid including but not limited to minimum/maximum days supply, quantities, refill restrictions, preferred versus non-preferred indicators, recipient age/sex restrictions, medical review requirements, prior authorization requirements, place of service, and combinations thereof;
- o family planning indicator;
- o indication of whether this is a chronic or acute medication;
- o over-the-counter (OTC) indicator;
- o DEA code;
- o Medicare indicator;

- o description and purpose of the drug code;
- o therapeutic class codes and descriptions including separate, distinct codes and descriptions from the American Hospital Formulary Service and the State Specific Therapeutic Classification System;
- o identification of discontinued NDCs;
- o identification of HCFA Rebate and State Rebate program status and HCFA drug rebate unit of measure;
- o identification of strength, units, quantity, and dosage form (powder, vial, liquid, cream, capsule, and so forth) on which price is based;
- o indication of designated as less than effective (DESI) status, and identical, related or similar to DESI drugs (IRS) status; and
- o other data available from the full NDDF.

3.3.5.2.7

Maintain a Procedure data set which contains the five character HCPCS code for medical-surgical and other professional services, 2nd level HCPC code for dental codes; a two character field for HCPCS pricing modifiers; and state specific codes for other medical services (such as, research and demonstration waivers, behavioral health and mental health); in addition, the Procedure data set must contain, six years of data to support claims on-line history, and, at a minimum, the following elements:

- o valid tooth surface codes and tooth number/quadrant designation;
- o date-specific pricing segments by program control code and provider type;
- o indicator of covered/not-covered and effective and end dates,
 - . allowed amount for each segment,
 - . multiple modifiers and the percentage of the allowed price applicable to each modifier;
 - . state-specified restrictions on conditions to be met for a claim to be paid including, but not limited to: category of service, specialty, lab certification, recipient age/sex restrictions, allowed diagnosis codes, prior authorization required, medical review required, place of service, pre and post-operative days, appropriate diagnosis, units of service, once-in-a-lifetime indicator, attachments required and so forth;
- o EPSDT reporting indicator;

- o family planning indicator;
- o full HCPCS description and lay description of procedure codes;
- o indication of when or whether claims for the procedure can be archived from on-line history;
- o TPL service class to indicate actions to be taken such as, cost avoid, pay and chase, pay and report, pay, and deny;
- o indication of non-coverage by managed care plans by managed care plan type including rural and urban; and
- o other information such as accident/trauma indicators for possible TPL, Federal cost-sharing indicators, Medicare coverage indicator.

3.3.5.2.8

Maintain a diagnosis data set utilizing the ICD-10 coding system, which supports relationship editing between diagnosis code and claim information including but not limited to:

- o age,
- o sex,
- o family planning indicator,
- o prior authorization,
- o EPSDT indicator,
- o TPL trauma and emergency trauma codes
- o inpatient length of stay criteria,
- o description of the diagnosis,
- o primary and secondary diagnosis code usage,
- o cross reference to procedure codes, and
- o accident/trauma indicator.

3.3.5.2.9

Maintain full ICD 10 descriptions.

3.3.5.2.10

Maintain a revenue code data set for use in processing claims for hospital outpatient services and which accepts HCPCS level information.

3.3.5.2.11

Maintain an Edit/Audit Criteria table to provide a user-controlled method of implementing service frequency, quantity limitations, and service conflicts for selected

procedure codes, revenue center codes, drug classes, and diagnosis codes, with on-line update capability.

3.3.5.2.12

Maintain pricing files based on: federal upper limit (FUL), state upper limit (SUL), wholesale acquisition cost (WAC), manufacture acquisition cost (MAC), estimated acquisition cost (EAC), average wholesale price (AWP), and direct pricing for drugs.

3.3.5.2.13

Provide the on-line capability to place edit/audit criteria limits across claim types and provider type and specialty, on types of service by procedure code and/or procedure code modifiers, revenue center code, diagnosis code and drug class, based on:

- o recipient age, sex, eligibility status, place of residence, medical eligibility coverage group;
- o diagnosis;
- o provider type, specialty, sub-specialty;
- o place of service;
- o claim type;
- o TPL;
- o federal matching rate;
- o dollars or units;
- o tooth and surface codes;
- o floating or calendar year period;
- o months, calendar weeks or days periods (up to six (6) years); and
- o other criteria necessary to implement Oklahoma policy.

3.3.5.2.14

Maintain the minimum data set prescribed by Part 11 of the State Medicaid Manual.

3.3.5.2.15

Maintain the flexibility to accommodate multiple reimbursement methodologies, including diagnosis related grouping (DRG) reimbursement for inpatient hospital care, resource based relative value scale, capitation fee for prepaid health plans or case manager services, and case-mix based payment structures.

3.3.5.2.16

Accommodate multiple benefit plans with different benefits and different payment methodologies.

3.3.5.2.17

Provide for identification and processing for case (family) premium payments.

3.3.5.3 Outputs

The MMIS Reference Data Maintenance function must provide the following outputs.

3.3.5.3.1

Generate audit trail reports showing before and after image of changed data, the ID of the person making the change, and the change date.

3.3.5.3.2

Generate listings of the Procedure, Diagnosis, Revenue Code, Diagnosis to Procedure and Procedure to Diagnosis, Usual and Customary Charge, and other listings based on variable, user-defined select and sort criteria.

3.3.5.3.3

Maintain on-line access to all Reference files with inquiry by the appropriate code, depending on the file or table being accessed.

3.3.5.3.4

Generate reports to meet all federal and state reporting requirements.

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3.3.5.3.5

Maintain on-line inquiry to procedure, drug, and diagnosis files by descriptions with search capability by phonetic and partial description and user defined selection criteria.

3.3.5.3.6

Summary of changes by procedure, revenue center code, NDC, diagnosis, and so forth.

3.3.5.3.7

Provide inquiry screens to all reference data, including:

- o all relevant pricing data and restrictive limitations for claims processing, and
- o all pertinent data for claims processing and report generation.

3.3.5.4 Interfaces

The Reference Data Maintenance function must accommodate an external interface with:

- o contracted services for medical supplies catalogue number, drug codes and pricing, and ICD 10;
- o HCFA for HCPCS updates and drug rebate update files;
- o HMOs for supplying pricing files; and
- o the state to provide fee schedules and allowable procedure codes.

3.3.6 ELECTRONIC DATA INTERCHANGE (EDI) AND CLAIM CAPTURE

The Electronic Data Interchange (EDI) and Claim Capture function provides the overall support collecting, tracking and reporting on claims data. Support for capturing claims information via hard copy or electronic media is supported.

3.3.6.1 Inputs

The MMIS EDI and Claim Capture function must accept the following inputs:

- o claim forms as mandated by HCFA, in both hard-copy and electronic formats (that are HIPAA compliant) and for fee for service and encounter (shadow claims) including:

- . HCFA-1500,
 - . UB92 [(including long term care (LTC)],
 - . NCPDP Pharmacy claim form, and
 - . American Dental Association (ADA) Dental claim form,
- o crossover claims for Medicare coinsurance and deductible, for Part A and Part B;
 - o claim adjustment documents, including corrected claim, remittance advice (RA), and other documents, and the explanation of benefits (EOB), claim and RA from Medicare;
 - o attachments required for claims adjudication, including:
 - . TPL Explanation of Benefits for denials by the TPL,
 - . sterilization, abortion, and hysterectomy consent forms,
 - . medical documentation to support the medical review process; and
 - . Medicare EOBs;
 - o non-claim specific financial transactions such as fraud and abuse recoveries, TPL recoveries, and cash receipts, both recipient specific and not;
 - o electronic media input including:
 - . magnetic tape,
 - . diskette, and
 - . direct entry via personal computer for electronic claim capture (ECC)/electronic claim management (ECM) using dial-up (or dedicated) telecommunications facilities or the internet; and
 - o all Health Insurance Portability and Accountability Act (HIPAA) compliant electronic formats for EDI.

3.3.6.2 Processing

The MMIS EDI and Claim Capture function must have the following processing capabilities:

3.3.6.2.1

Identify, upon receipt, each claim, adjustment, and financial transaction with a unique control number that includes date of receipt, batch number, and sequence of document within the batch.

3.3.6.2.2

Monitor and track all claims, adjustments, and financial transactions from receipt to final disposition.

3.3.6.2.3

Maintain an image of all claims, attachments, adjustment requests, and other documents.

3.3.6.2.4

Maintain batch controls and batch audit trails for all claims and other transactions entered into the system.

3.3.6.2.5

Identify any activated claim batches that fail to balance to control counts.

3.3.6.2.6

Edit to prevent duplicate entry of electronic media claims.

3.3.6.2.7

Accept claims and adjustments via hard-copy or electronic media formats from providers, billing services, and Medicare carriers and intermediaries.

3.3.6.2.8

Identify claims for services covered under each of the various OHCA programs.

3.3.6.2.9

Provide the capacity for key re-verification of critical fields, data entry software editing, supervisor audit verification of keyed claims, or other methods determined acceptable by the State.

3.3.6.2.10

Maintain extract files which contain key elements of support files to verify the validity of entered claim information and the accuracy of keying; extract files will be updated with current information during the same cycle for which update transactions are applied to file records.

3.3.6.2.11

Identify, and allow on-line correction to, claims suspended as a result of data entry errors.

3.3.6.2.12

Provide processes and data to meet minimum requirements of Part 11 of the State Medicaid Manual.

3.3.6.3 Outputs

The MMIS EDI and Claim Capture function must provide the following outputs:

3.3.6.3.1

All data shall be available for retrieval through the DSS/DW function.

3.3.6.3.2

All reports must be made available in data format for export and import purposes and through multiple medias such as paper, cd-rom, and so forth.

3.3.6.3.3

The following types of reports must minimally be available:

- o reports to meet all federal and state reporting requirements;
- o inventory management analysis by claim type, processing location, age, and status (for example, ready to pay next cycle);
- o input control listings;
- o returned claim logs; and
- o exception reports of claims in suspense in a particular processing location for more than a user-specified number of days.

3.3.6.3.4

On-line inquiry to claims, adjustments, and financial transactions, from data entry to adjudication, with access by, but not limited to, recipient ID, program, provider ID, and/or control number to include pertinent claim data and claim status.

3.3.6.3.5

Easy retrieval of claim and attachment images by control number while looking at claims history.

3.3.6.3.6

An audit trail record with each claim record that shows each stage of processing, the date the claim was entered in each stage, and any error codes posted to the claim at each step in processing.

3.3.6.3.7

Claim entry screens to include pertinent header and detail claim data and status.

3.3.6.3.8

Data entry operator statistics, including volume, speed, and accuracy.

3.3.6.3.9

Electronic submission statistics.

3.3.6.4 Interfaces

The EDI and Claim Capture function must accommodate an external interface with provider, biller, and Medicare carrier and intermediary electronic networks as applicable, including:

- o telecommunication links, and
- o the internet.

3.3.7 EDIT/AUDIT PROCESSING

The Edit/Audit Processing function ensures that claim records are processed in accordance with state policy. This processing includes application of non-history-related edits and history-related audits to the claim record. Claim records are screened against files and tables such as: recipient files, provider files, reference files (e.g. procedure, drug, diagnosis), pended and adjudicated claim records, and edit/audits (including both hard coded and table driven). Those claim records that do not satisfy program or processing requirements are handled according to table driven instructions. Any suspended claim records are reviewed by state staff using approved adjudication guidelines.

3.3.7.1 Inputs

The MMIS Edit/Audit Processing function must accept the following inputs:

- o claims that have been entered into the claims processing system from the claims entry function (paper and EMC);
- o claims that are recycled after correction;
- o claims recycled by edit by request;
- o claims released to editing after a certain number of cycles based on defined edit criteria; and
- o Provider, Recipient, and Reference (procedure, revenue center, drug, diagnosis, ambulatory patient codes, prior authorization, service limitation) data required to perform the edits and audits.

3.3.7.2 Processing

The MMIS Edit/Audit Processing function must have the following processing capabilities:

3.3.7.2.1

Reformat key-entered and EMC claims into common processing formats for each claim type.

3.3.7.2.2

Edit each data element on the claim record for required presence, format, consistency, reasonableness, and/or allowable values.

3.3.7.2.3

Edit each claim record completely during an edit or audit cycle, rather than ceasing the edit process when an edit failure is encountered. Identify all error codes for claims that fail daily processing edits at initial processing, in order to not require multiple re-submissions of claims.

3.3.7.2.4

Identify the processing outcome of claims (suspend or deny) which fail edits, based on the edit disposition.

3.3.7.2.5

Provide for on-line resolution of suspended claims.

3.3.7.2.6

Identify potential third-party liability (including Medicare) and deny the claim if it is for a service covered or presumed to be covered by a third-party, based on procedure codes, revenue center/OP codes, diagnosis codes, drug codes, categories of service, the TPL carrier coverage matrix, or a combination of data from these sources.

3.3.7.2.7

Provide the capability to distinguish between a Medicare denial versus private insurance denials.

3.3.7.2.8

Edit to assure that TPL has been satisfied or that a TPL denial attachment is present if required.

3.3.7.2.9

Edit and suspend claims for prepayment review for potential TPL based on procedure code, diagnosis code, and other State-specified criteria.

3.3.7.2.10

Edit to assure that the services for which payment is requested, is covered by the appropriate state medical assistance program.

3.3.7.2.11

Edit to assure that all required attachments, per the reference function, are present.

3.3.7.2.12

Edit for cost-sharing requirements on applicable claims.

3.3.7.2.13

Edit for and suspend claims requiring provider or recipient prepayment review.

3.3.7.2.14

Maintain a function to process all claims against an edit/audit criteria table and an error disposition table (maintained in the Reference Data Maintenance function) to provide flexibility in edit and audit processing.

3.3.7.2.15

Edit to assure that reported diagnosis, procedure, revenue center, and denial codes are present on Medicare crossover claims and all other appropriate claim types.

3.3.7.2.16

Edit for recipient eligibility on date(s) of service.

3.3.7.2.17

Apply edits to mother's eligibility in order to identify claims (including fee- for- service and capitation payments) for newborns for whom eligibility records have not yet been created.

3.3.7.2.18

Edit for valid recipient identification using date of birth and the first 3 characters of last name and the first 4 characters of first name.

3.3.7.2.19

Edit for special eligibility records indicating recipient participation in special programs where program service limitations or restrictions may vary.

3.3.7.2.20

Edit for recipient living arrangement.

3.3.7.2.21

Edit provider eligibility to perform category of service rendered on date of service.

3.3.7.2.22

Edit for provider participation as a member of the billing group.

3.3.7.2.23

Edit claims for recipients in nursing facilities against recipient authorization data, level of care, patient spenddown, Medicare denial, reserve bed and leave days, and admit/discharge information.

3.3.7.2.24

Edit for prior authorization requirements and to assure that a prior authorization number is present on the claim and matches to an active prior authorization on the MMIS.

3.3.7.2.25

Edit prior-authorized claims and cut back billed units or dollars, as appropriate, to remaining allowed units or dollars, including claims and adjustments processed within the same cycle.

3.3.7.2.26

Maintain edit disposition to deny claims for services that require prior authorization (PA) if no PA is identified or active.

3.3.7.2.27

Update the prior authorization record to reflect the services paid on the claim and the number of services still remaining to be used.

3.3.7.2.28

Perform automated cross-checks and relationship edits on all claims.

3.3.7.2.29

Perform automated audit processing using history claims, suspended claims, and same cycle claims.

3.3.7.2.30

Edit for potential duplicate claims based on a cross-reference of group and rendering provider, multiple provider locations, and across provider and claim types.

3.3.7.2.31

Identify exact duplicate claims in the system.

3.3.7.2.32

Perform automated edits using duplicate audit and suspect-duplicate criteria to validate against history and same cycle claims.

3.3.7.2.33

Refine duplicate checking criteria to achieve a cost effective balance between duplicate suspense rates and duplicate payments.

3.3.7.2.34

Maintain audit trail of all error code occurrences per claim header and claim detail.

3.3.7.2.35

Provide for an unlimited number of edits per claim.

3.3.7.2.36

Identify and track all edits and audits posted to the claim from suspense through adjudication.

3.3.7.2.37

Provide, for each error code, a resolution code, an override, force or deny indicator, and the date that the error was resolved, forced, or denied; overrides, denials, and forced claims shall carry the clerk ID.

3.3.7.2.38

Accept overrides of claim edits and audits in accordance with State guidelines.

3.3.7.2.39

Identify the claim disposition (state, state unit, contractor correction, deny), based on the edit status or force code with the highest severity; the severity shall be readily modifiable on the Reference tables.

3.3.7.2.40

Update claim history files with both paid and denied claims from the previous audit run.

3.3.7.2.41

Maintain a record of services needed for audit processing where the audit criteria covers a period longer than six (6) years (such as once-in-a-lifetime procedures).

3.3.7.2.42

Provide the capability to easily change the disposition of edits to (1) pend to a specific location/unit, (2) deny and print an explanatory message on the provider remittance advice, (3) pay and report, or (4) pay.

3.3.7.2.43

Maintain flexibility in setting claim edits to allow dispositions and exceptions to edits based on claim type (including encounter shadow claims, adjustments, history only adjustments, and so forth), submission media, provider type and specialty and sub-specialty, recipient medical assistance program, or individual provider number.

3.3.7.2.44

Edit for daily limits on dollars, units, and/or percentages as needed.

3.3.7.2.45

Edit claims with billed amounts that vary by a specified degree above or below allowable amounts.

3.3.7.2.46

Edit billing, performing, referring, and prescribing provider IDs for validity.

3.3.7.2.47

Edit for valid CLIA certification for laboratory procedures.

3.3.7.2.48

Edit claim for tooth numbers for procedures requiring tooth number or quadrant to procedure.

3.3.7.2.49

Edit for procedure to procedure at same date of service.

3.3.7.2.50

Edit for service limitations, including once in a lifetime procedures, procedure for age, and so forth.

3.3.7.2.51

Identify the quadrant based on tooth number for editing.

3.3.7.2.52

Edit and suspend dental claims with junk codes for manual pricing unless there is a prior authorization for the junk code for the recipient with the servicing provider.

3.3.7.2.53

Edit for program control and allow for services to ICF-MR adults for procedures limited to under 21 years of age.

3.3.7.2.54

Edit for timely filing according to State policy.

3.3.7.2.55

When applying cutbacks, cut back units on all claims except for encounter, and retain original units billed and units paid (result of cutback).

3.3.7.2.56

Accommodate the Medicare/Medicaid crossover claims for services rendered in all settings (regular Medicaid, Waivers, etc.) so that where applicable, Medicare would be the primary payer and Medicaid would be payer of last resort.

3.3.7.2.57

If the State continues utilizing annual “caps” on the number of inpatient days it pays for adult recipients, “track” all days (paid and no-paid) to begin ALOS data by recipient category.

3.3.7.2.58

Provide editing that allows for authorizing services by location for multi-location providers.

3.3.7.2.59

Provide processes and data to meet the minimum requirements of Part 11 of the State Medicaid Manual.

3.3.7.2.60

Maintain all historical inactive claims indefinitely on a permanent history and maintain access to these claims for special runs, processing, or reporting.

3.3.7.3 Outputs

The MMIS Edit/Audit Processing function must provide the following outputs:

- o All data shall be available for retrieval through the DSS/DW function.
- o All reports must be made available in data format for export and import purposes and through multiple medias such as paper, cd-rom, and so forth.
- o The following types of reports must minimally be available:
 - . reports to meet all federal and state reporting requirements;
 - . inventory management analysis by program, claim type, processing location, and age;
 - . claims inventory, quality control statistics on data entry processing activity, and average age of claims;
 - . error code analysis by program, claim type, provider and/or input media;
 - . edit/audit override analysis by program, claim type, edit/audit and clerk ID; and
 - . updated claim records used in subsequent processing; and
- o On-line inquiry into edit/audit status of claims in process.

3.3.7.4 Interfaces

The MMIS Edit/Audit Processing function has no external interfaces.

3.3.8 CLAIMS PRICING

The Claims Pricing function calculates the payment amount for each service according to the rules and limitations applicable to each claim type, category of service, and type of provider. This process takes into consideration factors such as the Medicaid allowed amount, TPL payments, Medicare payments, and any cost-sharing requirements.

Prices are maintained on the reference files or provider-specific rate files and are date-specific.

The Oklahoma MMIS must process and pay Medicare crossover claim records and adjustments. It must also accommodate cost-sharing in pricing for spend-down amounts, co-payments, TPL payments, and so forth.

3.3.8.1 Inputs

The MMIS Claims Pricing function must accept the following inputs:

- o claims that have been passed from the edit cycles for pricing, and
- o Reference and Provider pricing information.

3.3.8.2 Processing

The MMIS Claims Pricing function must have the following processing capabilities:

3.3.8.2.1

Identify the price for claims and adjustments according to the date-specific pricing data and reimbursement methodologies contained in the Provider or Reference Data Maintenance functions based on date of service on the claim.

3.3.8.2.2

Edit billed charges for high and low variances, and suspend paper claims at the state defined level of variance.

3.3.8.2.3

Identify and calculate payment amounts according to the fee schedules, per diems, rates, and rules established by the State.

3.3.8.2.4

Maintain access to pricing and reimbursement methodologies to appropriately price claims based on:

- o fee schedules for physicians, dentists, other practitioners based on procedure and modifiers and outpatient services based on revenue code, and procedure code for certain services;
- o per diems based on level of care for inpatient hospital services;
- o per diems based on revenue code or diagnosis and age for certain services or diagnosis related groupings (DRGs) for inpatient hospital services;

- o fee schedules for laboratory outpatient and other diagnostic services;
- o lowest of multi-source, direct pricing, Estimated Acquisition Cost (EAC) or Average Wholesale Price (AWP) minus a percentage of billed, plus dispensing fee for pharmacists;
- o per diems based on level of care for LTC;
- o base rate and mileage for transportation allowing for identification of pick-up and drop-off; and
- o Medicaid or other medical assistance program allowed amount or Medicare deductible (94%) and coinsurance amount (75%), except inpatient which is 100% and psychiatric which is 50% of the Medicare allowable without consideration of co-insurance.

3.3.8.2.5

Identify and deny billings on claims for items included in rates for inpatient stays (for example, outpatient diagnostic procedures within three days prior to inpatient stay).

3.3.8.2.6

Allow incentive payments (such as, percentage on allowable).

3.3.8.2.7

Maintain the capability to identify and calculate payment amounts for EPSDT procedures when state policy allows them to be paid at a higher rate.

3.3.8.2.8

Deduct copayments for all claim specific services, as defined by the State.

3.3.8.2.9

Maintain flexibility to accommodate future changes and expanded implementation of copayment without additional cost to the State.

3.3.8.2.10

Deduct either the provider reported or recipient data base spenddown amount, whichever is greater, when pricing long-term care claims.

3.3.8.2.11

For the medically needy spenddown utilize non-Title XIX first and apply the remainder to allowed charges based on first bill in.

3.3.8.2.12

Deduct TPL amounts, as appropriate, when pricing claims.

3.3.8.2.13

Provide the capability to generate payment of copay and deductible for recipients with TPL.

3.3.8.2.14

Provide the capability to generate payment based on cost-share for recipients with TPL (for example, CHAMPUS claims).

3.3.8.2.15

Price procedure codes allowing for multiple modifiers which enable reimbursement by program at varying percentages of allowable amounts.

3.3.8.2.16

Price units for procedures based on the cutback units not by reducing the price for the billed units by a percentage.

3.3.8.2.17

Provide the ability to price encounters and for those with Title XIX non-allowable services, price at a percentage of billed.

3.3.8.2.18

Maintain multiple date specific prices (up to 6 years) for each provider, procedure, and revenue code.

3.3.8.2.19

Provide the ability to price claims under different pricing methodologies and compare the differences, for example: DRG, APRG, and Per Diem

3.3.8.2.20

Provide processes and data to meet the minimum requirements of Part 11 of the State Medicaid Manual.

3.3.8.3 Outputs

The MMIS Claims Pricing function must provide the output of priced claims that are passed on for audit processing or suspended claims due to pricing edits.

3.3.8.4 Interfaces

There are no external automated interfaces identified for the Claims Pricing function.

3.3.9 ENHANCED CLAIMS EDITING

The Enhanced Claims Editing function provides improved claims editing support to ensure that claims are processed correctly and efficiently. It provides for editing to determine inappropriate billing, produce notifications for such billings and to provide instructions to providers for rebilling.

3.3.9.1 Inputs

The MMIS Enhanced Claims Editing function must accept the following inputs:

- o claims and adjustments that have met the minimum edit and audit requirements for payment, including:
 - . HCFA 1500s, excluding claims for transportation;
 - . UB92s;
 - . Dental; and
 - . Pharmacy; and
- o annual updates to edits and audits.

3.3.9.2 Processing

The MMIS Enhanced Claims Editing function must have the following processing capabilities:

3.3.9.2.1

An on-line, menu driven process to maintain and modify the enhanced claim payment policies for editing claims.

3.3.9.2.2

Perform periodic updates to the claims payment policies to incorporate annual HCPC, CPT-4, ICD-10 coding changes and reflect changes in auditing logic due to trends in billing practices.

3.3.9.2.3

Provide the ability to process with up to four (4) modifiers.

3.3.9.2.4

Perform edits and audits to determine inappropriate billings for the following procedures:

- o Surgery,
- o Medicine,
- o Radiology,
- o Outpatient,
- o DME,
- o Inpatient,
- o Dental,
- o Home Health,
- o Pathology, and
- o Laboratory.

3.3.9.2.5

Provide the capability to handle clinical logic (such as, incidentals, mutually exclusives, unbundling, assistant surgeon, pre and post op services included in the procedure).

3.3.9.2.6

Produce non-payment notification letters for inappropriate billings and include information indicating the correct codes to be submitted along with an explanation of the rationale for denial or RAs indicating the edit(s) failed and instructions on how to bill them.

3.3.9.2.7

Provide a duplicate claim check and validate that there is no duplicate claim for any suggested procedures.

3.3.9.2.8

Provide the ability to override enhanced claim edits.

3.3.9.2.9

Provide the ability to provide instructions on pricing a claim and set EOB to indicate the claim was paid with special pricing.

3.3.9.2.10

Identify claims requiring additional medical review based upon the diagnosis versus procedure exceptions, the diagnosis versus provider exceptions, procedure to specialty compatibility, and so forth.

3.3.9.2.11

Identify in claims history, claims that have been denied and for which a new procedure has been suggested and what the suggested procedure is.

3.3.9.2.12

Provide for editing an unlimited number of claim lines.

3.3.9.2.13

Provide the ability to “handle” units.

3.3.9.2.14

Identify claims for primary and secondary procedures that exceed state payment policies based upon submitted charges or allowed fees.

3.3.9.2.15

Maintain a record of unduplicated potential cost savings realized as a result of the expanded edits and audits.

3.3.9.2.16

Provide an on-line capability to run claims on-line, real-time against trial edit changes.

3.3.9.3 Outputs

The MMIS Enhanced Claims Editing function must provide the following outputs:

- o reports to meet all federal and state reporting requirements,
- o savings reports indicating savings generated from clinical products edits excluding denied claims that are to be rebilled.
- o auditing analysis reports profiling provider billing patterns and billing behavior.

3.3.9.4 Interfaces

There are no external interfaces required for the Enhanced Claims Editing function.

3.3.10 ADJUSTMENT PROCESSING

The MMIS Adjustment process supports the adjustment of previously adjudicated claims due to patient spend-down, TPL recoveries, re-pricing, and so forth. The function also supports tracking and reporting of adjusted claims and maintains a history and audit trail of all adjustments.

3.3.10.1 Inputs

The MMIS Adjustment Processing function must accept the following inputs:

- o adjudicated claims;
- o claim specific adjustments including EMC adjustments;
- o non-claim specific adjustments including gross adjustments (on-line and system generated);
- o on-line entered, claim-specific financial transactions, such as recoupments, mass adjustments, cash transactions, and so forth;
- o retroactive changes to patient spenddown, TPL retroactive changes, and retroactive changes to medical coverage codes (groups);
- o SURS case tracking automated adjustments from SURS worksheet; and
- o automated adjustments from TPL Case Tracking.

3.3.10.2 Processing

The MMIS Adjustment Processing function must have the following processing capabilities:

3.3.10.2.1

Maintain flexibility in coding structures by use of parameter and table oriented design techniques, for data such as adjustment types, to support changes to claims processing and reporting requirements.

3.3.10.2.2

Maintain complete audit trails of adjustment processing activities on the claims history files.

3.3.10.2.3

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.

3.3.10.2.4

Maintain a process to identify the claim to be adjusted, display it on a screen, and change the fields to be adjusted with minimal entry of new data.

3.3.10.2.5

Maintain the original claim and the results of all adjustment transactions in claims history; link all claims and subsequent adjustments by control number.

3.3.10.2.6

Reverse the amount previously paid/recovered and then process the adjustment so that the adjustment can be easily identified.

3.3.10.2.7

Provide the methodology to process the adjustment offset in the same payment cycle as the adjusting claim.

3.3.10.2.8

Provide the ability to adjust claim history only.

3.3.10.2.9

Re-edit, re-price, and re-audit each adjustment, including checking for duplication against other regular and adjustment claims, in history and in process.

3.3.10.2.10

Provide the ability to indicate when re-edit, re-price, and re-audit should be bypassed.

3.3.10.2.11

Maintain primary and secondary adjustment reason codes which indicates who initiated the adjustment, the reason for the adjustment, and the disposition of the claim for use in reporting the adjustment.

3.3.10.2.12

Provide the methodology to allow on-line changes to the adjustment claim record to reflect corrections or changes to information during the claim correction (suspense resolution) process.

3.3.10.2.13

Maintain an on-line mass-adjustment function to re-price claims, within the same adjudication cycle, for retroactive pricing changes including capitation rate changes, spenddown changes, recipient or provider eligibility changes, and other changes necessitating reprocessing of multiple claims.

3.3.10.2.14

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, plan type, provider number(s), provider type, recipient number(s), claim record code(s), procedure codes, drug code(s) by quarter, recipient age and sex, and claim type(s), warrant number(s), and claim status. Claims meeting the selection criteria and the projected financial result will be displayed for initiator review, and the initiator will have the capability to select or de-select chosen claims, re-calculating the projected result, and release the selected claims for continued adjustment processing.

3.3.10.2.15

Maintain an on-line mass-adjustment function to select and/or adjust claims with billed amounts less than allowed amounts.

3.3.10.2.16

Maintain a retroactive rate adjustment capability which will automatically identify all claims affected by the adjustment, create adjustment records for them, reprocess them, and maintain a link between the original and adjusted claim, on a schedule to be determined by the State.

3.3.10.2.17

Maintain a process to recover payments which are denied by the peer review organization (PRO), to identify claims resubmitted by hospitals following PRO denial, and to associate re-submissions with the original denial/recovery prior to payment of the resubmission.

3.3.10.2.18

Provide the ability to correct the tooth surface on dental claims and process as an adjustment.

3.3.10.2.19

Provide for system acceptance and processing of "unit dose credits" when prescription items which have been paid for by the State, are returned to the provider.

3.3.10.2.20

Maintain control to apply successive adjustments to the most current version of the claim.

3.3.10.2.21

Provide for input transactions to SUR and TPL of all collected dollars.

3.3.10.2.22

Provide on-line, updateable letter templates for receivables.

3.3.10.2.23

Automatically generate letters and follow-up letters for receivables to providers, based on State criteria and timeframes.

3.3.10.2.26

Maintain all letters, identifying provider, dollar amount of receivables, and date letter sent.

3.3.10.3 Outputs

The MMIS Adjustment Processing function must provide the following outputs:

- o The following types of reports must minimally be available:
 - . reports to meet all federal and state reporting requirements;
 - . counts and dollar amounts, positive and negative, totals of claims, adjustments, and other financial transactions, by recipient program, provider type, claim type, adjustment reason code, and originator;
 - . standard accounting and balance and control reports;
 - . range of re-coupmets by amount and time period for providers;

- . recouped dollars from provider showing credits and debits;
 - . report by reason code to show what was recovered/recouped/refunded by SUR, by case and total net;
 - . single aging report of outstanding accounts receivables, with flags on those that have no activity within a State-specified period of time;
 - . accounts receivable set-up, collected, and written off during the reporting period including beginning and ending balances by payment cycle and at month end;
 - . retroactive rate adjustments requested and performed, including detailed adjustment data and summary service counts, recipient counts, and dollar value by program and detailed category of service; and
 - . information which segregates and identifies claim-specific and non-claim-specific adjustments by type of transaction (payout, recoupment, or refund) and provider type on a cycle and total month basis.
- o Letters for receivables and follow-up letters for non-receipt of receivables due.

3.3.10.4 Interfaces

There are no external interfaces identified for the Adjustment Processing Function.

3.3.11 CLAIMS ADJUDICATION

The primary purpose of the Claims Adjudication function is to produce remittances advices for claims that have passed all edits and audits and have been priced, and for those which have been denied. The function also supports the automatic creation of an accounts receivable for a provider when net financial transactions (claims to be paid, adjustments, recoupments, and so forth) result in a negative amount.

3.3.11.1 Inputs

The MMIS Claims Adjudication function must accept the following inputs:

- o claims which have passed all edit, audit, and pricing processing, or which have been denied; financial transactions, such as recoupments, mass adjustments, cash transactions, and so forth;
- o retroactive changes to spenddown, TPL retroactive changes, and retroactive changes to program codes (from State funded to Title XIX); and

- o provider, recipient, and reference data.

3.3.11.2 Processing

The MMIS Claims Adjudication function must have the following processing capabilities:

3.3.11.2.1

Maintain payment mechanisms to providers.

3.3.11.2.2

Maintain a consolidated accounting function, by program and type and provider, and deduct/add appropriate amounts and/or percentages from processed payments.

3.3.11.2.3

Generate or reproduce provider remittance advices (RAs), on demand, within twenty-four (24) hours, for a state specified period of time, in electronic and/or hard-copy media, to include the following information:

- o an itemization of submitted claims that were paid, denied, or adjusted, and any financial transactions that were processed for that provider, including subtotals and totals;
- o an itemization of suspended claims, including dates of receipt and suspense, and dollar amount billed;
- o adjusted claim information showing both the original claim information and the adjusted information, with an explanation of the adjustment reason code and credits pending;
- o detail such as person's name of what recoupment is for;
- o indication that a claim has been rejected due to TPL coverage on file for the recipient and include available relevant TPL data on the RA;
- o explanatory EOB messages relating to the claim payment cutback, denial, or suspension;
- o summary section containing earnings information, by program, regarding the number of claims paid, denied, suspended, adjusted, in process, and financial transactions for the current payment period, month-to-date and year-to-date;
- o an Accounts detail and summary section, containing for each account the beginning balance, activity for the period, pending

credit, ending balance, the recoupment schedule, and totals;
and

- o list all relevant error messages per claim header and claim detail which would cause a claim to be denied or suspended.

3.3.11.2.4

Provide the capability to print informational messages on RAs, with multiple messages available on a user-maintainable message text table, with parameters such as program, provider type, provider specialty, claim type, and payment cycle date(s).

3.3.11.2.5

Provide the flexibility to suppress the generation of (both zero-pay and pay) check requests for any provider or provider type but generate associated remittance advices.

3.3.11.2.6

Maintain a process to automatically or manually, establish a new account receivable for a provider and alert the other Financial Processing portion of this function if the net transaction of claims and financial transactions results in a negative amount (balance due).

3.3.11.2.7

Update provider payment data and 1099/W2 data on the Provider data set.

3.3.11.2.8

Maintain a process of fiscal pends, wherein payments are held on adjudicated claims based on criteria established by the State, to include claim type, media, provider type, specific provider ID, program and dollars; after receipt of data for the current cycle concerning the dollar and claim volume, by program, the State will specify release of claims to payment.

3.3.11.2.9

Accept and process warrant information from the State.

3.3.11.2.10

Maintain tooth number and surface(s) on claims history.

3.3.11.2.11

Include tooth number and surface on RAs.

3.3.11.2.12

Provide the ability to add global messages on-line to be placed on RAs. Ability must provide for unlimited free-form text messages and must allow for multiple messages to be sent by provider type, provider specialty, or claim type with the date range the message is to appear for.

3.3.11.3 Outputs

The MMIS Claims Adjudication function must provide the following outputs:

3.3.11.3.1

The following types of reports must minimally be available:

- o all federal and state required reports;
- o expenditures by program, and special Federal funding categories (by cycle, Month-to-Date and state, federal, and calendar Year-to-Date, as appropriate);
- o counts and dollar, positive and negative, totals of claims, adjustments, and other financial transactions, by program, provider type, claim type, reason, originator;
- o standard accounting and balance and control reports;
- o remittance summaries and payment summaries;
- o detailed financial transaction registers;
- o data to assist in preparing the HCFA-25 and HCFA-37;
- o HCFA-64 worksheet by Federal financial participation rate;
- o range of recoupments by amount and time period for providers;
- o single aged outstanding accounts receivable, with flags on those that have no activity within a State-specified period of time;
- o cash receipts and returned checks;
- o accounts receivable set-up, collected, and written off during the reporting period including beginning and ending balances by payment cycle and at month end;
- o registers for checks/EFT with related remittance advice number;
- o all claims priced with junk codes that are priced by the system because of the presence of a prior authorization;
- o monthly fee for service dollars paid for dental services by procedure code;

- o summary of billed/allowed/paid dollars by unduplicated recipient; and
- o information which segregates and identifies claim-specific and non-claim-specific adjustments by type of transaction (payout, recoupment, or refund) and provider type on a cycle and total month basis.

3.3.11.3.2

Report recoupments back to SUR and TPL, indicating how much is recovered and so forth, reporting at the case level.

3.3.11.3.3

On-line access to claims history by procedure code, NDC, diagnosis, transaction control number (TCN), provider number, recipient number, date of service, range of dates of service, claim status, warrant number, referring provider number, category of service, cycle date, range of cycle dates, run date, paid date, range of paid dates, claim type, financial transaction type, source of transaction, edit error codes, clerk ID, and prior authorization number.

3.3.11.3.4

Web-enabled remittance advices (RA).

3.3.11.3.5

Payment and EFT requests to the state for providers and other entities.

3.3.11.3.6

Requests to the state for checks to be issued outside of the regular cycles.

3.3.11.3.7

On request paid claim history statement.

3.3.11.3.8

Sampling of Recipient Explanation of Medical Benefits (EOMB) which include all paid claims, and all claim-specific and non-claim specific adjustments, TPL transactions, and financial transactions related to the recipient, for a specific requested span of dates of service.

3.3.11.3.9

Archived claims in the same manner and format as on-line claims within seventy-two (72) hours of request.

3.3.11.4 Interfaces

The MMIS Claim Adjudication function must accommodate an external interface with the:

- o State for receipt of warrant information;
- o State, for payment requests; and
- o the internet.

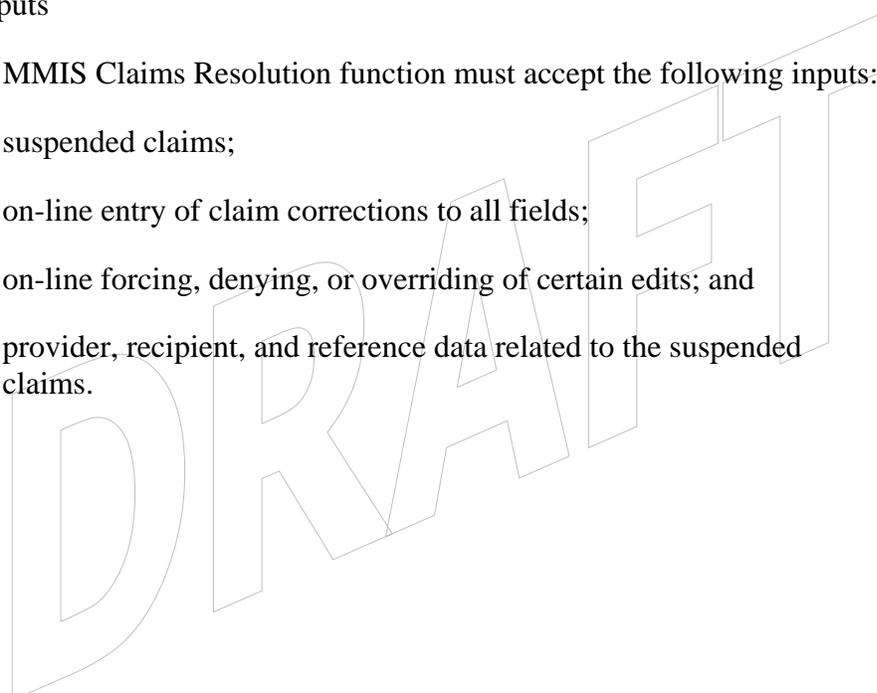
3.3.12 CLAIMS RESOLUTION

The purpose of the Claims Resolution function is to support the efficient correction of suspended claims. The function supports the sorting of suspended claims by location code and claims type, mass correction based on state approved criteria and the tracking of all suspended claims to resolution.

3.3.12.1 Inputs

The MMIS Claims Resolution function must accept the following inputs:

- o suspended claims;
- o on-line entry of claim corrections to all fields;
- o on-line forcing, denying, or overriding of certain edits; and
- o provider, recipient, and reference data related to the suspended claims.



3.3.12.2 Processing

The MMIS Claims Resolution function must have the following processing capabilities:

3.3.12.2.1

Provide on-line, real-time claims resolution, edit override capabilities for all claim types, and on-line adjudication.

3.3.12.2.2

Maintain claim correction screens that display all claims data as entered and subsequently corrected.

3.3.12.2.3

Completely re-edit corrected claims.

3.3.12.2.4

Maintain inquiry and update capability to claim correction screens with access by transaction control number, provider ID, recipient ID, location code, adjustment initiator ID, clerk ID, claim type, date of service, ranges of dates, prior authorization number, consistent with claims history inquiry screens.

3.3.12.2.5

Sort suspended claims to queues based on location code and claim type.

3.3.12.2.6

Provide the capability to forward suspended claims to other locations multiple times and receive suspended claims at each location.

3.3.12.2.7

Accept global changes to suspended claims based on State-defined criteria, and release claims to editing.

3.3.12.2.8

Provide the capability to link free form notes from all review outcomes/directions to the imaged claim.

3.3.12.2.9

Maintain error codes and messages that clearly identify the reason(s) for the suspension and highlight the fields in error on claim correction screens; display all failed edits on screens to facilitate claim correction.

3.3.12.2.10

Provide access to related provider data from the Provider Data Maintenance function through windowing, split screen, or other design techniques.

3.3.12.2.11

Provide access to related recipient data from the Recipient Data Maintenance function through windowing, split screen, or other design techniques.

3.3.12.2.12

Provide automatic generation of exception sheets on-line, identifying all related information needed to work the claim, for example any duplicate claims in the system and the capability to generate paper exception sheets, on request.

3.3.12.2.13

Provide access to related reference data from the Reference Data Maintenance function through windowing, split screen, or other design technique.

3.3.12.2.14

Identify and provide access to potential duplicate claims and related claims data from the claims history and status files through windowing, split screen, or other design technique.

3.3.12.2.15

Provide for the capture and maintenance of the medical reviewer ID, claims resolution worker ID, by error/edit for each suspended claim in claims history.

3.3.12.2.16

Identify and provide access to the status of any related limitations for which the recipient has had services, such as the number of office visits paid per month.

3.3.12.2.17

Assign a claim status of "suspended" to all claims to be corrected.

3.3.12.2.18

Assign a unique status to corrected claims.

3.3.12.2.19

Provide the capability of entering multiple error codes for a claim to appear on the Remittance Advice (RA).

3.3.12.2.20

Maintain all claims on the suspense file until corrected, automatically recycled, or automatically denied according to State specifications.

3.3.12.2.21

Provide the capability to identify operators who can perform a force, deny, or override on an error code based on individual operator IDs and authorization level.

3.3.12.2.22

Provide processes and data to meet minimum requirements of Part 11 of the State Medicaid Manual.

3.3.12.2.23

Provide for special batches of claims to adjudicate in order to provide the claim resolution staff the ability to monitor the claims to ensure the claims process correctly.

3.3.12.2.24

Provide for the ability to force release of claims.

3.3.12.3 Outputs

The MMIS Claims Resolution function must provide the following outputs:

- o The following types of reports must minimally be available:
 - . reports to meet all federal and state reporting requirements,
 - . aging suspend report,
 - . volumes on resolution, and
 - . statistical reports.
- o Updated claim records to recycle through edit and audit processing.
- o On-line screens to support the claims resolution process, as defined above, and to document claim resolutions once they have been accomplished.

3.3.12.4 Interfaces

The MMIS Claims Resolution function has no external interfaces.

3.3.13 MEDICAL AUTHORIZATION PROCESSING

The Medical Authorization Processing function is a mechanism to review, assess, and pre-approve or deny selected non-emergency medical services prior to payment. It serves as a cost-containment and utilization review mechanism for OHCA, and enables the MMIS to approve payment for only those treatments and services that are medically necessary, appropriate, and cost-effective. Additional objectives of the state which are implemented through the Medical Authorization Processing function are to:

- o enable the state to periodically revise the types of services (typically at the procedure code level) for which medical authorization is required;
- o control the amount and length of time that the state and Medicaid pay for specified services;
- o provide the capability to change at any time the scope of services authorized and to extend or limit the effective dates of authorization; and
- o identify the status of medical authorizations, to include in-process, approved, denied and utilized.

3.3.13.1 Inputs

The MMIS Medical Authorization Processing function must accept the following inputs:

- o on-line entry of medical authorization receipt, approval, denial, or change information by OHCA staff, DDS staff, DHS Aging Services staff, OFMQ staff, and College of Pharmacy staff, to prior authorization data sets which support all services requiring prior authorization;
- o tape, from outside agents of the State, such as OFMQ for prior authorization;
- o reported changes in recipient status; for example, death, change in level of care, level of severity and eligibility for programs;
- o updates from claims processing which "count down" authorized services, units, dollars, and/or percentages and from adjustment processing to "add back" services, units, dollars and/or percentages; and

- o medical authorization requests from providers on-line via PC modem or through the web.

3.3.13.2 Processing

The MMIS Medical Authorization Processing function must have the following processing capabilities:

3.3.13.2.1

Provide the capability to scan to image, medical authorization packages for each medical authorization.

3.3.13.2.2

Maintain a medical authorization data set with the following minimum information:

- o a unique, system assigned medical authorization number;
- o the ID of requesting provider or case management number;
- o the recipient ID for whom services are requested;
- o multiple line-items for requested and approved authorized services by revenue code, procedure code(s), all modifiers, range of procedure codes, NDC codes, ranges of NDC codes, tooth numbers, quadrants, units of billed and authorized; dollar amount billed and authorized, percentages of billed and authorized;
- o units, dollars, and/or percentages of service exhausted/remaining, including those recouped in claim adjustments;
- o beginning and ending dates during which the medical authorization is valid;
- o indicator that the provider assigned the medical authorization can be overridden;
- o cross-reference to claims paid under the medical authorization;
- o referral for review “to” clerk ID and referral date;
- o ID's of authorizing and entering person;
- o medical authorization request date of receipt, date of entry, and date of decision; and
- o approval or denial reason code.

3.3.13.2.3

Provide the capability to pend medical authorization requests for decisions.

3.3.13.2.4

Provide the capability to update pended medical authorizations to indicate additional information is required.

3.3.13.2.5

Provide the capability to forward (refer) a medical authorization request and all related images to staff referred to for review and update pended medical authorizations with decisions.

3.3.13.2.6

Provide the capability to update or adjust approved medical authorization lines for which claims have not been paid against.

3.3.13.2.7

Provide the capability to restrict the payment of claims unless all medical authorization data elements match the corresponding claims data elements.

3.3.13.2.8

Provide the capability to generate a medical authorization for all parties involved (that is, if the surgeon requests a medical authorization, that authorization should automatically apply to the hospital, anesthesiologist for the same date of service, same diagnosis, and same place of service).

3.3.13.2.9

Maintain a free-form text area on the medical authorization record for notation of special considerations.

3.3.13.2.10

Provide a flag to allow the system to identify authorizations with special considerations and maintain adequate space to provide up to six (6) years of history.

3.3.13.2.11

Accept on-line, real-time entry and update of medical authorization requests.

3.3.13.2.12

Maintain password control of inquiry, entry, update, or change to the medical authorization data set.

3.3.13.2.13

Edit to prevent duplicate medical authorization numbers from being entered into the system.

3.3.13.2.14

Edit medical authorizations on-line to include:

- o valid provider ID and eligibility, enrolled and active status, or valid case management number;
- o valid recipient ID and eligibility, including medical coverage, place of residence;
- o valid revenue code, procedure, NDC, valid recipient age for service, valid service for provider type, valid recipient program or plan for service; and
- o duplicate authorization check for previously authorized or previously adjudicated services, including the same services over the same timeframe by different providers if prior authorized to a single provider.

3.3.13.2.15

Identify errors on medical authorizations as to the specific field in error and the particular edit that was failed and over-ride capability on any edit.

3.3.13.2.16

Accept on-line, real-time corrections to medical authorizations.

3.3.13.2.17

Maintain and update medical authorization records based on claims and claim adjustments processed, relative to the authorization, to indicate that the authorized service has been used or partially used up, including units and/or dollars if limited to prior authorized units and/or dollars, the TCN of the claim, the date of service, and the date the claim was paid.

3.3.13.2.18

Provide on-line, updateable letter templates for all medical authorization letters with the ability to add free form text specific to a provider or recipient.

3.3.13.2.19

Automatically generate letters to recipients, county offices, agencies and/or providers for medical authorizations denied and reasons why, letters to agencies, county offices and/or providers requesting additional information, and letters to all for medical authorization approvals.

3.3.13.2.20

Maintain all notices sent and date notice sent.

3.3.13.2.21

Perform mass updates of medical authorization records; for example, when there is a change made and a procedure no longer requires medical authorization.

3.3.13.2.22

Archive old medical authorization records at State direction.

3.3.13.2.23

Provide processes and data to meet the minimum requirements of the State Medicaid Manual, Part 11.

3.3.13.2.24

Provide flexibility in the medical authorization function including that mid-stream changes do not become problematic for the client, provider, or Medicaid Program (that is, changes in the plan of care or the ability of a provider to meet the plan during a certain period of time such that services/billings/etc. are “rejected” unnecessarily).

3.3.13.3 Outputs

The MMIS Medical Authorization Processing Editing function must provide the following outputs:

3.3.13.3.1

Provide on-line access to the medical authorization data set(s).

3.3.13.3.2

Maintain on-line inquiry to all information in the medical authorization data set with access by recipient ID, recipient name, provider ID, provider name, case management number, procedure code, procedure description, medical authorization number, clerk ID, and combination thereof.

3.3.13.3.3

Generate notices to providers, recipients, county offices, and/or agencies as directed by the State.

3.3.13.3.4

Generate reports which, at a minimum, include:

- o reports to meet all federal and state reporting requirements,
- o type of medical authorization and medical authorization number, approved/denied by authorizer, units, percentages and/or dollar value of services used and not used;
- o duplicate or overlapping medical authorizations;
- o frequency of medical authorization types requested and authorized;
- o cost savings (unit amount requested versus unit amount approved);
- o utilization of units used rapidly in comparison to dates approved for;
- o utilization reports (including the number of times particular services/procedures were performed) with summary data including by program, and provider or case management unit;
- o medical authorizations by entering clerk ID, sorted by authorization type, including the status and date of entry, date of referral, and date of decision for each medical authorization;
- o monthly reports of denials (including denial reason), approvals, pends, in-

process (including reason), with YTD totals; and

- o medical authorizations not used within six (6) months of approval.

3.3.13.3.5

Display the full procedure description on all reports.

3.3.13.3.6

Provide the ability to request reports by a user specified procedure code or range of codes for a specific timeframe.

3.3.13.4 Interfaces

The MMIS Medical Authorization Processing function must accommodate an external interface with:

- o OFMQ,
- o the College of Pharmacy,
- o DDS, D,
- o the internet,
- o the State WAN for access by counties and DHS Aging Services, and
- o any outside agents of the State for updating of prior authorization data.

3.3.14 LONG TERM CARE PROCESSING

The purpose of the LTC Processing function is to support the processing of nursing facility and other LTC facility claims through the maintenance of recipient-related LTC facility data and provider-specific certification and rate data. OHCA current utilizes a turnaround document (TAD) process for LTC claims but intends to convert to a UB-92 and approved HIPAA EDI format with the implementation of the new MMIS. The OHCA LTC Processing function supports the state's objectives to:

- o reimburse providers for LTC facility services,
- o efficiently administer and manage the LTC programs through LTC cost and utilization reports,
- o monitor certification of LTC facilities, and
- o develop payment methodologies for LTC services.

3.3.14.1 Inputs

The inputs to the MMIS LTC Processing function are:

- o provider-specific LTC data;

- o UD92s and HIPAA compliant EDI format claims from providers; and
- o recipient eligibility data including authorization status, level of care, provider number, begin/end dates, and spenddown amount.

3.3.14.2 Processing

The MMIS LTC Processing function must have the following processing capabilities:

3.3.14.2.1

Maintain access to data through user friendly systems navigation technology and a graphical user interface (GUI) that allows users to move freely throughout the system using pull down menus and “point and click” navigation without having to enter identifying data multiple times.

3.3.14.2.2

Provide for context-sensitive help on screens for easy, “point and click” access to valid values and code definitions by screen field.

3.3.14.2.3

Maintain date-specific LTC data by recipient, minimally including:

- o provider number, name, address, and type;
- o level of care, begin and end dates, and effective date;
- o therapeutic leave days allowed and used;
- o hospital days allowed and used;
- o primary and secondary diagnosis;
- o spenddown amount, effective date, amount remaining; and
- o review dates.

3.3.14.2.4

Maintain current and historical, date-specific LTC data by provider (LTC facility) to include:

- o certified bed data such as level of care, number of beds, and begin and end dates;
- o reimbursement rate and begin and end dates by level of care;
- o contract begin and end date; and
- o administrator, co-administrator and operator names.

3.3.14.2.5

Process “S” level of care claims (split like state share, creating two separate claims).

3.3.14.2.6

Maintain current and historical LTC data to support reporting.

3.3.14.2.7

Identify patient spenddown amounts, current and retroactive changes, Medicare and other third-party resources, and deduct them from payments to providers when appropriate and maintain spenddown balances for the month.

3.3.14.2.8

Track recipient leave days both therapeutic and hospital.

3.3.14.2.10

Maintain recipient-related data from claims submitted (for example, date of death).

3.3.14.2.11

Provide processes and data to meet minimum requirements in Part 11 of the State Medicaid Manual.

3.3.14.2.13

Support LTC pilot projects, including:

- o Medicare/Medicaid dual eligible, co-pay, deductibles, buy-in;
- o others/leftovers;
- o exclusions;
- o mandatory and voluntary; and
- o overlapping and contiguous geographic areas.

3.3.14.2.14

Support the Uniform Comprehensive Assessment Tool (UCAT) and the Minimum Data Set (MDS).

3.3.14.3 Outputs

The MMIS LTC Processing function must provide the following outputs:

3.3.14.3.1

The following types of reports must minimally be available:

- o reports to meet all federal and state reporting requirements;
- o analysis of leave days, by facility type and leave day type;
- o discrepancies between patient spenddown amounts on the claim and on the recipient data set;
- o tracking of non-bed-hold discharge days;
- o re-certifications due within sixty (60) days;
- o facility rosters of recipients with mentally impaired/mentally retarded (MI/MR) indicators;
- o facility rosters for all facilities that are at or over or nearing state defined capacity thresholds for specified diagnosis codes;
- o hospital claims/bed-hold analysis/comparison;
- o patients identified with a date of death from claims;
- o reports generated by diagnosis;
- o non-payment by facility, for lack of prior authorization; and
- o paid days of care by month of service, by facility, by program, indicating days of care covered by patient spenddown and other payors.

3.3.14.3.2

On-line inquiry screens which minimally accommodate the following:

- o inquiry to current and historical recipient LTC data with access by recipient ID and provider ID; and
- o inquiry to current and historical provider LTC data with access by provider ID.

3.3.14.4 Interfaces

There are no external interfaces for the LTC Processing function.

3.3.15 PRE-ADMISSION SCREENING AND ANNUAL RESIDENT REVIEW (PASRR) AND MEDICAL ELIGIBILITY DETERMINATION AND TRACKING SYSTEM (MEDATS) – (PASMED)

The PASMED function is designed to control and track the level of care and expenditures for recipients receiving hospital, nursing facility, home and community based waiver, ICF/MR, and development and disability services.

3.3.15.1 Inputs

The MMIS PASMED function must accept the following inputs:

- o client identification information from telephone referrals from clients, nursing facilities, discharge planners, hospitals, Department of Human Services (DHS) area nurses and so forth;
- o client medical decisions for level of care, intermediate care facility for the mentally retarded (ICF/MR), medical assistance, incapacity, disability, blind;
- o client decisions for PASRR level I and II information, ICF/MR pre-approval and certification for Medicaid;
- o Developmental Disability Services Division (DDSD) home and community based waiver (HCBW) approval including, level of care and other information; and
- o PASRR letter-generation information.

3.3.15.2 Processing

The MMIS PASMED function must have the following processing capabilities:

3.3.15.2.1

Provide for context-sensitive help on screens for easy, “point and click” access to valid values and code definitions by screen field.

3.3.15.2.2

Maintain quick access to screens, for example, a key could be pressed while viewing a preferred screen, the system would then be immediately logged off. When the user logged back on the preferred screen would come back up automatically.

3.3.15.2.3

Provide split screen capability that would allow the user to work on two different computer subsystems at the same time on one computer screen.

3.3.15.2.4

Provide an intake ability to record all information on referrals including who telephoned the referral and who and what the referral is about for PASRR and system generated requests for medical reviews for MEDATS and establishment of a case to track manage all activity relevant to the pre-admission screening or medical review.

3.3.15.2.5

Provide for unique identification of PASRR cases and MEDATS cases.

3.3.15.2.6

Provide the ability to retrieve basic identifying and demographic information, current and historical, on providers and clients when keying in the provider number or name and/or client number or name on a screen.

3.3.15.2.7

Provide the ability to identify whether there is an existing case record for PASRR for the client.

3.3.15.2.8

Maintain PASRR database on all mentally impaired (MI) and mentally retarded (MR) level II pre-admission and resident reviews.

3.3.15.2.9

Maintain automated tracking of all level of care evaluation (LOCE) units' medical decisions [ICF/MR, nursing facilities (NFs), HCBW, disability, incapacity, blind and MA] and level of care (LOC) decisions relevant to a case.

3.3.15.2.10

Maintain and track billing of level II PASRRs.

3.3.15.2.11

Provide on-line, updateable letter templates for all PASRR referrals and final determination letters, letters requesting additional information, and so forth, allowing for a free-form comments section.

3.3.15.2.12

Generate all PASRR referrals, final determination, and information request letters to clients, NFs and other interested parties per federal regulations.

3.3.15.2.13

Maintain the history of letters sent.

3.3.15.2.14

Maintain statistics on all unit output and work load activity.

3.3.15.2.15

Track all level I PASRR screening for all clients in Medicaid certified NFs.

3.3.15.2.16

Generate reports for DHS area nurses (by area and by type of decision).

3.3.15.2.17

Maintain a separate MEDATS subsystem in the MMIS. The MEDATS function is to record medical and level of care decisions made by DHS nurses and the LOCE unit staff on Medicaid applicants and recipients. It also serves as a form of communication to DHS employees and is a historical record of our medical decisions.

3.3.15.2.18

Automatically identify cases that are due for annual review and list on-line six months prior to review due date and maintain until review is completed.

3.3.15.2.19

Provide the ability to e-mail DHS area nurses medical review decisions.

3.3.15.2.20

Provide claim histories to assist with auditing waivers.

3.3.15.2.21

Provide automated retrieval of paid claims relevant to a case that resulted in authorization for admission.

3.3.15.3 Outputs

The MMIS PASMED function must provide the following outputs:

- o All data shall be available for retrieval through the DSS/DW function.
- o All reports must be made available in data format for export and import purposes and through multiple medias such as paper, cd-rom, and so forth.
- o The following types of reports must minimally be available:
 - . federal and state mandated reports.
 - . PASMED clients referred,
 - . monthly/annual PASRR workflow,
 - . MEDATS decisions daily audit log,
 - . MEDATS decision reviews due,
 - . MEDATS monthly decision completions,
 - . MEDATS decisions pending,
 - . unit activity log, and
 - . waiver audit reports;
- o 36 types of PASRR letters; and
- o MEDATS decisions by LOCE unit/DHS nurses.

3.3.15.4 Interfaces

The PASMED function must accommodate an external interface with:

- o DHS and the Department of Mental Health for access to certain LOCE unit screens;
- o DDS for access to the HCBW screens;
- o DHS (DDS) system for letter generating purposes and daily downloading of MEDATS decisions; and
- o Web interface with our providers and consumers for the exchange of forms and other information.

3.3.16 MANAGED CARE

The Managed Care function is designed to assure recipient access to necessary medical care, while at the same time controlling medical assistance program costs. Under such models, the state has developed a network of HMOs and PCP/CMs who are contracted to provide medical services to Medicaid program recipients. Recipients receive services covered under the specific capitated plan from the managed care plan. In

addition, recipients receive pharmacy and certain other wrap-around services outside of the managed care plan.

The objectives of Oklahoma's managed care program are:

- o increased recipient access to healthcare,
- o increased use of case management and preventive services, and
- o optimal patient outcomes.

3.3.16.1 Inputs

The MMIS Managed Care Processing function must accept the following inputs:

- o health maintenance organization (HMO) and primary care provider/case manager (PCP/CM) contract documents,
- o provider eligibility data from the provider data maintenance function,
- o electronic file of updates for recipient managed care plan choices from the enrollment agent,
- o recipient managed care enrollment data from the recipient data maintenance function,
- o recipient PCP choices from HMOs,
- o encounter data in the form of “shadow claims” from HMOs and PCP/CMs,
- o claim data from the financial function for claims paid for capitation payment to PCP/CMs and HMO’s,
- o claim data from the financial function for claims paid as fee-for service for recipients in managed care having services outside those covered by the specific managed care plan(s) they are enrolled with, and
- o reference data from the reference data maintenance function.

3.3.16.2 Processing

The MMIS Managed Care Processing function must have the following processing capabilities:

3.3.16.2.1

Maintain on-line access to all recipient, provider, encounter (shadow claims), reference data related to managed care.

3.3.16.2.2

Maintain flexibility in coding structures by use of parameter and table oriented design techniques, for data such as, medical eligibility coverage groups and program identifiers, managed care plan identifiers, and so forth, to support changes to claims processing and reporting requirements.

3.3.16.2.3

Maintain access to data through user friendly systems navigation technology and a graphical user interface (GUI) that allows users to move freely throughout the system using pull down menus and “point and click” navigation without having to enter identifying data multiple times.

3.3.16.2.4

Provide for context-sensitive help on screens for easy, “point and click” access to valid values and code definitions by screen field.

3.3.16.2.5

Maintain managed care related recipient data in the recipient data maintenance function including recipients geographic location based on longitude and latitude.

3.3.16.2.6

Maintain indicators for recipients certified as members of recognized Indian tribes; and recipient profile information such as, language spoken, handicap access needed, health status identifying specialized medical needs, and recipient risk assessment data.

3.3.16.2.7

Support and accept a recipient having multiple managed care plan assignments at a single point in time (for example, individual plans for pharmacy, vision, primary care, acute care and so forth).

3.3.16.2.8

Accept and process on-line recipient enrollment/disenrollment to managed care models on a day-specific basis.

3.3.16.2.9

Provide the ability to associate managed care recipients with the managed care plans in which they are enrolled.

3.3.16.2.10

Provide the ability to lock-in and lock-out recipients to managed care plans.

3.3.16.2.11

Provide for automatic assignment of recipients, when they have not made a choice, to managed care models and plans based on state specified criteria including:

- o geographic location (by longitude and latitude) of recipient and providers in the model/plan; available “slots” in a managed care plan;
- o recipient’s needs indicated on profile, such as language spoken, handicap access, specific medical status;
- o HMO membership of others members of family; and
- o recipient’s claim history and historical usage of a provider that is a PCP/CM, part of a preferred provider organizations (PPO)/exclusive provider organizations (EPO)/outpatient delivery organizations (ODO), or a PCP in a plan.

3.3.16.2.12

Provide the ability to update managed care plan assignments/choices on-line.

3.3.16.2.13

Accept and process retroactive enrollment and disenrollment of recipients to all managed care models.

3.3.16.2.14

Capture, store, and retrieve date-specific, recipient-specific managed care enrollment history.

3.3.16.2.15

Incorporate the Health Benefit Manager system and processes in the MMIS.

3.3.16.2.16

Accept manual and auto-enrollments of recipients to managed care plans, produce notices, track notices, track contact with recipients, assign managed care plan enrollment by recipient choice, and assign managed care plan enrollment by default (no recipient response), indicating who made the choice by default.

3.3.16.2.17

Maintain managed care related provider data in the provider data maintenance function for managed care providers including:

- o individual providers affiliated with a managed care plan;
- o geographic location of primary care providers based on longitude and latitude;
- o original and current number of “slots” (how many recipients can be enrolled) available in the managed care plan; and
- o provider profile information such as language spoken, handicap access needed, health specialties identifying specialized medical abilities.

3.3.16.2.18

Support multiple managed care models including:

- o Primary Care Provider Case Management (PCP/CM),
- o Preferred Provider Organizations (PPO),
- o Exclusive Provider Organizations (EPO),
- o Outpatient Delivery Organizations (ODO), and
- o Health Maintenance Organizations (HMO),

with payment by methods such as, capitated payment for a group of covered services within a plan and fee-for service payment for covered services outside any plan the recipient is enrolled with, and payment of management fees to an assigned managing provider and fee-for service payments for services and so forth.

3.3.16.2.19

Provide for a cross reference of individual providers identifying those that are, PCP/CMs, a member of a PPO, those in an HMO network, and members of other managed care models, as well as the managed care plan to its individual member providers, with effective and end dates. A single managed care plan must be able to

identify an unlimited number of individuals who are associated with the managed care plan.

3.3.16.2.20

Maintain managed care provider-related data including capitation rates for specific groups of recipients for each managed care provider and weight of automatic assignment.

3.3.16.2.21

Calculate and generate capitated payments to participating managed care organizations whose pricing is based on a capitation payment model and automatically process adjustments/recoupsments. Capitation payment must be pro-rated to the days the recipient is enrolled with the managed care provider in the given payment period.

3.3.16.2.22

Calculate and generate payment for PCP/CM including payment for case management fee, case management fee plus fee-for-service, and/or capitation payment and fee-for-service.

3.3.16.2.23

Provide the ability to pay capitated payments at provider specific rates based on recipient demographics including eligibility program, place of residence, age, sex, risk factors, and so forth.

3.3.16.2.24

Accept and process recipient health risk assessment data and determine risk factors.

3.3.16.2.25

Ability to apply edits/audits which prevent claims from being paid when managed care program recipients receive plan covered services from sources other than the capitated plans in which they are enrolled.

3.3.16.2.26

Ability to apply edits/audits which prevent claims from being paid when they have not received a referral or authorization as may be required by the managed care plans, such as the PCP/CM they are enrolled with.

3.3.16.2.27

Ability to identify, edit, and correctly adjudicate fee-for-service claims for services not covered by a specific managed care plan.

3.3.16.2.28

Ability to receive, process (edit and price), and report on encounter data in the form of shadow claims for managed care recipient enrollees.

3.3.16.2.29

Ability to perform basic edits on these shadow claims to ensure integrity and allow for the pricing of these shadow claims.

3.3.16.2.30

Provide methodology to track the utilization rates for program enrollees and to compare such utilization rates to comparable groups of non-managed care recipients and across different managed care plans, to assure sufficient savings are achieved.

3.3.16.2.31

Identify, bill, receive, and reconcile, by recipient, insurance premium payments, including the ability to buy-in to employer or state operated insurance plans (for example CHIP) and allow for recipient co-pay based on a sliding scale of ability to pay.

3.3.16.2.32

Capture and process encounter data for use in utilization/quality assurance reporting (HEDIS) and capitation rate setting purposes.

3.3.16.2.33

Support "stop loss" provisions and the establishment of "risk adjustment" payment methodologies.

3.3.16.2.34

Provide the ability to calculate and issue risk control payments such as, kick payments for delivery, based on the provider performing the delivery, the procedure, and the diagnosis on the encounter data shadow claim.

3.3.16.2.35

Capture, store, and retrieve, managed care provider-related data for all managed care models.

3.3.16.2.36

Generate transactions to the DHS eligibility system PS/2 with the maximum amount of “slots” available for a managed care plan and generate error transactions when the managed care plan of choice has reached capacity.

3.3.16.2.37

Generate transactions to DHS eligibility system PS/2 with managed care enrollment information for each recipient enrolled in managed care. This includes the recipient’s Plan and PCP information.

3.3.16.2.38

Generate electronic rosters updates daily, and monthly paper summary rosters for all HMOs and PCP/CMs.

3.3.16.2.39

Generate electronic encounter data remittance advices.

3.3.16.2.40

Provide for web enabled communication for delivery of rosters and so forth to managed care plans. Maintain an audit trail of all rosters distributed through the internet.

3.3.16.2.41

Allow for the payment of capitated rates on a daily pro-rated basis based on the day the recipient is enrolled.

3.3.16.2.42

Provide for monthly capitated payments and weekly payment for newly enrolled recipients.

3.3.16.2.43

Provide for capitation payments for newborns, even if eligibility not on file, based on the mother’s eligibility and receipt of an encounter data shadow claim for delivery.

3.3.16.2.44

Compare actual fee-for-service payments versus capitated payment amounts periods of retroactive eligibility in order to pay the lesser amount.

3.3.16.2.45

Perform automated adjustments and recoupments of capitated payments.

3.3.16.2.46

Establish "Risk Pools" to allow for payment hold backs and/or incentive payments.

3.3.16.2.47

Allow for the merging of the Medicaid and Medicare payment stream.

3.3.16.2.48

Provide for daily updates of BENDEX.

3.3.16.2.49

Deduct fee-for-service equivalent rate for HMOs and one month capitation rate for PCP/CMs from payment for all recipient self-referred family planning services or EPSDT services.

3.3.16.2.50

Automatically and on-demand, produce notices/letters to recipients about their eligibility, enrollment/disenrollment, unavailability of chosen plan, and any changes relevant to managed care plans.

3.3.16.2.51

Maintain on-line information on notices/letters sent to each recipient and/or case such as which notice/letter was sent and what date it was mailed.

3.3.16.2.52

Maintain notices/letters templates on-line and allow for on-line changes.

3.3.16.2.53

Provide the ability to on-line request notices/letters to be sent.

3.3.16.2.54

Establish a risk adjustment payment methodology that uses state or industry defined criteria such as DPS.

3.3.16.2.55

Provide the ability to calculate member months per PCP/CM and Health Plan

3.3.16.2.56

Provide for rules-based auto assign and recipient choice enrollment, operating with multiple layers of managed care models, for example, plans for pharmacy, transportation, and hospitals.

3.3.16.3 Outputs

The MMIS Managed Care function must provide the following outputs:

- o All data shall be available for retrieval through the DSS/DW function.
- o All reports must be made available in data format for export and import purposes and through multiple medias such as paper, cd-rom, and so forth.
- o The following types of reports must minimally be available:
 - . all federal and state required reports including those needed to support the 1115b waiver;
 - . amount and type of services provided by capitated plans to enrolled recipients, as reported on encounter forms;
 - . numbers of services paid outside each plan;
 - . number and cost of fee-for-service claims paid for managed care enrollees provided by Indian Health Services (HIS);
 - . managed care enrollees by source of their enrollment;
 - . total medical assistance expenditures for managed care recipients versus non-managed care expenditures by program and eligibility category;
 - . identification of recipients who are eligible but not enrolled in managed care and those recipients who are not eligible to be enrolled but have been assigned to a HMO or PCP/CM;
 - . a detailed list of all PCP/CM and Managed Care providers;
 - . by health plan and PCP/CM of open prior authorizations for recipients newly enrolled to managed care;
 - . managed care enrollment statistics;

- . encounter data remittance advices provided to managed care providers; and
- . Managed care rosters for all health plans and PCP/CMs that contain related recipient data in the recipient data maintenance function including an indicator for recipients certified as members of recognized Indian tribes; all TPL information; and recipient profile information such as, language spoken, handicap access needed, health status identifying specialized medical needs (including any open prior authorizations, and recipient risk assessment data).
 - o Notices/letters to recipients.
 - o On-line listings of managed care PCP/CMs and/or PCPs located within the state- specified radius of a recipient.

3.3.16.4 Interfaces

The MMIS Managed Care function must accommodate an external interface with:

- o the internet and the State LAN for managed care providers, to send rosters with recipient TPL data and encounter data remittance advices, and accept encounter data for this function;
- o the state eligibility system; and
- o the enrollment agent.

3.3.16 EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) PROCESSING

The EPSDT processing function serves as the state's mechanism to enroll, adjudicate, identify, and track EPSDT services, referrals and costs, and to generate EPSDT informing and screening letters to eligible recipients. All Medicaid eligible children under age 21 are eligible for EPSDT services. The state does not require Medicaid eligible children to be formally enrolled in the EPSDT program. The EPSDT processing function supports the state's goals of:

- o providing Oklahoma medical assistance recipients under the age of 21 with a continuing system of health screenings and treatment services to permit early detection of potentially chronic or disabling health conditions and referrals as medically necessary,
- o encouraging regular health care for these recipients to reduce the occurrence of more serious and costly health problems, and
- o maximizing federal funds for the provision of health care to Oklahoma eligible recipients under the age of 21.

EPSDT-eligible children are allowed to receive services not always available to the general medical assistance population. EPSDT screening and treatment services are submitted on the HCFA-1500, the UB-92, dental claim form, and managed care plan encounters using special state assigned procedure codes , revenue center codes, or Current Dental Terminology (CDT) codes.

The MMIS should support the generation of EPSDT informing and screening letters to recipients. The primary objectives of the automated EPSDT function of the MMIS are to:

- o maintain identification of all individuals eligible for EPSDT services,
- o provide paid claim records data to the state for EPSDT paid services, and
- o provide reports for tracking and monitoring purposes and to meet federal and state reporting requirements (HCFA 416).

3.3.17.1 Inputs

The MMIS EPSDT Processing function must accept the following inputs:

- o recipient demographics and program eligibility,
- o the periodicity schedule,
- o paid claims data from the Claims Processing functions,
- o reference data for procedure codes,
- o immunization data from the Health Department, and
- o Department of Education school data files to match for EPSDT recipients.

3.3.17.2 Processing

The MMIS EPSDT Processing function must have the following processing capabilities:

3.3.17.2.1

Maintain flexibility in coding structures by use of parameter and table oriented design techniques, for data such as, HCFA identified EPSDT procedures, to support changes to claims processing and reporting requirements.

3.3.17.2.2

Maintain access to data through user friendly systems navigation technology and a graphical user interface (GUI) that allows users to move freely throughout the system using pull down menus and “point and click” navigation without having to enter identifying data multiple times.

3.3.17.2.3

Provide for context-sensitive help on screens for easy, “point and click” access to valid values and code definitions by screen field.

3.3.17.2.4

Maintain the EPSDT periodicity schedule.

3.3.17.2.5

Provide on-line inquiry to all EPSDT data with access by recipient ID and provider number.

3.3.17.2.6

Maintain, for each EPSDT eligible recipient, the current and historical screening results, referral, diagnosis and treatment, and immunizations, including the provider numbers and dates.

3.3.17.2.7

Identify screening claims adjudicated during claims processing.

3.3.17.2.8

Identify abnormal conditions, by screening date, and whether the condition was treated or referred for treatment.

3.3.17.2.9

Track abnormal conditions that have been referred but not yet treated, to claims submitted for the recipient, until all abnormal conditions have been treated or the State specifies that tracking should be stopped.

3.3.17.2.10

Update recipient EPSDT data with screening results and dates, and referral and treatment dates for abnormal conditions.

3.3.17.2.11

Provide on-line, updateable letter templates for all EPSDT notices.

3.3.17.2.12

Automatically generate notices to caseheads for notice of screenings due, screenings missed, and abnormal conditions not treated, based on State criteria.

3.3.17.2.13

Maintain all notices sent, identifying case and recipient, and date notice sent.

3.3.17.2.14

Generate a file to DHS of all notices sent, identifying case and recipient, and date notice sent.

3.3.17.2.15

Generate a file to each HMO and PCP/CM of notices sent to recipients enrolled with the HMO or PCP/CM, identifying case and recipient, and date notice sent.

3.3.17.2.16

Process data files from schools, performing a match by name, SSN, date of birth, sex, and so forth and generate a file to the appropriate school identifying the school assigned number, the Medicaid recipient number, any HMO, any Primary Care Provider, eligibility begin and end dates, and date of last screening.

3.3.17.2.17

Track EPSDT screenings by PCP/CM and generate an incentive payment (Kick payment) based on the State defined threshold.

3.3.17.2.18

Track immunizations provided by fee-for-service providers to EPSDT recipients enrolled in managed care and generate an adjustment to the capitation payment based on State defined criteria.

3.3.17.2.19

Ensure that HCFA 416 and MSIS balances for the number of EPSDT eligibles.

3.3.17.3 Outputs

The MMIS EPSDT Processing function must provide the following outputs:

- o All data shall be available for retrieval through the DSS/DW function.

- o All reports must be made available in data format for export and import purposes and through multiple medias such as paper, cd-rom, and so forth.
- o The following types of reports must minimally be available:
 - . the mandated Federal EPSDT report (HCFA-416), identifying whether they are enrolled in any type of managed care, in the federally required format.
 - . Management reports which can be sorted by county; by HMO, PCP/CM, or none; by provider number; by aid category; then ordered alphabetically by the head of case with children identified under the case, which include English language descriptions of report data, and which detail the following:
 - screenings performed;
 - abnormalities found;
 - immunizations delivered;
 - dental procedures performed;
 - orthodontic procedures performed, including date of approval;
 - referral treatments recommended and initiated;
 - age groupings and geographic summaries of the above;
 - summary screening and results reports;
 - detailed EPSDT-related service reports, by recipient, on request;
 - number of days between screening and referred treatment;
 - screening cost analysis, by screening provider, showing utilization and expenditure data;
 - health status analysis reports, by county, using key child health indicators such as procedure codes or claim form indicators to identify health status such as immunized children;
 - expenditures for children who were screened compared to those who were not screened;
 - untreated abnormalities after thirty (30) days and sixty (60) days, by recipient, and

- provider EPSDT service participation information, by county and specialty, sub-specialty.
- o Non-participation and other monitoring/tracking reports as necessary.
- o On-line retrieval of EPSDT data screening results, treatment provided, and the dates associated with each.
- o The EPSDT last screening date included as part of the recipient eligibility verification response to provider inquires.

3.3.17.4 Interfaces

The MMIS EPSDT Processing function must accommodate an external interface with the:

- o Department of Education for school data files,
- o Department of Health for immunization data,
- o internet, and
- o State WAN for access by counties.

3.3.18 THIRD PARTY LIABILITY (TPL) PROCESSING

The TPL processing function helps the State of Oklahoma utilize the private health, Medicare, and other third party resources of its medical assistance recipients, and ensures that Medicaid and the state are the payors of last resort. This function works through a combination of cost avoidance (non-payment of billed amounts for which a third party may be liable) and post-payment recovery (post-payment collection of Medicaid and the state paid amounts for which a third party is liable).

Cost avoidance is the preferred method for processing claim records with TPL. This method must be implemented automatically by the MMIS through application of edits and audits which check claim information against various data fields on recipient, TPL, reference, or other MMIS files. Post-payment recovery is primarily a back-up process to cost avoidance, and is also used in certain situations where cost avoidance is impractical or unallowable.

The TPL information maintained by the MMIS will include recipient TPL resource data, insurance company data, employer health insurance data, health plan coverage data, post payment recovery threshold information, and tracking data. The TPL processing function will assure the presence of this information for use by the Edit/Audit Processing, Financial Processing, and Claim Pricing functions, and will also use it to perform the functions described in this subsection for TPL Processing.

3.3.18.1 Inputs

The following are inputs to the TPL function of the MMIS:

- o data matches with files from other government programs, such as the Defense Enrollment Eligibility Reporting System (DEERS), the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); private insurance carriers, or other State specified sources;
- o current and/or retroactive Medicare information from BENDEX, or other sources;
- o on-line health coverage data, including retroactive changes to TPL data, supplied by the State;
- o worker's compensation data for matching;
- o TPL-related data from claims, claim attachments, or claims history files, including but not limited to:
 - . diagnosis codes, procedure codes, or other indicators suggesting trauma or accident;
 - . indication that a TPL payment has been made for the claim (including Medicare);
 - . indication that the recipient has reported the existence of TPL to the provider submitting the claim;
 - . indication that TPL is not available for the service claimed; and
 - . subrogation indicators;
- o recipient eligibility and suspect TPL resource information from the State based on initial and continuing recipient eligibility determinations;
- o TPL information identified while working adjustments for recoupments;
- o correspondence and phone calls from recipients, carriers, and providers;
- o parameters entered on-line to identify paid claims for tracking and potential recovery;
- o parameter-driven requests for paid and denied claims histories for fulfillment of attorney requests;
- o the state's Great Plains system "gross" TPL related deposit/receivable data; and

- o recipient, reference, and provider data.

3.3.18.2 Processing

The TPL processing function must include the following capabilities:

3.3.18.2.1

Provide for context-sensitive help on screens for easy, “point and click” access to valid values and code definitions by screen field.

3.3.18.2.2

Provide for context-sensitive help on screens for easy, “point and click” access to valid values and code definitions by screen field.

3.3.18.2.3

Provide for multiple, date-specific TPL resources (including Medicare) for each recipient.

3.3.18.2.4

Maintain all third-party resource information by recipient including but not limited to:

- o name, ID number, date of birth, SSN of eligible recipient;
- o insurance carrier name and ID;
- o policy number or Medicare health insurance code (HIC) number;
- o group name and number;
- o CHAMPUS sponsor identification number, service branch, recipient relationship to policyholder;
- o source code indicating source of suspect TPL information;
- o primary carrier indicator identifying if this is the policy to be billed first;
- o policy deductible and co-pay;
- o insurance alternate mailing address;
- o name and address of policyholder, relationship to eligible recipient, SSN of policyholder;
- o indicator of TPL resource exhaustion;

- o employer name and address of policyholder;
- o premium amount;
- o type of policy, type of coverage, and inclusive dates of coverage;
- o railroad number;
- o date and source of TPL resource verification; and
- o unlimited free-form text notes/comments.

3.3.18.2.5

Maintain third-party carrier information that includes but is not limited to:

- o carrier name and ID,
- o contact person and telephone number,
- o corporate correspondence address and telephone number,
- o claims submission address(s) and telephone number,
- o billing media,
- o billing number, and
- o care responsibility code.

3.3.18.2.6

Maintain the capability to display, inquire into, or update recipient third party liability data and carrier data on-line.

3.3.18.2.7

Generate a carrier and recipient third party liability update transactions, in an agreed upon State approved format and media, on an agreed upon periodic basis, for the State.

3.3.18.2.9

Edit on-line, real time transaction data for presence, format, validity, and consistency with other data in the update transaction and in the TPL files.

3.3.18.2.10

Maintain a process to identify projected allowed amount for previously denied claims in order to estimate savings due to TPL.

3.3.18.2.11

Provide for on-line resolution of TPL edit errors and the capability to add denial edit codes to claims.

3.3.18.2.12

Identify all payment costs avoided due to established TPL, as defined by the State and federal governments.

3.3.18.2.13

Maintain an automated tracking capability for post payment recovery actions which applies to health insurance, casualty insurance, estates and all other types of recoveries, and which can track individual or grouped claims from the initiation of recovery efforts to closure.

3.3.18.2.14

Provide for unique identification of recovery records.

3.3.18.2.15

Provide for on-line display, inquiry, and updating of recovery case records with access by unique recovery case identification number, case type, policy number, policyholder name, policyholder social security number, claim number, recipient name or number, carrier name, carrier number, provider name or number, attorney name, accident number, the states Great Plains system "H number" or a combination of these data elements.

3.3.18.2.16

Provide for attorney name, attention line, address and telephone number on recovery case records.

3.3.18.2.17

TPL accounts receivable for recoveries must be integrated within the consolidated accounting ledger reflecting all receivables due, payments made, and adjustments or write-offs applied.

3.3.18.2.18

Provide the capability to bill carriers for “pay and chase” claims and automatically create a case once claims have accumulated to the State defined threshold amount.

3.3.18.2.19

Provide for on-line display of all “gross” receivables for TPL on the MMIS for which claims detail postings have not been completed and the total amount unposted.

3.3.18.2.20

Maintain a process to automatically identify previously paid claims for recovery when TPL resources are identified or verified retroactively, and automatically create a recovery case to initiate recovery within a time period specified by the State.

3.3.18.2.21

Maintain a process to generate invoices to carriers and attorneys using HIPAA criteria, or other State approved criteria that are consistent with industry standards and format and/or paper if required.

3.3.18.2.22

Provide for the initiation of recovery action at any point in the claim processing cycle.

3.3.18.2.23

Automatically set all claims for a recipient to cost avoid if there is no carrier response to an insurance verification response after a State defined period.

3.3.18.2.24

Implement processing procedures which identify and support recovery actions on Medicaid paid claims which become eligible for Medicare coverage as the result of a successful Medicare appeal process.

3.3.18.2.25

Provide for automated tracking of recoveries, and posting of recoveries to individual claim histories.

3.3.18.2.26

Provide for claims adjusted to post TPL recovery amounts to be excluded from edit/audit processing (history-only adjustments).

3.3.18.2.27

Provide the ability to selectively direct claims for Medicare recoupment when Medicare coverage is discovered while posting recovered dollars to a recovery case.

3.3.18.2.28

Provide the capability to delete any and all TPL related data on-line.

3.3.18.2.29

Track individual claims and multiple claims for a recipient that reach a State-defined threshold (for example, \$200) and automatically create a questionnaire report with all claims data where a possible recovery should be initiated. Provide for on-line review capability and the ability to automatically set up the recovery case.

3.3.18.2.30

Provide the ability to add or delete claims that are included in any recovery case created for review.

3.3.18.2.31

Provide the ability to add and update the threshold amount on-line.

3.3.18.2.32

Accept free-form user notes on automated recovery tracking records.

3.3.18.2.33

Maintain six (6) years on-line claims history and open TPL recovery cases, of on-line, current and historical information on third-party resources for each recipient and the third-party carrier information to support this.

3.3.18.2.34

Maintain all open recovery cases on-line.

3.3.18.2.35

Maintain closed recovery cases on-line for three (3) years.

3.3.18.2.36

Maintain and flag claims that are part of a TPL recovery/cost avoidance case on-line for three (3) years after the case is closed before archiving.

3.3.18.2.37

Provide a flag on recipients for which a TPL recovery/cost avoidance case has been created and maintain the recipient data on-line for three (3) years after the recovery/cost avoidance case is closed.

3.3.18.2.38

Provide the capability to purge old closed TPL recovery cases to a cd-rom, based upon state defined criteria.

3.3.18.2.39

Automatically create questionnaires for accident/trauma based on State-defined criteria. Provide for on-line review capability and the ability to cancel or approve the questionnaire.

3.3.18.2.40

Provide the capability to automatically set up a case for recovery based on the on-line approval of an accident/trauma questionnaire.

3.3.18.2.41

Provide the ability to add and update the criteria for questionnaires on-line.

3.3.18.2.42

Provide a process to perform data matching with other government agencies and private insurers to identify potential TPL resources.

3.3.18.2.43

Edit all batch input transactions from data match processes to ensure consistency and validity of data.

3.3.18.2.44

Accept indicators of recipients for whom insurance premiums have been paid by the State, including but not limited to data such as effective dates.

3.3.18.2.45

Provide a process to correctly pay deductible amounts/coinsurance amounts for those individuals for whom insurance premiums have been paid by the State, including Medicare and premium purchase group or individual health insurance beneficiaries.

3.3.18.2.46

Maintain a secure on-line maintainable TPL Cost Avoidance/Recovery Matrix.

3.3.18.2.47

Maintain a process to meet the requirements of the State Medicaid Manual regarding Medicaid Payments for Recipients Under Group Health Plans, including the capability to perform cost-effectiveness analysis.

3.3.18.2.48

Implement processing procedures which correctly identify and cost avoid claims having potential TPL, and flag claims for future recovery to the appropriate level of detail.

3.3.18.2.49

Provide for on-line updateable templates of letters and questionnaires to carriers, employers, recipients, providers, and attorneys when recoveries are initiated, when premium payments are to be made, when TPL resource data is needed, or when accident information is required and was not supplied with the incoming claim.

3.3.18.2.50

Automatically generate letters and questionnaires to carriers, employers, recipients, providers, and attorneys according to State criteria.

3.3.18.2.51

Provide the ability to add or update the letter and questionnaire criteria parameter on-line.

3.3.18.2.52

Automatically generate claim facsimiles, which can be sent to carriers, attorneys, or other parties.

3.3.18.2.53

Provide the ability to retrieve paid claims from history, to assist in recovery, based on parameters including but not limited to:

- o pay date,
- o date of service,
- o claim type,
- o provider number,
- o provider type,
- o category of service,
- o recipient ID,
- o diagnosis code or range,
- o procedure code,
- o drug code, and
- o drug therapeutic class.

3.3.18.2.54

Provide processes and data to meet minimum requirements of the State Medicaid Manual, Part 11 and Section 3900, State Medicaid Manual, Part 3.

3.3.18.3 Outputs

The MMIS TPL function must provide the following outputs:

3.3.18.3.1

All data shall be available for retrieval through the DSS/DW function.

3.3.18.3.2

All reports must be made available in data format for export and import purposes and through multiple media such as paper, cd-rom, and so forth.

3.3.18.3.3

Generate all federal and state required reports to support the TPL function.

3.3.18.3.4

Generate cost-avoidance summary savings reports, including Medicare but identifying it separately.

3.3.18.3.5

Generate listings and totals of cost-avoided claims.

3.3.18.3.6

Generate listings and totals of third-party resources utilized.

3.3.18.3.7

Generate listings and totals of potential recovery claims based on user-input selection parameters.

3.3.18.3.8

On-line screens for the review and cancellation or approval of questionnaires for accident/trauma.

3.3.18.3.9

Generate letters based on approval of an accident/trauma questionnaire.

3.3.18.3.10

Report amounts billed and collected, current and historical, from the TPL recovery tracking system, by carrier, recipient, and clerk ID.

3.3.18.3.11

Generate an aging report for attempted recoveries by carrier and recipient.

3.3.18.3.12

Report the number and amount of recoveries by type; for example, estate, private insurance, and so forth.

3.3.18.3.13

Report unrecoverable amounts by type and reason, carrier, and other relevant data, on an aged basis and in potential dollar ranges.

3.3.18.3.14

Report potential trauma and/or accident claims for claims which meet specified dollar threshold amounts.

3.3.18.3.15

Report services subject to potential recovery when date of death is reported.

3.3.18.3.16

Provide unduplicated cost-avoidance reporting by program category and by type of service, with accurate totals and subtotals.

3.3.18.3.17

Provide monthly listings of TPL carrier coverage data.

3.3.18.3.18

Provide audit trails of changes to TPL data.

3.3.18.3.19

Provide summary and detailed reports on premiums, deductibles, and coinsurance paid by Medicaid on behalf of the recipient.

3.3.18.3.20

Letters and questionnaires to carriers, employers, recipients, providers, and/or attorneys, based on State-defined criteria, when recoveries are initiated, when premium payments are to be made, when TPL resource data is needed, or when accident information is required and was not supplied with the incoming claim.

3.3.18.3.21

Automatically generate claim facsimiles which can be sent to carriers, attorneys, or other parties.

3.3.18.3.22

On-line inquiry screens which will minimally accommodate the following, using a minimal number of screens:

- o Recipient current and historical TPL data;
- o TPL Matrix, security needs to be set at screen level;
- o TPL carrier data;
- o Recovery cases;
- o Threshold and Criteria information;
- o TPL Cost avoidance matrix; and
- o Claims suspended/denied for TPL errors.

3.3.18.3.23

Provide verified recipient TPL update transactions generated from data matches, claims, recoveries and so forth, to the State, in an agreed upon format and media, on a periodic basis.

3.3.18.3.24

Provide reports of recipient TPL resources terminated during a specified reporting period.

3.3.18.3.25

Provide a carrier update transactions, to the State, in an agreed upon format and media, on an agreed upon periodic basis.

3.3.18.3.26

Generate cd-roms of purged TPL recovery cases based on state defined criteria.

3.3.18.4 Interfaces

The TPL function must interface with and support where necessary:

- o the State, for providing a TPL carrier and recipient TPL update transactions;
- o other governmental agencies through data matching;
- o private insurers, such as health and automobile, through data matching; and
- o workers' compensation through data matching.

3.3.19 CASE MANAGEMENT

OHCA recognizes the need to automate the case management and tracking of various activities relating to the management of cases. The case management function must allow the recording of case information, the tracking of the case processes, and to produce any associated reports.

3.3.19.1 Inputs

The MMIS Case Management function must accept the following inputs:

- o suspended for medical review claims;

- o manual referrals for medical review for determination of medical necessity;
- o claims for recipients that have reached a state defined threshold,
- o claims for certain procedures, NDCs and diagnoses as defined by the state;
- o claims history of recipient services;
- o provider, recipient, and reference data related to the suspended claims; and
- o other inputs may include internal/external e-mails, faxes, phone calls, letters, or on-line referrals or inquiries.

3.3.19.2 Processing

The MMIS Case Management function must have the following processing capabilities:

3.3.19.2.1

Provide for context-sensitive help on screens for easy, “point and click” access to valid values and code definitions by screen field.

3.3.19.2.2

Provide on-line, real-time claims medical review and edit override capabilities for all claim types.

3.3.19.2.3

Maintain claim medical review screens which display all claims data as entered and subsequently updated.

3.3.19.2.4

Maintain inquiry and update capability to claim medical review screens with access by control number, provider ID (servicing and/or pay-to), recipient ID, and/or claim location.

3.3.19.2.5

Accept forced edits to suspended for medical review claims based on State-defined criteria, and release claims to editing or claim pricing processing as appropriate.

3.3.19.2.6

Provide access to related provider data from the Provider Data Maintenance function through windowing, split screen, or other design techniques.

3.3.19.2.7

Provide access to related recipient data from the Recipient Data Maintenance function through windowing, split screen, or other design techniques.

3.3.19.2.8

Provide access to related reference data from the Reference Data Maintenance function through windowing, split screen, or other design technique.

3.3.19.2.9

Identify and provide access to potential duplicate claims and related claims data from the claims history and status files through windowing, split screen, or other design technique.

3.3.19.2.10

Provide access to the status of any related limitations for which the recipient has had services, such as the number of office visits paid per month.

3.3.19.2.11

Assign a claim status of "suspended for medical review" to all claims to be reviewed.

3.3.19.2.12

Assign a unique status to medically reviewed claims.

3.3.19.2.13

Provide the capability of entering multiple EOB codes for a claim to appear on the Remittance Advice (RA).

3.3.19.2.14

Maintain all claims for medical review on the suspense file until reviewed, automatically recycled, or automatically denied according to State specifications.

3.3.19.2.15

Provide the capability to identify operators who can perform a force or override on an error code based on individual operator IDs and authorization level.

3.3.19.2.16

Provide the ability to accept referrals for medical review by e-mail and automatically create a case, populating the recipient demographic data based on the input of the recipient ID and provider demographic data based on input of the provider ID.

3.3.19.2.17

Provide on-line “to do” listings of referrals outstanding, cases without medical decisions, and so forth.

3.3.19.2.18

Maintain an automated tracking capability to accept referrals for cases for review of medical necessity and the ability to maintain the recipient the referral is for, why it is being referred, who it is referred by, and what the medical decision is.

3.3.19.2.19

Provide for unique identification of medical review cases.

3.3.19.2.20

Provide for on-line display, inquiry, and updating of medical review case records.

3.3.19.2.21

Ability to limit access to medically sensitive information contained in a case through different levels of security.

3.3.19.2.22

Provide the ability to identify that a recipient has been “authorized” for service based on the medical decision and the ability to forward notice of that decision to related parties such as the referring person, the recipient, and/or the provider.

3.3.19.2.23

Provide for immediate access to all recipient claims history relative to the services medical authorization is being sought for (DME services, Hemophiliac services, Pharmacy, Home Health, in-home nursing services and so forth).

3.3.19.2.24

Provide for on-line updateable templates of notices of medical decision and requests for additional information to recipients, providers, and referring parties.

3.3.19.2.25

Provide for the ability of adding free-form text to template letters on an ad hoc basis.

3.3.19.2.26

Automatically generate notices and letters according to State criteria.

3.3.19.2.27

Provide the ability to add or update the notice and letters criteria parameter on-line.

3.3.19.2.28

Provide the ability to maintain “notes” by recipient to identify recipients referred for case management, those under case management, and those released from case management and who is in charge of review of this recipient.

3.3.19.2.29

Provide for an immediate alert to anyone inquiring on the MMIS on this recipient to the “notes” for this recipient.

3.3.19.2.30

Provide the ability to flag recipients and providers in the “notes” capability as to any reviews such as medical, legal and so forth, the recipient or provider may be under.

3.3.19.2.31

Provide the ability to flag recipients who should be receiving restricted services for a period of time and provide this information in the “notes” capability.

3.3.19.2.32

Provide processes and data to meet minimum requirements of Part 11 of the State Medicaid Manual.

3.3.19.3 Outputs

The MMIS Case Management function must provide the following outputs:

- o All data shall be available for retrieval through the DSS/DW function.
- o All reports must be made available in data format for export and import purposes and through multiple medias such as paper, cd-rom, and so forth.
- o The following types of reports must minimally be available:
 - . reports to meet all federal and state reporting requirements,
 - . medical review cases that have been closed,
 - . medical authorizations requiring progress reviews based on severity of authorized services and end date of authorization, and
 - . reports on address changes of recipients under case management.
- o Updated claim records to recycle through claim editing or pricing processing as appropriate.
- o On-line screens to support the medical review case management, as defined above, and to document claim medical reviews once they have been accomplished.

3.3.19.4 Interfaces

The Case Management function must externally interface for e-mail capability.

3.3.20 FINANCIAL ACCOUNTING AND REPORTING

The Financial Accounting function encompasses claim payment processing, accounts receivable processing, and all other financial transaction processing. It ensures that all funds are appropriately disbursed for claim payments and all post-payment transactions are applied accurately.

3.3.20.1 Inputs

The MMIS Financial Accounting function must accept the following inputs:

- o Transactions containing total amount of dollars, per check, received by the State on the Great Plains system for TPL recoveries, drug rebates, medical refunds and so forth.
- o Transactions for corrections to receivables entered to the Great Plains system and corrections to manual checks.

- o Transactions (ADM-12) for manual checks written by the State.
- o Transactions for paper checks, written by the state due to failed EFT, for history purposes.
- o Transactions of new and updated EFT provider information from the State Treasury Office (STO).
- o Requests to override EFT and create paper checks for a date range and check pulls.
- o Transactions of warrant status from the State Treasury Office (STO) including checks pulled at STO.
- o Claims payment data from the MMIS.

3.3.20.2 Processing

The MMIS Financial Accounting function must have the following processing capabilities:

3.3.20.2.1

Process the transactions received from the Great Plains system for checks received, maintaining the unique control number from the Great Plains system, the entity the check received from, the bank the check is written from, the check number, the amount of the check, and the unit the receivable directed to.

3.3.20.2.2

Process any change transactions received from the Great Plains system for corrections to checks received.

3.3.20.2.3

Provide an automated alert and the Great Plains receivable information to the unit responsible to post the detail, for example TPL, drug rebate, medical refund, and so forth.

3.3.20.2.4

Maintain on-line access and update capability to a single consolidated accounting system which provides for “posting” the detail of checks received by the Great Plains system to MMIS cases for TPL recovery, drug rebate, medical refunds and so forth.

3.3.20.2.5

Provide for the balancing of details posted to each Great Plain receivable transaction. There may be multiple recovery cases or drug rebate invoices for each Great Plain receivable transaction. Update and reflect appropriate data on the claims history and provider paid claims summary information.

3.3.20.2.6

Generate transactions to the Great Plain system with the gross dollar amount of receivables created and invoiced and write-offs taken on the MMIS by the Great Plains system accounting code.

3.3.20.2.7

Process ADM-12 transactions for manually written checks generating a claims history record.

3.3.20.2.8

Process EFT provider information updating provider records to reflect their status with EFT.

3.3.20.2.9

Accept requests to override EFT payment to a provider and create the warrant request as a paper check request.

3.3.20.2.10

Process warrant information from the STO, updating payment information such as EFT transaction number, check number, cycle date, and date payment sent.

3.3.20.2.11

Process any check pull information, voiding claim(s) where appropriate.

3.3.20.2.12

Maintain flexibility in coding structures by use of parameter and table oriented design techniques, for data such as, accounting codes and receivable posting instructions.

3.3.20.2.13

Generate provider 1099/W2's tape and reports annually, which indicate the total paid claims plus or minus any appropriate adjustments and financial transactions.

3.3.20.2.14

Maintain a process to adjust providers' 1099/W2's earnings reports and update claims history and/or the consolidated accounting system accordingly.

3.3.20.2.15

Maintain lien and assignment information to be used in directing or splitting payments to the provider and lien holder.

3.3.20.2.16

Identify providers with credit balances and no claim activity, by program, during a State-specified number of months.

3.3.20.2.17

Accept claim-specific and gross recoveries, regardless of submitter (provider, carrier, recipient, drug manufacturer); apply gross recoveries to providers and/or recipients as identifiable.

3.3.20.2.18

Provide a process to designate to which Federal fiscal year claim adjustments and other financial transactions are to be reported.

3.3.20.2.19

Maintain a process to identify and recoup payments, from the provider, made for services after a recipient's date of death.

3.3.20.2.20

Generate transactions to the Great Plains system for claims including a state share.

3.3.20.2.21

Produce the HCFA 64.9 with different pages for CHIP cost share reporting.

3.3.20.2.22

Produce a HCFA 2082-like report.

3.3.20.2.23

Produce the MSIS tapes.

3.3.20.2.24

Produce current reports from the distribution list including behavioral health reports, psychology reports, expenditure reports and so forth.

3.3.20.2.25

Produce the county summary reports.

3.3.20.2.26

Produce unduplicated active recipients and providers report by fiscal year.

3.3.20.2.27

Produce quarterly recipient ranking by total claims by county and by aid category.

3.3.20.2.28

Produce the HCFA 372 waiver reports including the cost effectiveness reports currently being designed.

3.3.20.2.29

Update claims history with warrant number and warrant issued date from the STO Register file.

3.3.20.2.30

Maintain a process to capture back-up withholding and report on 1099.

3.3.20.3 Outputs

The MMIS Financial Accounting function must provide the following outputs:

- o all federal and state required reports;
- o expenditure reports to the Great Plains system by accounting codes for the HCFA 340;

- o end of the month balancing reports, such as, paid, outstanding, and issued warrants, including, canceled by statute, canceled, and stop-pay warrants;
- o gross receivables invoiced by accounting code;
- o weekly claims warrant requests to STO;
- o monthly capitation warrant requests to STO;
- o weekly claims warrant registers;
- o monthly capitation warrant registers;
- o weekly claims balancing reports;
- o monthly capitation balancing reports;
- o 1099 tapes to the IRS, W2 tapes to the SSA, and earnings information as necessary to the Oklahoma Tax Commission;
- o the HCFA 64.9 report;
- o HCFA 2082-like reports;
- o MSIS tapes; and
- o HCFA 372 waiver reports;
- o current reports from the distribution list including behavioral health reports, psychology reports, expenditure reports and so forth; and
- o the county summary reports.

3.3.20.4 Interfaces

The Financial Accounting function must accommodate an external interface with the:

- o State, for interface with the Great Plains system,
- o STO, to provide warrant requests,
- o STO to receive warrant information and EFT provider information,
- o IRS, to provide 1099,
- o SSA to provide W2 information,
- o Oklahoma Tax Commission, and

- o the MMIS.

3.3.21 RETROSPECTIVE DRUG UTILIZATION REVIEW (DUR)

The Drug Utilization Review (DUR) function provides for a prospective and retrospective review of drug utilization by recipients. Retrospective DUR provides a methodology to monitor recipients who receive multiple drug prescriptions with indications of possible drug interaction conflicts, to monitor the pharmacists and providers who are dispensing and ordering drugs, and to monitor recipients' patterns of utilization, for detecting inappropriate drug therapies.

The objectives of the retrospective DUR system are to:

- o promote efficiency and cost-effectiveness in the use of pharmaceutical services,
- o eliminate unnecessary and/or inappropriate use of drugs and help identify possible inappropriate drug therapy patterns,
- o develop therapeutic class criteria to reduce the incidence of drug therapy failure and drug-induced illness, and
- o establish and maintain drug history profiles.

3.3.21.1 Inputs

The MMIS Retrospective Drug Utilization Review function must accept the following inputs:

- o recipient data,
- o claims history data,
- o provider data,
- o DUR reporting parameters, and
- o DUR criteria/standards set by DUR board based on OBRA.

3.3.21.2 Processing

The MMIS Retrospective Drug Utilization Review function must have the following processing capabilities:

3.3.21.2.1

Generate a file of paid drug claims, in a State specified format and media, on an agreed upon periodic basis;

3.3.21.2.2

Generate a file of physician, clinic, and pharmacy provider data, including name and address, in a state specified format and media, on an agreed upon periodic basis;

3.3.21.2.3

Generate a file of recipient data and necessary control reports.

3.3.21.3 Outputs

The MMIS Retrospective Drug Utilization Review function must provide the following outputs:

- o All data shall be available for retrieval through the DSS/DW function.
- o All reports must be made available in data format for export and import purposes and through multiple medias such as paper, cd-rom, and so forth.
- o The claim file for the state or outside DUR contractor.
- o The provider file for the state or outside DUR contractor.
- o The recipient file for the state or outside DUR contractor.
- o Control reports.

3.3.21.4 Interfaces

The MMIS Retrospective Drug Utilization Review function must accommodate an external interface with any outside DUR contractor.

3.3.22 PROSPECTIVE DRUG UTILIZATION REVIEW (PRO-DUR)/ELECTRONIC CLAIMS MANAGEMENT (ECM)

The Drug Utilization Review (DUR) function provides for a prospective and retrospective review of drug utilization by recipients. Prospective DUR can prevent the dispensing of inappropriate drugs through direct intervention.

The MMIS shall have an integrated prospective DUR system that incorporates direct access to the MMIS for the purpose of performing prepayment review of drug therapy before prescriptions are filled. In addition, the prospective DUR function shall

use the access network for direct, electronic claims management (ECM) of drug claim records. Prospective DUR must be performed prior to claim adjudication. The proposal must consider the existing the existing switching companies, including, but not limited to, National Data Corporation and Envoy.

3.3.22.1 Inputs

The MMIS Prospective Drug Utilization Review (PRO-DUR)/Electronic Claims Management (ECM) function must accept the following inputs:

- o DUR criteria and standards set by the DUR Board based on OBRA,
- o claims history data,
- o recipient data,
- o provider data,
- o reference data,
- o DUR reporting parameters,
- o Claim submittal from providers, and
- o inquiries and response comments from providers.

3.3.22.2 Processing

The MMIS Prospective Drug Utilization Review (PRO-DUR)/Electronic Claims Management (ECM) function must have the following processing capabilities:

3.3.22.2.1

Provide for an interactive session that accepts submitted pharmacy claims and processes to identify and alert the provider problems associated with inappropriate drug use prior to dispensing.

3.3.22.2.2

Allow for the submitting provider to respond to alerts by overriding alerts or reversing the claim submitted.

3.3.22.2.3

Provide the capability to identify alerts that are to be a warning on claim denials.

3.3.22.2.4

Provide an audit trail of all inquiries, including who made the inquiry, information input, and response provided.

3.3.22.2.5

Provide alerts for drugs requiring prior authorization, and allow providers to immediately apply for prior authorization, submit information required to justify prior authorization, receive authorization if appropriate, and complete claim adjudication on-line.

3.3.22.2.6

Provide for pricing of pharmacy claims according to the appropriate program control code according to the State policy, including pricing actions such as FUL, MAC, WAC, EAC, AWP, SUL and so forth, including pricing of compound drugs in accordance with state policy.

3.3.22.2.7

Provide for on-line real-time prospective drug utilization review and electronic claims management (on-line claim adjudication) PRO-DUR/ECM for all pharmacy claims utilizing both variable and non-variable NCPDP formats.

3.3.22.2.8

Allow for submittal of decimal units on claims and calculate payment based on the decimal versus rounding to a whole unit.

3.3.22.2.9

Provide for prospective drug utilization review for drug to drug, drug to therapeutic class, pregnancy, high and low utilization, early and late refills, pediatric usage, geriatric usage, duplicate therapy, duration of therapy and other available modules for drug utilization review and send appropriate alerts and accept appropriate overrides of alerts.

3.3.22.2.10

Process all pharmacy claims in PRO-DUR/ECM consistent with State policy.

3.3.22.2.11

Allow for on-line pharmacy claim reversal/adjustment for one month plus days supply from date of adjudication.

3.3.22.2.12

Allow for editing across claim types including pharmacy against J codes to insure both are not billing for nursing home and inpatient stays or pharmacy claims against Durable Medical Equipment.

3.3.22.2.13

Provide for editing claims for an active prescriber number.

3.3.22.2.14

Provide for an enrollment status that indicates whether a prescriber only has retired and/or died.

3.3.22.2.15

Support managed care editing for inclusion or exclusion of pharmacy services.

3.3.22.2.16

Provide for increases and decreases in payments based on utilization and physician and pharmacist pairings.

3.3.22.2.17

Maintain an on-line audit trail of all PRO-DUR/ECM transactions, including all data submitted by the provider and all responses sent to the provider.

3.3.22.2.18

Provide on-line electronic claims management component meeting the requirements of the State Medicaid Manual, Part 11.

3.3.22.2.19

Ability to accept multiple NDCs and associate price to calculate total allowed for compound drugs.

3.3.22.2.20

Allow for variable dispensing fees.

3.3.22.3 Outputs

The MMIS Prospective Drug Utilization Review (PRO-DUR)/Electronic Claims Management (ECM) function must provide the following outputs:

- o All data shall be available for retrieval through the DSS/DW function.
- o All reports must be made available in data format for export and import purposes and through multiple media such as paper, cd-rom, and so forth.
- o The following types of reports must minimally be available:
 - . periodic reports required by HCFA,
 - . expenditure reports,

- . family planning expenditure reports,
- . recipient and provider profiles,
- . reports to the DUR Board for review of output and approval of corrective actions,
- . audit trail reports of all PRO-DUR/ECM transactions,
- . management reports, and
- . updated parameter data set.

3.3.22.4 Interfaces

The MMIS Prospective Drug Utilization Review (PRO-DUR)/Electronic Claims Management (ECM) function must accommodate an external interface with drug dispensing providers' access equipment and/or networks.

3.3.23 DRUG REBATE PROCESSING

Federal regulations provide for drug manufacturers, with whom HCFA has a formal agreement and whose drug products are covered by Medicaid, to give financial rebates determined by the volume of the manufacturer's products dispensed by the program. Oklahoma requires the MMIS to provide automated support to carry out the federal mandates related to drug rebate processing.

3.3.23.1 Inputs

The following are inputs to the Drug Rebate Processing function of the MMIS:

- o data from HCFA and OHCA (for any state funded rebate program) which identifies manufacturers with whom rebate agreements exist,
- o data from HCFA and OHCA which updates manufacturer information on participation status in the rebate program and the rebate amount and units of measure,
- o paid claims data including adjustments,
- o disputes from drug manufacturers,
- o interest rate information,
- o invoicing media requests from manufacturers,

- o updates, including, postings of the detail on drug rebate deposit/receivables, reconciliation and dispute resolution information and adjustments to previous entries,
- o reference data, and
- o the State’s Great Plains system “gross” drug rebate related deposit/receivable data.

3.3.23.2 Processing

The Drug Rebate Processing function must include the following capabilities:

3.3.23.2.1

Provide for context-sensitive help on screens for easy, “point and click” access to valid values and code definitions by screen field.

3.3.23.2.2

Maintain and update data on manufacturers with whom rebate agreements exist, including:

- o manufacturer ID numbers and labeler codes;
- o indication of collection media;
- o indication of invoicing media;
- o contact name and mailing address and phone numbers (voice and fax) for manufacturers; and
- o manufacturer (labeler) enrollment dates and termination dates.

3.3.23.2.3

Provide for validating units of measure from HCFA file to MMIS drug file for consistency and reporting on exceptions.

3.3.23.2.4

Calculate and generate rebate adjustments based on retroactively corrected HCFA and OHCA rebate data, by program.

3.3.23.2.5

Determine, from paid claim data (including any eligible encounter data), the amount of rebates due by NDC and UPC, and generate, according to media requested, invoices, separately identifying rebate amounts and interest amounts by program (such as, Medicaid and state programs) and by rebate quarter.

3.3.23.2.6

Maintain identification of the original drug rebate quarter for the claim throughout any adjustments made to the claim.

3.3.23.2.7

Determine the rebate amounts and adjustments overdue, calculate interest, and generate new invoices separately identifying rebate amounts and interest by program (such as Medicaid and state programs) and by rebate quarter.

3.3.23.2.8

Generate invoice details and post payment details consistent with ROSI and PQAS.

3.3.23.2.9

Generate invoice cover letters, collection letters and follow-up collection letters according to state criteria.

3.3.23.2.10

Provide on-line, updateable letter templates for invoice letters, collection letters, follow-up collection letters, and so forth, allowing for a free-form comments section.

3.3.23.2.11

Maintain the history of letters sent to manufacturers.

3.3.23.2.12

Provide for the identification of disputed rebate amounts and units, where a drug manufacturer has disputed the units invoiced.

3.3.23.2.13

Provide for timely update of the payment details and adjustments to the MMIS consolidated accounting system.

3.3.23.2.14

Maintain drug rebate invoice and payment data indefinitely.

3.3.23.2.15

Provide for identification and exclusion of claims for drugs not eligible for the drug rebate program, such as vaccines.

3.3.23.2.16

Provide for identification and exclusion of claims from providers dispensing drugs that are not eligible for the drug rebate program, such as Indian Health Services (IHS).

3.3.23.2.17

Maintain on-line access to quarterly manufacturer drug rebate invoice detail.

3.3.23.2.18

Provide on-line access to six (6) years of historical drug rebate invoices, including supporting claims level detail with selection criteria by labeler, by quarter, by NDC, or any combination there of.

3.3.23.2.19

Provide navigation directly from the drug rebate invoice screens to paid claims history by selecting the TCN, to NDC data by selecting the NDC, and to provider data by selecting the provider number.

3.3.23.2.20

Provide for on-line posting of accounts receivables by labeler by NDC for each quarter, by rebates receivable and interest receivable.

3.3.23.2.21

Provide for unit conversion of units paid per claim to HCFA units billed and HCFA units billed to units paid per claim for drug rebate.

3.3.23.2.22

Maintain both the units paid (as used to calculate claims pricing within the Oklahoma MMIS) and the HCFA units billed for drug rebate on claim history.

3.3.23.2.23

Maintain an audit trail of invoices, payments and adjustments, including source codes, adjustment codes and dates.

3.3.23.2.24

Provide on-line access to accounts receivable data, invoice history, payment history, adjustment history, and the audit trail at the labeler/quarter/NDC level.

3.3.23.2.25

Provide capability to adjust accounts receivable balances for:

- o Rebates only at labeler/quarter level,
- o Interest only at labeler/quarter level, and
- o Rebates and units at NDC level which would also update labeler/quarter balances.

3.3.23.2.26

Provide on-line screens for interest computation.

3.3.23.2.27

Provide screens for on-line maintenance of comprehensive dispute tracking, including an automated tickler file to flag, track and /or report on responding and non-responding manufacturers and disputes.

3.3.23.2.28

Provide screens for logging and tracking all telephone conversations, letters, inquiries, and other correspondence and actions taken by manufacturers, OHCA and others.

3.3.23.2.29

Provide for the automatic generation of manufacturer mailing labels and the ability to generate mailing labels on-request.

3.3.23.2.30

Meet all HCFA regulations and State regulations in regard to drug rebate, including OHCA policies and procedures.

3.3.23.3 Outputs

The MMIS Drug Rebate Processing function must provide the following outputs:

- o All data shall be available for retrieval through the DSS/DW function.
- o All reports must be made available in data format for export and import purposes and through multiple media such as paper, cd-rom, and so forth.

- o The following types of reports must minimally be available:
 - . reports to meet all federal and state reporting requirements,
 - . information needed to account for exceptions in calculating rebate amounts, such as drugs not covered for reasons related to DESI or IRS status, uncovered over-the-counter drugs, drugs not under rebate agreement with HCFA or the State, and so forth;
 - . reports, weekly or on request, which display current and past accounts receivable information for drug rebate;
 - . reports to the State of payment discrepancies and disputes and on-line information necessary to support dispute resolution when manufacturers and the State differ with respect to calculation of rebate amounts;
 - . statistical reports;
 - . invoice summary reports;
 - . adjustments and/or journal entry reports;
 - . reconciliation reports between OHCA and manufacturers, based on invoiced versus paid and resulting differences in terms of units, rate per unit and rebate;
 - . performance and productivity reports; and
 - . other reports and screens to be defined by OHCA.
- o Generation of quarterly HCFA tapes.
- o Generation of invoices and cover letters, collection letters, follow-up collection letters, and mailing labels.

3.3.23.4 Interfaces

The Drug Rebate Processing function must accommodate an external interface with:

- o HCFA;
- o drug manufacturers, through multiple media including tape, diskette, web enabled electronic, and paper; and
- o the State's Great Plains system.

3.3.24 SECURITY MANAGEMENT

This function is for the provision of automated support needed in order to manage the security of the MMIS. The state will maintain the security tables that control access to the MMIS, data, and system software, by user.

3.3.24.1 Inputs

The MMIS Security Management function must accept the following inputs:

- o Additions and changes of user security profiles, and
- o Log-ons to the MMIS requesting access.

3.3.24.2 Processing

The MMIS Security Management Processing function must have the following processing capabilities:

3.3.24.2.1

Maintain flexibility in coding structures by use of parameter and table oriented design techniques.

3.3.24.2.2

Provide for context-sensitive help on screens for easy, “point and click” access to valid values and code definitions by screen field.

3.3.24.2.3

Provide for a single unique log-ons for each user of the MMIS.

3.3.24.2.4

Provide for user passwords that will expire on a staggered schedule and that can be changed at any time by appropriate State or Contractor management personnel.

3.3.24.2.5

Provide for restriction of application and/or function within application (inquiry only, update capability) to specific log-ons.

3.3.24.2.6

Provide for on-line audit trails of all update transactions by user log-on, time entered, and source of entry (workstation), including all attempted transactions.

3.3.24.2.7

Provide for access control to all data and to the applications software employing a security system to restrict access to varying hierarchical levels of data and function.

3.3.24.2.8

Provide the capability to establish multilevel security settings by either group(s) or individual(s).

3.3.24.2.9

Provide for independent security access to any standalone component of the MMIS that is not part of the “core” MMIS.

3.3.24.2.10

Provide on-line screens for the maintenance of MMIS security minimally providing for the maintenance of unique user profiles and their unique log-on, password, and security profile.

3.3.24.2.11

Provide for the same hierarchical password protection, as well as a system-inherent mechanism for recording any change to a software module or subsystem.

3.3.24.3 Outputs

The MMIS Security Management function must provide the following outputs:

- o All data shall be available for retrieval through the DSS/DW function.
- o All reports must be made available in data format for export and import purposes and through multiple media such as paper, cd-rom, and so forth.
- o The following types of reports must minimally be available:
 - . Audit trails of system log-ons, and
 - . Lists of users and their security profile.

3.3.24.4 Interfaces

There are no external interfaces identified for the Security Management Function.

3.3.25 CUSTOMER SERVICE

One of OHCA’s main objectives is to provide quality customer service to the recipients, providers of services, and its stakeholders. OHCA needs to acquire the tools to facilitate providing customer service.

3.3.25.1 Inputs

The following are inputs to the MMIS Customer Service function:

- o Telephone calls from recipients, providers, counties, representatives/legislators, advocacy groups, out of state entities, potential providers, plans, and Medicare inquiring on information such as:
 - . why claims have not been paid;
 - . services clients are entitled to based on their eligibility;
 - . recipient eligibility and eligibility-related information about the recipient, including TPL;
 - . Oklahoma medical assistance policy;
 - . how to:
 - submit claims,
 - utilize the Eligibility Verification and Provider Inquiry System,
 - utilize PRO-DUR/ECM,
 - and so forth;
 - . why recoveries are being made for TPL, SUR, and other;
 - . how to seek prior authorization; and
 - . other questions and requests pertaining to Oklahoma medical assistance programs, policies and operational procedures.

3.3.25.2 Processing

The MMIS Customer Service function must include the following capabilities:

3.3.25.2.1

Provide for context-sensitive help on screens for easy, “point and click” access to valid values and code definitions by screen field.

3.3.25.2.2

Maintain flexibility in coding structures by use of parameter and table oriented design techniques, for data such as, call types.

3.3.25.2.3

Provide for an automatic call attendant capability that provides a hierarchical menu driven capability for directing user calls to appropriate OHCA staff and providing general information regarding frequently asked questions.

3.3.25.2.4

Maintain an automated call tracking capability for all calls received, tracking information such as time and date of call, identifying information on caller (recipient, provider and so forth), and any information keyed in regarding call, such as call type, inquiry description, response description and so forth.

3.3.25.2.5

Provide for unique identification of call records.

3.3.25.2.6

Provide for on-line display, inquiry, and updating of call records with access by call type, recipient number, provider number, inquirers name, recipient name, provider name, or a combination of these data elements.

3.3.25.2.7

Provide for the automated population of call screens, based on recipient and/or provider call is in reference to, with relevant recipient and provider information such as:

- o eligibility information and dates;
- o enrollment status and dates;
- o demographics such as name, telephone number and so forth; and
- o managed care information such as PCP/CM or HMO name and telephone number and so forth.

.3.25.2.8

Provide the capability to easily navigate (at a point and click) from call logging screens to other data relevant to providers and recipients within the MMIS such as claims history, eligibility information, and so forth.

3.3.25.2.9

Provide the capability to maintain free-form notes to each call record.

3.3.25.2.10

Provide the capability to refer or forward call records to other OHCA units for resolution.

3.3.25.2.11

Provide the capability to update and maintain call records with basic call identifying information such as caller, who call is about, customer service clerk ID, date of call, date of referral, unit being referred to, nature of call, details of call, call resolution clerk ID, resolution date, resolution, call status.

3.3.25.2.12

Provide for automated inquiry and response for claims status information via a voice response component of the Eligibility Verification and Provider Inquiry System and the and for the request and receipt of, remittance advices available through the Internet.

3.3.25.2.13

Provide for on-line updateable templates of letters to recipients and providers providing call resolution information.

3.3.25.2.13

Automatically generate letters to recipients and providers.

3.3.25.2.14

Provide the ability to automatically fax-back to callers with attachments containing requested information such as claims histories and so forth.

3.3.25.3 Outputs

The MMIS Customer Service must provide the following outputs:

- o All data shall be available for retrieval through the DSS/DW function.

- o All reports must be made available in data format for export and import purposes and through multiple medias such as paper, cd-rom, and so forth.
- o The following types of reports must minimally be available:
 - . call statistics such as calls per hour through the day, through the week,
 - . average number of rings per call and the number of dropped calls;
 - . call distribution by customer service clerk;
 - . calls by call type;
 - . number of calls referred to other units;
 - . unresolved calls; and
 - . average call length.
- o Letters to recipients and providers.
- o Call referrals to other units.
- o Fax-back of information to recipients and providers.

3.3.25.4 Interfaces

The MMIS Customer Service function must accommodate an external interface with the state's telephone system.

3.3.26 QUALITY ASSURANCE

OHCA wants to optimize the quality of services it provides to its eligible population. To accomplish this objective the State requires the necessary tools and processes to monitor and report on the services being provided.

3.3.26.1 Inputs

The inputs to the Quality Assurance includes:

- o claims history (including encounters) data;
- o recipient eligibility data; and
- o industry related standards such as HEDIS, QISMC, and so forth.

3.3.26.2 Processing

The MMIS Quality Assurance function must include the following capabilities:

3.3.26.2.1

Provide the ability to answer federal requirements for quality assurance and waiver requirements for the 1115b waiver and waiver extension request.

3.3.26.2.2

Provide the ability to operate under the Quality Improvement System for Managed Care (QISMC) the HCFA guidelines for measuring all forms of managed care.

3.3.26.2.3

Provide the ability to accept HEDIS plan generated report data and inquire, analyze (including statistical applications with associated graphing), manipulate, and report on this data.

3.3.26.2.4

Provide the ability to accept national norms and compare these to Oklahoma HEDIS data and inquire, analyze, manipulate, and report on this comparison.

3.3.26.2.5

Provide the ability to generate HEDIS-like measures for fee-for-service.

3.3.26.2.6

Provide the ability to easily define and produce extracts of data from the MMIS.

3.3.26.2.7

Provide easy access to prior authorization data including provider, recipient, and claims data for utilization review.

3.3.26.2.8

Provide the ability to analyze the utilization of services by regions/counties with a demographic breakdown.

3.3.26.2.9

Provide the ability to generate an administrative data set from MMIS fee-for-service claims and claims requiring prior authorization.

3.3.26.2.10

Provide for the collection and processing of immunization data from the Health Department or other external agencies.

3.3.26.2.11

Provide the ability to interface with other systems such as Indian Health Services.

3.3.26.2.12

Provide the ability to collect and process individual education plans from Oklahoma Public Schools to gather information on:

- o speech therapy,
- o physical therapy,
- o behavioral health,
- o hearing Aids,
- o eye glasses, and so forth.

3.3.26.2.13

Provide for physician profiling and comparison of practice patterns from encounter data to national norms and standards of practice.

3.3.26.2.14

Provide the ability to generate physician “report cards”.

3.3.26.2.15

Provide for the ability to import various data sets (such as, AHCPR Conquest 2; JCO – ORIX – database for hospital utilization data; FAF – Foundation for Accountability Fact) and analysis and reporting capability to Oklahoma encounter data.

3.3.26.2.16

Generate quarterly utilization reports by:

- o County,
- o Age, and
- o Sex.

3.3.26.2.17

Provide for identification of over and under utilization in managed care by creating profiles on:

- o Referrals to self for services outside capitation, and
- o Referrals to self for primary care.

3.3.26.2.18

Provide the ability to detect inappropriate hospital stays and visits, such as utilizing SI/IS criteria to look at primary and secondary diagnosis(es) and verify whether admission and/or continued stay criteria are met. Also, look at diagnosis codes and treatment codes to ensure that treatment was appropriate. Utilize the same rationale for any institutional stay including, ICF/MR, NF, behavioral health, and so forth.

3.3.26.3 Outputs

The Quality Assurance function must provide the following outputs:

- o reports evaluating appropriateness of care;
- o reports evaluating quality of care; and
- o reports identifying any care not meeting accepted standards.

3.3.26.4 Interfaces

The Quality Assurance function must interface with all MMIS files and data.

3.3.27 INTERNET

OHCA wants to facilitate the authorized access to information through the use of the Internet. The contractor must provide the capability and infrastructure to allow this to occur.

3.3.27.1 Inputs

Inputs to the Internet web page include:

- o claims data, including status, payment, and history;
- o medical authorization data;
- o recipient data;
- o remittance advices; and
- o medical assistance administrative data.

3.3.27.2 Processing

The Internet function must include the following capabilities:

3.3.27.2.1

The MMIS Contractor must provide a secure web site for access by authorized providers and OHCA approved entities.

3.3.27.2.2

The secure web site must include:

- o instructions on how to use the secure site,
- o a site map, and
- o contact information.

3.3.27.2.3

The secure web site must provide for claims-related Internet functionality including:

- o electronic claims and encounter data submission,
- o claims and encounter data capture with limited edits
- o inquiry to edit disposition information,
- o claims processing status,
- o remittance advice for active providers for the last ten (10) cycles,
- o prior authorization requests and responses (approval/denials/requests for additional information, and
- o help capability.

3.3.27.2.4

The secure web site must provide for recipient-related Internet functionality including completing and submitting recipient application for eligibility.

3.3.27.2.5

The secure web site must provide for recipient eligibility verification-related Internet functionality including:

- o interactive provider eligibility verification inquiry and response, and
- o receipt of provider requests for, and distribution of, historical listings of eligibility verification inquiries made and the responses given.

3.3.27.2.6

The secure web site must provide for sharing of medical assistance administrative and program-related data such as recipient, providers, payment data and so forth between authorized entities such as:

- o Older Oklahomans,
- o schools,
- o county offices,
- o mental health service agencies, and
- o the like.

3.3.27.2.7

Provide the ability for LTC screening forms to be completed and submitted via Internet (PASR, LTC 300A).

3.3.27.2.8

The contractor must provide links from its MMIS web site to other state and federal web sites, including but not limited to: the OHCA site, State of Oklahoma Home Page, and the HCFA site.

3.3.27.2.9

The MMIS Contractor must provide/takeover all current Contractor Internet functionality and connect/interface with the OHCA/State Internet/Intranet site(s).

3.3.27.3 Outputs

The outputs from the Internet include:

- o claims data, including status, payment, and history;
- o medical authorization data;
- o recipient data;
- o remittance advices; and
- o medical assistance administrative data.

3.3.27.4 Interfaces

The interfaces to the Internet site includes:

- o MMIS files and data;
- o providers; and
- o OHCA and other state staff.

3.3.28 MANAGEMENT AND ADMINISTRATIVE REPORTING (MARS)

The purpose of the Management and Administrative Reporting (MARS) function is to provide programmatic, financial, and statistical reports to assist the state and federal government with fiscal planning, control, monitoring, program and policy development, and evaluation of the Oklahoma medical assistance programs.

The MARS function is a comprehensive management tool which provides information on program status and trends, has the ability to analyze historical trends, and predicts the impact of policy changes on programs. This function uses key information from other MMIS functions to generate standard reports.

The major inputs to MARS are data from all the claims processing functions, including capitated encounters, and the Reference Data Maintenance, Recipient Data Access, and Provider Data Maintenance functions. The major process is the generation of reports and program data, and the major outputs are the financial, statistical, and summary reports and data required by federal regulations, and other reports and data that assist the state in the management and administration of the Oklahoma Medical Assistance Programs.

This function must be flexible enough to meet both existing and proposed changes in format and data requirements of federal and state management statistical reporting without major reprogramming or expense, and provide maximum flexibility to accommodate future changes to meet the unique reporting needs of Oklahoma's medical assistance programs.

3.3.28.1 Inputs

The MMIS shall accommodate the following inputs related to the MARS function:

- o All current and historical adjudicated claims data, suspended claims data, adjustments, financial transactions, and data from all the claims processing functions, and financial processing functions such as TPL, Drug Rebate for recoveries, for State defined reporting periods.
- o Reference data, for the State defined reporting period, from the reference data maintenance function.
- o Provider data, for the State defined reporting period, from the provider data maintenance function.
- o Recipient data, on both participating and non-participating recipients, for the State defined reporting period, from the recipient data access, LTC processing, Waiver Care processing, EPSDT processing, and TPL processing functions.
- o MEDATS information.

- o Financial data, for the reporting period, from other sources (electronic, paper, tape, diskette, cd-rom not available from the MMIS financial processing function.
- o Electronic data from sources outside the Department as inputs for the purposes of generating reports and processing, such as data matches.

3.3.28.2 Processing

The MMIS MAR function must have the following processing capabilities:

3.3.28.2.1

Maintain source data from all other functions of the MMIS, to create State and federally required reports at frequencies defined by the State.

3.3.28.2.2

Compile subtotals, totals, averages, variances, and percents of items and dollars on all reports as appropriate.

3.3.28.2.3

Generate user-identified reports on a schedule specified by the State.

3.3.28.2.4

Generate reports of claims, utilization, and financial data using individual or combined selection parameters which include but are not limited to:

- o funding source and/or program,
- o amount of Federal Financial Participation (FFP) to be claimed,
- o State financial cost codes and federal categories of service,
- o HCFA reporting categories,
- o type of transaction (original/adjustment/financial)
- o date of service,
- o date of billing,
- o date of payment,
- o date of adjudication,
- o specific recipient eligibility category,

- o geographic area defined by the State,
- o programmatic group, (waiver, managed care, or other)
- o provider ID, provider type, specialty and sub-specialty,
- o claim type,
- o place of service,
- o units or quantity of service,
- o service, procedure, drug code, therapeutic class, or code ranges thereof,
- o diagnosis code or code ranges,
- o time period (Federal and State fiscal year, calendar year, month, quarter, cycle, or other), and
- o any combination of the above.
- o Generate reports to include the results of all State initiated financial transactions, by State specified categories, whether claim-specific or non-claim-specific.

3.3.28.2.5

Identify, separately or in combination as requested by the State, the various types of recoupments and collections; for example, third-party liability collections or fraud and abuse recoupments.

3.3.28.2.6

Meet all requirements for the Medicaid Statistical Information System (MSIS).

3.3.28.2.7

Generate a HCFA 2082 type report with county detail.

3.3.28.2.8

Report HCFA 2082 type data, on paper or other media specified by the State, for State medical programs.

3.3.28.2.9

Provide claims data for MSIS.

3.3.28.2.10

Maintain the uniformity, comparability, and balancing of data through the MARS reports, and between these and other functions' reports, including reconciliation of all financial reports with claims processing reports.

3.3.28.2.11

Provide detailed and summary level counts of services by service, program, and eligibility category, based on State specified units (days, visits, prescriptions, or other); provide counts of claims, counts of unduplicated paid participating and eligible recipients, and counts of providers by State specified categories.

3.3.28.2.12

Provide a statistically valid trend methodology approved by the State, for generating MAR reports.

3.3.28.2.13

Produce MEDATS – team member completion report.

3.3.28.2.14

Perform other types of statistical analyses as needed by program managers and report in the media specified by the State.

3.3.28.2.15

Provide charge, expenditure, program, recipient eligibility, and utilization data to support State and federal budget forecasts, tracking, and modeling, to include but not be limited to:

- o participating and non-participating eligible recipient counts and trends by program and category of eligibility;
- o utilization patterns by program, recipient medical coverage groups, provider type, and summary and detailed category of service;

- o charges, expenditures, and trends by program and summary and detailed category of service;
- o lag factors between date of service and date of payment to determine billing and cash flow trends; and
- o any combination of the above.

3.3.28.2.16

Include a description of codes and values on reports.

3.3.28.2.17

Provide for user specification of selection, summarization, and unduplication criteria when requesting claim detail reports from claims history.

3.3.28.2.18

Produce reports, including but not limited to the following, which show:

- o whether processing time frames for claims, adjustments, and other financial transactions are within the timely processing guidelines specified in State and Federal regulations;
- o claim filing information based on comparisons of date of service to date of receipt and date of receipt to date of payment;
- o types and numbers of errors occurring during claims processing (suspended claim analysis) by program, provider, provider type, specialty and sub-specialty, and category of service;
- o expenditures by service type showing service provided, unduplicated recipients, units of service; and programmatic group;
- o claims throughput analysis;
- o analysis of variance between the anticipated and actual utilization in various programmatic areas;
- o comparisons of past, current, and future utilization trends by recipient eligibility category, category of service, and programmatic group;
- o current and past provider payment amounts;
- o average cost per eligible and per paid (participating) recipient by program, eligibility category, and category of service;

- o historical trends of payments and average costs by program, eligibility category, and category of service;
- o the amount of financial liability against the programs, including in-process claims, retroactive TPL and patient spenddown responsibility recoveries and adjustments;
- o recipient participation analysis and summary, showing utilization rates, payments, and number of recipients by eligibility category, and program;
- o provider participation analysis and summary, showing payments, services, category of service, program, and recipient eligibility categories;
- o utilization of services against benefit limitations;
- o expenditure and utilization data, by procedure code, to assist in determining reimbursement methodologies;
- o waiver and special program participation and expenditure data, including services, payments, billed amounts, eligibles, unduplicated paid (participating) recipient counts, and total cost of care by date of service and date of payment, and federally required waiver reports, by waiver and special program; services provided under each waiver program, presented in such a way that it can be distinguished from information on the same services provided to non-waiver recipients;
- o information which compares the cost of providing care to target populations under waiver programs with comparable populations in non-waiver care settings;
- o information which supports the identification of comparable populations to which waiver program eligibles may be compared;
- o Federal and State waiver care reports, including the HCFA 372 and the "lag" report, generated on the schedule and in the format acceptable to the federal or State agency, with format and frequency easily adjustable as requirements change;
- o TPL and cost-settlement analysis, including billings and collections, by program;
- o procedure revenue code, NDC usage analysis by program, recipient aid category, age, provider type, specialty, sub-specialty, and category of service;
- o geographic (longitude/latitude of county, managed care regions, state) participation and expenditure analysis, and summaries by program and overall;

- o claims paid for by service, such as abortion, sterilization, by program and recipient aid category, and the associated number of recipients;
- o providers ranked by payment amount and other factors, by program and overall;
- o recipients ranked by pay amount and other factors, by program and overall;
- o paid, suspended, denied, and duplicate claim statistics, by provider type, by specialty, by sub-specialty, category of service, and program, both detail and summary level;
- o monthly aggregate data on units of service by provider type, by specialty, by sub-specialty, and category of service, and program, and
- o claims paid by specific procedure, revenue code, NDC, diagnosis, by program and recipient aid category.

3.3.28.2.19

MARS reports must be available on both a date of payment and date of service basis.

3.3.28.2.20

All data shall be available for retrieval through the DSS/DW function.

3.3.28.2.21

All reports must be made available in data format for export and import purposes and through multiple media such as paper, cd-rom, and so forth.

3.3.28.2.22

Provide the State with on-line capability to develop, design, modify, and test alternative report parameters and maintain an indexed library of such report parameters to have reports run by.

3.3.28.2.23

Meet all reporting requirements of MEDATS and produce MEDATS reports such as reviews due in three (3) months.

3.3.28.3 Outputs

The MMIS MAR function must provide the following outputs:

- o All data shall be available for retrieval through the DSS/DW function.
- o All reports must be made available in data format for export and import purposes and through multiple medias such as paper, cd-rom, and so forth.
- o All reports necessary to manage and administer the Oklahoma medical assistance programs and OHCA.
- o All reports to meet all federal and state reporting requirements,

3.3.28.4 Interfaces

The MMIS MAR function has no external interfaces.

3.3.29 DECISION SUPPORT SYSTEM/DATA WAREHOUSE (DSS/DW)

The Decision Support System/ Data Warehouse will be used to enhance the Management and Reporting Subsystem (MARS) and SURS functionalities by providing the state with the ability to access large volumes of data to produce customized reports and more effective utilization information.

3.3.29.1 Inputs

The MMIS DSS/DW function must accept the following inputs:

- o The data to be extracted and sent to the DSS/DW must minimally include appropriate data necessary to support the generation of reports for the pre-defined report templates, the Executive Information System, and the query capability for ad-hoc reporting. This data must minimally include:
 - . Fee for service and capitation claims data;
 - . Claims adjustments data;
 - . Claim specific and non-claim specific financial transactions data;
 - . Consolidated accounting ledger data;
 - . Drug Rebate invoice, collections, and receivables data;
 - . Encounter data;
 - . Encounter data reversals/adjustments data;
 - . Managed care roster history data;

- . Provider/managed care entity data, including demographics, provider network information, and so forth;
 - . Recipient eligibility, demographic, enrollment, and roster history data;
 - . Reference data, such as procedure, diagnosis, drug, pricing and such;
 - . Referral and pre-authorization of medical service data;
 - . Health risk assessment data;
 - . Cost containment data;
 - . Outcomes data;
 - . HEDIS measures and data, with the ability to make changes to these measures somewhat effortlessly as the measures change as frequently as yearly;
 - . Long-term care data, including acuity level;
 - . EPSDT data;
 - . Vital Records data;
 - . Budgetary data; and
 - . Normative data.
- o Any supplementary data sources needed for proposed analysis capability, such as trend and outcome measure, must be provided for in the design of the initial load and updating of the database.
 - o The initial population of the database must provide for six (6) years of historical data.
 - o In general, updates will be applied on a weekly basis even for those updates to the MMIS which occur on a more frequent basis such as eligibility data updates. For those updates to the MMIS or other source data systems which occur less frequently than weekly, updates will be applied based on the periodicity of the update of those pieces of data on the MMIS.

3.3.29.2 Processing

The MMIS DSS/DW function must have the following processing capabilities:

3.3.29.2.1

Provide an audit trail of all updates/changes to the data including what the change was and when it occurred.

3.3.29.2.2

The DSS/DW must provide for data validity editing, data scrubbing and data transformation prior to loading/updating to the database.

3.3.29.2.3

The DSS/DW must employ proven database design and data management methodologies to validity edit, scrub, and transform raw data into “analytically ready” decision support database. These methodologies must address:

- o Analyzing completeness of updates based on historical and projected data volume for the source;
- o Integrating various data types and formats, such as, medical claims, costs, encounters, eligibility information, and provider information;
- o Standardizing data into a common format to enable normative comparisons;
- o Customizing of database design in accordance with OHCA’s analytical and ad hoc reporting requirements;
- o Enhancing data with relevant analytical groupings and classification schemes; and
- o Assessing and improving the quality of data contained within the database.

3.3.29.2.4

The DSS/DW must provide for the automatic return of a notification of data validity errors that provides adequate detail to identify the data in error and what the error is and provide for the automated receipt of corrected data.

3.3.29.2.5

Provide the ability to reverse or back-out of an update in the event it is discovered an update is erroneous or corrupted.

3.3.29.2.6

Provide the ability to create and maintain summary level databases from extracts on an incremental basis.

3.3.29.2.7

Provide for storage of cost and expenditure data in signed fields in order to identify negative numbers.

3.3.29.2.8

Provide for the storing and retrieval of recipient information including 100% of recipient income data.

3.3.29.2.9

Provide for storage of dates to support the DSS/DW into the next century without enhancements.

3.3.29.2.10

Minimally maintain six (6) years of validated and scrubbed historical data.

3.3.29.2.11

Maintain client service data for once in a lifetime procedures.

3.3.29.2.12

Archive off specific data to retrievable storage that provides a capability to retrieve and access within one working day at the user level.

3.3.29.2.13

The DSS/DW must utilize a directory/catalogue methodology that enables the users to easily and quickly navigate through the system, including screens and available data, with descriptions, in order to find the information that is required.

3.3.29.2.14

OHCA prefers that the directory/catalogue methodology allow for the capture and management of information such as, but not limited to, the following:

- o user profiles,
- o data migration management,
- o security access,
- o event management (such as notifications of extract jobs and/or problems), ability to capture and forward the identified problem to a 'help desk' or resource.
- o log-on parameters,

- o ad hoc report scheduling information,
- o search methodology for selecting data and/or subsets of data,
- o depiction of data contained in the data repository (overview), and
- o report request information.

3.3.29.2.15

The DSS/DW tool set must provide query capability that includes the following:

- o 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);
- o 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;
- o 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;
- o access to the full range of data attributes on the database for building queries;
- o ability to schedule queries to run during 'off-peak' hours and to save generated data sets automatically in a variety of different formats (.xls, .dbf, and so forth) to a specified location;
- o options to select query report presentation to be displayed on-line, in a formatted hard-copy report, or downloaded to disk for PC-based analysis;
- o 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;
- o the ability to save extracted data, based on selected storage parameters, and the ability to retrieve the saved extracted data for use at a later time;
- o selection parameter capability to have any value, set of individual values, or range of values;
- o capability to construct and utilize compound expressions that evaluate more than one comparison at a time, using any valid combination of logical operators (AND, OR, NOT, IF, ELSE, THEN), comparison operations (<, <=, >, >=, =, <>, not equal to), and parentheses;
- o support for stratified random sampling with appropriate statistics;

- o generation of random sampling with associated statistics (for example, universe statistics, confidence levels, and so forth);
- o capability to execute queries that perform unduplicated counts (for example, unduplicated count of recipients receiving services), duplicated counts (for example, total number of services provided for a given aid category), or a combination of unduplicated and duplicated counts;
- o capability to perform a minimum of four (4) level sorts for a requested query; and to drill-down to identifiable data;
- o a selection of report templates that generate a broad scope of information typically sought by Medicaid agencies to assist program management and decision making;
- o calculation capabilities, including: sum, average, count, minimum, maximum, subtotaling and grand totaling, simple and complex cross-tabulation;
- o 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, ratios and so forth;
- o capability to recreate query results previously generated by use of an “as of date”;
- o capability to estimate the query processing time to pre-define a maximum query processing time for both on-line and batch retrieval requests;
- o capability for automatic and manual termination of queries that exceed State pre-defined processing time thresholds;
- o capture of the user's ID for each query and store the processing time, by user ID, of the query; and to pre-process or edit a user-developed query to determine if the selected reporting parameters need to be changed to improve the efficiency, correctness, or time frame for the extraction effort. Allow the user to change the report parameters based on findings and resubmit; and
- o capability to prompt user with suggestions of query structure for more efficient operation (wizard-type building for queries).

3.3.29.2.16

The DSS/DW tool set should provide flexible report formatting/editing capabilities such as:

- o print preview capabilities;

- o ability to import, export and manipulate data files from various spreadsheet applications, word processing applications, and database management tools, as well as the database;
- o ability to retain query results for access by others;
- o capability of sorting in ascending and descending order at a minimum of four (4) levels.
- o 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;
- o page formatting features for creating presentation quality reports;
- o capability for user-defined headers, footers, columns, and rows with header/footer information including items such as: date, run time, and page numbers on reports; and
- o capability to segregate and subtotal data, and define page breaks based upon user-defined parameters within reports.

3.3.29.2.17

The DSS/DW tool set(s) should have sufficiently flexible graphics capabilities to provide the user with the flexibility of reporting query output in a variety of ways. It is preferred these capabilities include the following:

- o geographical mapping;
- o a range of graph types for data presentation, including bar chart, pie chart, stacked, and side-by-side bar charts, single and multiple line charts, three (3) dimensional graphs, tree graphs, probability plots, trend lines, and other common-use graphical presentation methods;
- o customization of chart attributes, including orientation, legends, tic marks, intervals, and scaling;
- o ability to manipulate the font style and size of any embedded text or numeric information;
- o standard editing capabilities as well as optional capabilities for shadowing, mirroring, highlighting, and flipping axes;
- o capability to interface with a variety of printers, including laser, dot matrix, and plotter;

- o enhanced graphical representation capabilities that can interface with other programs, such as power point and web based applications; and
- o gray scale and pattern printing and a symbol library.

3.3.29.2.18

The DSS/DW function must provide for an executive information system capability including:

- o be extremely easy to use without needing extensive training;
- o provide users with the ability to quickly assimilate and compare aggregate and summary-level information and to quickly identify problems and opportunities;
- o be designed to maximize the professional efficiency and effectiveness of managers and professional staff in their access, use, presentation, and reporting of information;
- o provide non-technical end-users with an extensive array of executive-level yet powerful and highly flexible capabilities for users to identify and test assumptions about the program (particularly with regard to budget management, cost containment, utilization management, program operations, and access and quality of care), including performance expectations;
- o provide users with extensive and highly flexible capabilities for the visual presentation of information in tabular and graphic/chart form;
- o use modern type and typographic techniques to provide a high degree of legibility and readability, and to provide the capacity for printing to high-quality laser printers;
- o provide high resolution on-screen multicolor displays of information and must provide flexible capability for users to print reports, text, tables, maps, and charts/graphs in hard copy form (black, white, color) using high resolution printers (600 dpi or greater print resolution);
- o present all information in well designed, polished tables and high-quality graphs, charts, and maps;
- o provide users with executive-level features for the statistical and economic analysis of information; and
- o capability to ‘zip’ reports to self executable zip files to electronically transfer either inside or outside the agency.

3.3.29.2.19

The DSS/DW must provide analytic capability to, at a minimum, allow for:

- o tracking of an individual's enrollment within and across health plans, to and from the fee for service payment model, and individuals with significant differences in utilization following transition between service models;
- o summary and comparison of utilization, costs, expenditures, services, and outcomes, and access by the unique characteristics of plans, providers, and clients;
- o trend analysis (as related to costs, utilization, expenditures, services, disease categories, fee-for-service versus managed care, etc.) for plans, providers, and clients over time;
- o on-line access to public and private sector normative data libraries and internally generated Oklahoma Medicaid-specific norms;
- o identification of inpatient and preventive ambulatory episodes of care;
- o automatic case-mix, age-sex, and severity adjustments;
- o generation of easily interpreted, provider profiles comparing peers based on state-defined criteria such as, provider type, specialty, sub-specialty, practice size and type, and case mix based on severity of illnesses;
- o quality of care measurements, including admissions, re-admissions, discretionary surgeries, complications of treatment, C-sections, and deaths;
- o automatic integration of eligibility data with medical claims data to enable rate calculations (for example, admissions rate, cost per capita, etc.);
- o tracking and reporting claims and encounter information on both a paid and incurred basis;
- o subsetting on any field or combination of fields in the database;
- o automatic adjustments for incomplete data;
- o forecasting program costs accurately and evaluating cost containment and quality improvement initiatives;
- o identifying high-cost cases to better focus utilization review and case management programs;
- o evaluating managed care plan network adequacy related to access by primary and specialty care;

- o profiling provider performance to support different managed care designs and contracting, such as, fully and partially capitated, PPOs, fee-for-service management, as well as quality and efficiency of care evaluations; and
- o improving the management of recipient health risk by targeting health assessments, immunizations and other preventive actions.

3.3.29.2.20

Establish a Web gateway technology situated between the Web Server and the DSS/DW. This technology must minimally include the capability to:

- o effect a translation of a request initiated from a Web browser directed to the DSS/DW;
- o access data, via the Web gateway, within the enabled DSS/DW; and
- o initiate and migrate data from the DSS/DW to specified Web servers.

3.3.29.2.21

The Data Warehouse server must include sufficient RAID or other technology to ensure adequate redundancy to meet service level requirements.

3.3.29.2.22

Provide at a minimum, thirty (30) tool licenses to support all DSS/DW functionality.

3.3.29.2.23

Develop initial and on-going training plan for initial and on-going training in the use of all tools.

3.3.29.2.24

Provide upgrades of product(s) to no less than –1 of non-Beta tested product.

3.3.29.2.25

The DSS/DW shall differentiate fee/for/service claims data from managed care encounter data (and vice versa). The system must apply all functionality described above to one or both sets of data separately or combined.

3.3.29.2.26

- o The DSS/DW shall report on any of the stored information utilizing a Geographical Information System (GIS). The contractor must obtain, implement, and operate an approved GIS to, among other things, accurately compare the accessibility of providers to Medicaid recipients, including

Medicaid providers and managed care plans and their networked providers.
The GIS must pinpoint individuals by longitude and latitude.

3.3.29.2.27

The OKMMIS DSS/DW will implement highly sophisticated analysis methods to detect abnormal patterns in utilization, billing practices, procedure coding, diagnosis coding, referral patterns, and provider and beneficiary identification both within a fee-for-service and/or managed care environment.

The Contractor will be responsible for identifying providers that exhibit aberrant behavior. The State will identify the criteria to be used by the Contractor to identify these providers. SURS reports or other sources may be used to develop this information. The Contractor will be responsible to produce the reports that identify the providers that fall within these categories and the report production schedule will be determined by the State.

The DSS/DW must provide case management and tracking capabilities to retain all pertinent electronic documentary evidence for referral and recovery when criminal or administrative sanctions appear warranted. In addition, the DSS must allow for the seamless housing of all verbal and written contacts, the documenting of the provider or beneficiary's utilization reports, and the capability to store query criteria and analysis results.

3.3.29.2.28

The contractor shall develop, coordinate and conduct a hands-on training program for State of Oklahoma staff on all aspects of the DSS/DW. All state users must be trained. The training sessions must be held at the OHCA Lincoln Blvd. site. Prior to the systems acceptance test, there must be initial training sessions for key staff. Training for all staff must occur in the month the approved system is implemented. On-going training must be conducted on a quarterly basis for all new system users. The training room at the OHCA Lincoln Blvd. site can accommodate up to 12 trainees at once.

3.3.29.3 Outputs

The DSS/DW function must provide for all data outputs in data format for export and import purposes and through multiple media such as paper, cd-rom, and so forth.

3.3.29.4 Interfaces

The DSS/DW function must accommodate an external interface with any outside data sources needed.

3.3.30 SURVEILLANCE AND UTILIZATION REVIEW (SUR) /FRAUD & ABUSE

The Surveillance and Utilization Review function supports the investigation of potential misuse of the Medicaid program and other programs administered by OHCA by providers and recipients. It analyzes historical data and develops profiles of health care delivery, and reports those users whose patterns of care or utilization deviate from established normal patterns of health care delivery.

This function serves as a management tool to allow the state to evaluate the delivery and utilization of medical care, on a case by case basis, to safeguard the quality of care, and to guard against fraudulent or abusive use of the Oklahoma Medicaid Program, by either recipients or providers.

3.3.30.1 Inputs

The MMIS SUR/Fraud and Abuse function must accept the following inputs:

- o encounter data, claims, and all adjustment history;
- o provider demographic and enrollment data;
- o recipient demographic and eligibility related data; and
- o reference data for descriptions of diagnosis, procedure, and drug codes, and prior authorization history.

3.3.30.2 Processing

The MMIS SUR function must have the following processing capabilities:

3.3.30.2.1

Maintain an on-line parameter-driven multiple control files which allow the State to specify data extraction criteria, report content, parameters, and weighting factors necessary to properly identify aberrant situations.

3.3.30.2.2

Allow the user to modify the standard exception control limits.

3.3.30.2.3

Allow the user to override the default values of all other exception control limits.

3.3.30.2.4

Provide the capability for flexible maintenance of report parameters to allow customization and addition of files/records.

3.3.30.2.5

Accept (and retain until changed) parameters that define whether managed care only, fee-for-service-only, or all data are to be included in the SUR reports.

3.3.30.2.6

Accept (and retain until changed) parameters that define which SUR health plan comparison reports are to be produced.

3.3.30.2.7

Provide a system configuration that supports the transfer of data from provider and claims subsystems without significant reformatting of incoming files.

3.3.30.2.8

Provide the capability to associate all referred services to the referring/admitting/prescribing provider.

3.3.30.2.9

Provide the capability to associate individual providers in their practice affiliation, such as a group practice.

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3.3.30.2.10

Provide the capability to associate periods of eligibility with recipient service activity (that is, match the eligibility and enrollment status of the recipient at a point in time with the service rendered at that time).

3.3.30.2.11

Provide the capability to link all services to a single recipient regardless of the number of historical changes in recipient ID.

3.3.30.2.12

Provide the capability to cross-reference all provider IDs to a single ID; report selectively and collectively on provider utilization.

3.3.30.2.13

Provide the capability to associate services furnished in a clinic setting to both the clinic and servicing provider.

3.3.30.2.14

Maintain source data from all functions of the MMIS so as to create State and federally required reports at frequencies defined by the State.

3.3.30.2.15

Provide the ability to perform all functions necessary to develop and process queries including:

- o the ability to create queries and reports at the same time queries are running;
- o a user friendly, English language query language to construct database queries;
- o the capability to preprocess or edit a user-developed query to determine if the selected reporting parameters need to be changed to improve the efficiency, correctness or time frame for the extraction effort. Allow the user to change the report parameters based on findings and resubmit;
- o the capability to estimate the query processing time to pre-define a maximum query processing time;
- o include standards from outside sources for comparison reported;
- o the ability to use inclusive and exclusive parameters over a user specified timeframe;

- o an on-line library/catalog for storage and retrieval of standardized or frequently used queries, with some sort of security levels (creator, user, read-only) to eliminate inadvertent changes to the query;
- o the ability to access the information in the Query Library by index (user ID, type of query, date of run, etc.);
- o the ability to modify and re-use existing queries;
- o easy “point and click” access to policy manuals;
- o for SUR reporting purposes, maintain access to claims, including all adjustments, encounter data, prior authorization history, provider demographic and enrollment data, recipient demographic and eligibility related data, reference data, and extract data, according to State parameters on multiple control files;
- o generate statistical profiles and sampling, by providers and recipients, summarizing information contained in encounter data, claims, and prior authorization history; for specified periods of time;
- o provide a proven statistical methodology to classify recipients into peer groups using user-defined criteria such as age, sex, race, ethnicity, living arrangement, geographic region, program, aid category, special program indicator, fund category, placement level, and LTC indicator (or any combination thereof) for the purpose of developing statistical profiles;
- o provide a proven statistical methodology to classify private/public providers into peer groups using user defined criteria such as program, category of service, provider type, multiple specialties, multiple sub-specialties, type of practice/organization, enrollment status, facility type, geographic location, billing vs. performing provider, size, or any combination thereof, for the purpose of developing statistical profiles;
- o provide a proven statistical methodology to classify and reclassify treatment into user defined groups, by diagnosis code, drug code, procedure code, groups or ranges of codes, geographical region, or combinations thereof, for the purpose of developing statistical profiles;
- o provide for claims data selection, including all adjustments, by date of payment and date of service, for report generation purposes;
- o generate statistical norms and statistical samples, by peer or treatment group, for each indicator contained within each statistical profile by using averages and standard deviations or percentiles.

- o maintain a process to evaluate the statistical profiles of all individual providers or recipients within each peer group against the exception criteria established for each peer group;
- o identify providers and recipients who exhibit aberrant practice or utilization patterns, as determined by an exception process, comparing the individuals' profiles to the limits established for their respective peer groups;
- o identify waiver services on recipient and provider reports;
- o maintain data necessary to support surveillance and utilization review for special programs or populations, such as, various models of managed care, and EPSDT;
- o provide the capability to report all services ordered and/or authorized by a physician or case manager/gatekeeper in the referring providers' profile;
- o generate profiles for group billers and HMO's, and individual rendering providers separately, based on group provider claims;
- o generate profiles for billing services or other non-traditional providers;
- o generate profiles across eligibility programs/benefit packages;
- o generate lists of providers and recipients who are found to be exceptional, ranked according to State defined variables such as cost, volume (number of recipients served and dollars paid), severity, and so forth;
- o support for stratified random sampling with appropriate statistics;
- o generation of random sampling with associated statistics (for example, universe statistics, confidence levels, and so forth);
- o provide a process to select, extract and transmit claims data at the request of the user (on-demand), in such a way that sufficient information is available to make a determination of mis-utilization, and such information is displayed for the user;
- o provide for user on-line specification of selection, summarization, and criteria for un-duplicating data when requesting claim detail reports from claims history;
- o generate frequency distributions, as defined by the users;
- o maintain a process to apply weighting and ranking to exception report items to facilitate identification of deviators;
- o maintain a process to link all services rendered to LTC residents, while resident in, or on leave days from, a facility, by facility ID;

- o include a description of all procedure, drug, and diagnosis codes, CLIA certification codes, specialty, sub-specialty, and any other codes on all reports;
- o provide access, to six (6) years of SURS history and summary files, which include, but are not limited to, summary utilization data defined by the user, such as number of services, amount billed, amount allowed, amount paid, and average paid per code; permit such access by procedure code, diagnosis code, provider, recipient, groupings of providers or recipients, or other selection criteria and any combination thereof; and
- o roll off claims history by date of service, not date paid.

3.3.30.2.16

Provide for the automated input of identified claims to SURS case tracking.

3.3.30.2.17

Provide the State with the capability to develop, design, modify, and test alternative report parameters and maintain an indexed library of such report parameters.

3.3.30.2.18

Allow users the capability, with help screens, to extract data from SURS reports, manipulate the extracted data, free form cut and paste, and specify the desired format and media of the output; and

3.3.30.2.19

Provide the capability to run a complete SUR reporting cycle on demand.

3.3.30.2.20

Ability to route or mail reports to other user locations and the ability to view these reports at the same time.

3.3.30.2.21

Provide the ability to print part of a report versus the complete report.

3.3.30.2.22

Utilize client/server architecture that is table driven and highly adaptable to data structures and warehouse design.

3.3.30.2.23

Provide the ability to schedule and prioritize queries, to run multiple queries at once; and prompt the user when the query has completed.

3.3.30.2.24

Provide the capability for the analysis of treatment patterns across different claim types, such as, physician office visits and pharmacy prescriptions to hospital stays, ambulance trips, and equipment rentals.

3.3.30.2.25

Provide the capability to quickly perform pattern recognition queries across all data elements in the data selected.

3.3.30.2.26

Provide the capability to drill down from on-line reports to analyze underlying data, such as claims detail.

3.3.30.2.27

Provide the capability of care being depicted as a global view of a client's treatment over time across all settings.

3.3.30.2.28

Provide the capability to perform pattern analysis of illogical or inappropriate billing patterns across any healthcare setting.

3.3.30.2.29

Provide the capability for development of pre-defined templates, algorithms and the capability for a user to develop customized pattern-recognition queries.

3.3.30.2.30

Provide the capability to generate output files containing data that highlights patterns and/or practices that fall outside the bounds of predicted norms.

3.3.30.2.31

Provide the capability to allow analysis to be iterative, allowing for multiple real-time analysis review cycles.

3.3.30.2.32

Provide the ability to search for unmatched complementary services or diagnoses reported within user defined timeframes.

3.3.30.2.33

Provide capability for Trend Analysis and Detection Analysis.

3.3.30.2.34

Provide integrated mapping capability which includes capabilities to clearly illustrate suspicious concentrations of services within a geographical vicinity, highlights unreasonable distances between provider location and client's residences.

3.3.30.2.35

Provide capability to access, integrate, and mine information utilizing advanced pattern-recognition and neural technology.

3.3.30.2.36

Provide the ability to identify cases with the highest potential for fraud and/or abuse.

3.3.30.2.37

Utilize advanced modeling techniques, such as neural networks and fuzzy rules.

3.3.30.2.38

Provide the ability to isolate subtle patterns of fraud and adapt to changing fraud schemes.

3.3.30.2.39

Provide the ability to produce priority ranked suspect lists.

3.3.30.2.40

Provide for comprehensive provider profiling and fraud and abuse detection.

3.3.30.2.41

Provide for comprehensive recipient profiling and fraud and abuse detection.

3.3.30.2.42

The SUR subsystem should have sufficiently flexible graphics capabilities to provide the user with the flexibility of reporting query output in a variety of ways. It is preferred these capabilities include the following:

- o geographical mapping;
- o a range of graph types for data presentation, including bar chart, pie chart, stacked, and side-by-side bar charts, single and multiple line charts, three (3) dimensional graphs, tree graphs, probability plots, trend lines, and other common-use graphical presentation methods;
- o customization of chart attributes, including orientation, legends, tic marks, intervals, and scaling;
- o ability to manipulate the font style and size of any embedded text or numeric information;
- o standard editing capabilities as well as optional capabilities for shadowing, mirroring, highlighting, and flipping axes;
- o capability to interface with a variety of printers, including laser, dot matrix, and plotter;
- o enhanced graphical representation capabilities that can interface with other programs, such as power point and web based applications; and
- o gray scale and pattern printing and a symbol library.

3.3.30.2.43

The SUR / Fraud and Abuse Function must provide capabilities including:

- o provide users with extensive and highly flexible capabilities for the visual presentation of information in tabular and graphic/chart form;
- o use modern type and typographic techniques to provide a high degree of legibility and readability, and to provide the capacity for printing to high-quality laser printers;
- o provide high resolution on-screen multicolor displays of information and must provide flexible capability for users to print reports, text, tables, maps, and charts/graphs in hard copy form (black, white, color) using high resolution printers (300 dpi or greater print resolution);

- o present all information in well designed, polished tables and high-quality graphs, charts, and maps;
- o provide users with executive-level features for the statistical and economic analysis of information; and
- o capability to ‘zip’ reports to electronically transfer either inside or outside the agency.

3.3.30.2.44

The SUR system will implement highly sophisticated analysis methods to detect abnormal patterns in utilization, billing practices, procedure coding, diagnosis coding, referral patterns, and provider and recipient identification both within a fee-for-service and/or managed care environment.

3.3.30.3 Outputs

The MMIS SURS/Fraud and Abuse function must provide the following outputs:

3.3.30.3.1

All data shall be available for retrieval through the DSS/DW function or extract, as appropriate.

3.3.30.3.2

All reports must be made available in data format for export and import purposes (such as, Excel, Access, Word, .dbf, and so forth) and through multiple media such as paper, cd-rom, and so forth.

3.3.30.3.3

Management summary reports, by peer group, to include:

- o summary matrix item totals,
- o frequency distributions, and
- o exception report item totals, including norms, exception limits, and number of exceptions.

3.3.30.3.4

Profile reports, including:

- o recipient exception profiles,
- o provider exception profiles,
- o all recipient summary profiles, and
- o all provider summary profiles.

3.3.30.3.5

Other reports, including:

- o supporting reports,
- o claim detail reports,
- o special reports,
- o severity index report, and
- o control file reports.

3.3.30.3.6

Detail of paid services, with sufficient information to facilitate analysis of data for the most recent thirty-six (36) months of paid claims, for selected providers and recipients, reported at time intervals specified by the State.

3.3.30.3.7

Claim detail, from the adjudicated claim record, with multiple select and sort formats, which shall include but not be limited to:

- o provider ID and name,
- o provider specialties and sub-specialties,
- o recipient ID, name, or other demographic information,
- o referring/prescribing provider ID,
- o category of service,
- o internal control number,
- o prior authorization number,
- o program,
- o date or date range of service,
- o payment date,
- o place and type of service,
- o diagnosis code(s), with description,
- o procedure/drug code(s), with description,
- o therapeutic class code(s),
- o drug generic code(s),
- o lock-in indicator,
- o billed and paid amounts, and
- o brand certification.

3.3.30.3.8

Produce a single report, ancillary, ambulatory, and inpatient services provided to LTC residents, while resident in, or on leave days from, a facility.

3.3.30.3.9

Summary reports, by living arrangement (nursing home, home for the aged, group home, and so forth) which list the following for each facility:

- o facility identification and data,
- o number of recipients served by each performing provider,
- o dollars paid, by type of service, to each performing provider for services to recipients, by living arrangement, and
- o dates of service.

3.3.30.3.10

Detail reports, by living arrangement (nursing home, home for the aged, group home, and so forth) which include:

- o names and IDs of recipients using inpatient services during an LTC confinement,
- o hospital stay dates of service,
- o amount billed per hospital stay, and
- o ICNs of the hospital claims.

3.3.30.3.11

Physician detail reports, by provider number, which identify the number of visits to various types of facilities (nursing home, home for the aged, group home, and so forth) by performing providers, and give details for recipients, including date of service, procedure code, and amount billed.

3.3.30.3.12

Annual ranking reports by dollars for the top 15% of recipients, by diagnostic group and/or payment amount.

3.3.30.3.13

Summary and detail information on hospital stays, including length of stay, room and board charges, ancillary charges, and medical expenses prior to and immediately following the hospital stay by program and medical coverage group.

3.3.30.3.14

Reports, as specified by the State, which identify all services rendered to recipients who are receiving a specific treatment or drug, are enrolled in State specified program groups, have a certain living arrangement, or are receiving services from certain providers or provider groups.

3.3.30.3.15

Capability to force profiling of selected providers or recipients.

3.3.30.3.16

Weighting and ranking of exceptions, as specified by the State.

3.3.30.3.17

A narrative description of procedures, drugs, and diagnoses on reports.

3.3.30.3.18

Identification of recipients receiving services from different, user selected providers or provider types, on the same or overlapping dates of service.

3.3.30.3.19

Cross-referencing of multiple provider services rendered to one recipient on the same date of service.

3.3.30.3.20

Summary and detail information on waiver lengths of stay, including lengths of stay in hospitals and nursing homes while in the waiver group.

3.3.30.3.21

Provide the capability of using a report viewer to enable users and provide the ability to sort, group, regroup, summarize, window by time, and perform other output management functions, including referring back to the original claims data for a more detailed view.

3.3.30.3.22

Provide all reports to meet all federal and state reporting requirements.

3.3.30.4 Interfaces

There are no external automated interfaces identified for the SURS/Fraud and Abuse function.

3.3.31 SUR CASE TRACKING

OHCA requires the capability to track SUR cases from identification through the life of the Fiscal Agent contract. This tracking ability requires that the contractor provide the functionality and tools to accomplish this objective.

The SUR Case Tracking System is intended to replace many of the manual functions throughout the SUR Review Process with systematic approaches. Utilizing state of the art technology should provide automation to replace many of the current manual operations such as providing auto-assignment of case reviews, online updating of case documentation, imaging of incoming correspondence, photocopied medical records from onsite audits, and so forth. The SUR Case Tracking should provide for retrieval of data files of reports generated within the MMIS SURS/Fraud and Abuse, AD-Hoc, and DSS and link the reports to related SURS Case Reviews. All case documentation is linked to a SURS Case utilizing a unique identifier. All SUR case documentation will be linked and cross-referenced systematically to provide an audit trail of all SURS review activities for each SUR case.

The imaging of all gathered documents, incoming correspondence, etc., will provide a fully electronic SUR case file for each SUR case. The availability of SUR Case files being available online for six (6) years will provide immediate access to SUR case review files.

3.3.31.1 Inputs

The MMIS SUR Case Tracking function must accept the following inputs:

- o adds, changes and deletes of SUR cases;
- o hearing results from Medical Advisory Committee (MAC);
- o notes from provider site visits, responses and information from provider response letters and questionnaires;
- o imaged documentation to be attached to SUR cases;
- o decisions on initiating recoupment activity;
- o receivable information from the MMIS financial accounting function;
- o complaints and referrals from outside parties and agencies about recipients or providers;

- o information from providers and medical consultants via the internet;
- o selected claim details from the SUR function;
- o selected exception profiles, summary profiles, and other reports identifying abhorrent patterns and practices from the SUR function and the Decision Support System/Data Warehouse function; and
- o fraud and abuse alerts from HCFA.

3.3.31.2 Processing

The MMIS SUR Case Tracking function must have the following processing capabilities:

3.3.31.2.1

Maintain an automated tracking capability for SUR review activities and potential post payment recovery actions which can track individual or grouped claims from the initiation of review efforts, through any recovery action, to closure.

3.3.31.2.2

Provide for automated assignment of unique identification number for each SUR review and recovery case and must also allow for manual assignment of unique identification numbers.

3.3.31.2.3

Provide the capability to link all documentation (imaged documents, SUR reports, letter, spreadsheets, and so forth) to the SUR case using the unique identifier;

3.3.31.2.4

Provide for on-line display, inquiry, and updating of SUR review and recovery cases records with access by key identifiers.

3.3.31.2.5

Provide the capability to maintain data on each SUR case including:

- o notations such as physical characteristics and observations from provider on-site reviews;
- o responses from the notification letters and questionnaires received from providers;
- o free form notes regarding the case;

- o an indicator to initiate proper action;
- o progress status of the review process, including management review results;
- o results from Medical Advisory meetings and other pertinent meetings;
- o indication that an appeal has been filed, the date appeal was filed, the type of appeal, and the filer;
- o the date of appeals notification, and the decision;
- o the date and decision, any actions to be taken, and so forth regarding any outside entity reviews of the case;
- o settlement agreements on the case and the status and status dates of progress in the settlement; and
- o SUR management approval/disapproval.

3.3.31.2.6

Provide the capability to image responses received from providers, recipients and other entities involved in the SUR case and attach these imaged documents to the case to which they pertain.

3.3.31.2.7

Provide data access and update capability to SUR cases with security at a user, screen, record, and field level.

3.3.31.2.8

Upon initiation of a SUR case, automatically populate the case with the demographic information for the specific provider or recipient the case pertains to.

3.3.31.2.9

Provide the capability to update the SUR cases with date, time, and place of all hearings and provide an automated notification to the MAC and OHCA Legal Division.

3.3.31.2.10

Provide the capability to generate a feed from the SUR Case Tracking function to the MMIS financial accounting function to generate adjustments through a batch process. This would allow the SUR analyst to release cases for recoupment once the case has been finalized.

3.3.31.2.11

Create a feed from the MMIS financial function to the SUR Case Tracking function to report when recoupments have been satisfied.

3.3.31.2.12

Allow for notification from the MMIS financial system to the SUR Case Tracking function when a write-off is applied to a SUR accounts receivable.

3.3.31.2.13

Provide the ability to add or delete claims that are included in any SUR case created.

3.3.31.2.14

Maintain six (6) years of on-line recipient data, provider data, claims history to support SUR review and recovery case activity.

3.3.31.2.15

Maintain all open SUR recovery cases on-line.

3.3.31.2.16

Maintain closed SUR recovery cases on-line for six (6) years.

3.3.31.2.17

Provide for on-line updateable templates of letters and questionnaires to recipients, providers, and state agencies involved in SUR review and recovery cases and the ability to add free-form text to letter templates on a case by case basis.

3.3.31.2.18

Automatically generate letters and questionnaires to recipients, providers, and state agencies according to State criteria.

3.3.31.2.19

Automatically generate claim facsimiles, which can be sent to recipients, providers, and state agencies involved in the SUR case.

3.3.31.2.20

Provide the capability to send confirmation letters to providers to verify the scheduled review date and indicate what is to be reviewed and whether or not there are any records being requested for review.

3.3.31.2.21

Provide the capability to define the criteria to be used for automated selection of providers and recipients for SUR review.

3.3.31.2.22

Provide the capability to monitor and track case activity.

3.3.31.2.23

Provide the capability to manually and automatically assign and/or re-assign cases to a unit and an analyst based on user-defined criteria such as, type of case (all provider types, specific provider types, re-evaluations, priority cases, and so forth) and assign cases to the SUR manager for review.

3.3.31.2.24

Provide the capability to systemically define the load level (the percentage of total cases, the total number of cases in the analyst's workload, a maximum number of cases to be assigned, and so forth) for each analyst.

3.3.31.2.25

Provide the capability to review cases assigned to a unit and/or analyst, validate or modify the automated assignments, and assign a unit and or analyst to those cases that could not be automatically assigned.

3.3.31.2.26

Provide the capability to access the queue and select SUR cases for validation. Once the validated status indicator is entered for the case, the case will be ready for recoupment.

3.3.31.2.27

Provide the capability to prepare the referral packages for the Medical Advisory Committee (MAC), Consultant Referrals, and/or CEO Appeals.

3.3.31.2.28

Provide the capability to forward documentation to the Medical Advisory Committee (MAC) and/or the CEO with a Statement of Facts form on selected provider cases.

3.3.31.2.29

Provide the capability to extract re-evaluations from the SUR Case Tracking function which have come due since the last selection process and add to the SUR selection universe.

3.3.31.2.30

Provide the capability to extract referrals from the SUR cases that have been received since the last case selection process, and add them to the SUR selection Universe.

3.3.31.2.31

Provide the capability to eliminate providers and recipients who meet the de-selection criteria from the selection universe.

3.3.31.2.32

Provide the capability to retrieve documents attached to SUR cases and transmit the documents via direct access referral, e-mail, or postal service.

3.3.31.2.33

Provide the capability to choose specific provider, provider organization, recipient, enrollee, billing agent, or other population that will be the target of the exception process.

3.3.31.2.34

Provide the capability to specify the attributes of the population such as provider office location, recipient age, provider type, from/to dates of activity, service codes, and/or diagnosis codes for the target population.

3.3.31.2.35

Provide the capability to automatically or manually select providers and recipients for utilization review based on user-defined criteria such as, internal requirements for the number of cases which must be reviewed, the Exception Log Report, provider or recipient's status within the Medicaid program, review status, referral status, and re-evaluation status.

3.3.31.2.36

Provide the capability to image and attach all documentation related to a SUR review and recovery case and retrieve and review on-line or send to print.

3.3.31.2.37

Provide the capability to extract managed care information including, report data, recipient and provider database, detail service data (encounters, capitation, and fee-for-service) and other information needed for review and analysis.

3.3.31.2.38

Provide the capability to extract, from the provider database, the demographic, eligibility, and other information for a provider under review.

3.3.31.2.39

Provide the capability to review the detail service data extracted for the provider or recipient, and document significant diagnoses, procedures, drugs, and any deviations from the norm.

3.3.31.2.40

Provide the capability to define the criteria to be used to eliminate a provider or recipient from the review process. De-selection criteria includes such items as termination of provider or recipient eligibility during the report period, providers who are currently under review, recipients who are currently restricted, and providers who may be under review by another state agency.

3.3.31.2.41

Provide the capability to request information from the provider under review, or from a sample of recipients for whom Medicaid claims were paid to the provider, and/or from external entities who can supply information needed to complete the review. The information needed must include, but is not limited to, requesting/receiving medical records on a recipient, and other notices to the provider being reviewed.

3.3.31.2.42

Provide the capability to receive and track complaints about providers and recipients, referrals from an outside agency, or any other requests for information.

3.3.31.2.43

Provide the capability to accept updates in the SUR case tracking function from the SUR function pertaining to identify exceptions.

3.3.31.2.44

Provide the capability to import and populate data from the claim detail report to spreadsheet type software.

3.3.31.2.45

Provide the capability to automatically download and upload case information from field worker laptop from/to the SUR case it pertains to.

3.3.31.2.46

Provide the capability for reviewers to update the audit report and recommendation and upload this information to the SUR case.

3.3.31.2.47

Provide the capability for producing an unduplicated list of the physicians and pharmacy providers for whom detail service records were included in the Recipient Claims Sample for a recipient under review.

3.3.31.2.48

Provide the capability of capturing Fraud Detection Alerts and maintaining the name and address of the source, the fraud detection models supplied, the effective dates of the model, and the date the alert and materials were received.

3.3.31.2.49

Provide case management and tracking capabilities to retain all pertinent electronic documentary evidence for referral and recovery when criminal or administrative sanctions appear warranted. In addition, the SURS Case Tracking system must allow for the seamless housing of all verbal and written contacts, the documenting of the provider or beneficiary's utilization reports, and the capability to store query criteria and analysis results.

3.3.31.2.50

Provide an automated systematic assessment process for determining the effectiveness of the SUR Exception processing and reporting to assure the providers/recipients identified are the most likely providers/recipients to have aberrant practice patterns.

3.3.31.2.51

Provide an automated systematic assessment process for determining the effectiveness of the SURS review process in terms of the number and types of reviews conducted, the overpayments identified for recoupment, and the time expended in the review of a case or cases.

3.3.31.3 Outputs

The MMIS SUR Case Tracking system must provide the following outputs:

3.3.31.3.1

All data shall be available for retrieval through the DSS/DW function or extract.

3.3.31.3.2

All reports must be made available in data format for export and import purposes and through multiple media such as paper, cd-rom, and so forth.

3.3.31.3.3

Generate letters to providers for whom problems have been identified.

3.3.31.3.4

Provide on-line inquiry capability for:

- o OHCA Legal, MAC, SUR staff and medical consultants to review data obtained during the desk audit or on-site audit, the case file, and any follow-up information which has been collected; and
- o SUR recovery cases and indicating the sum, terms and schedule for the recoupment of each of the SUR recovery cases.

3.3.31.3.5

Case documentation for forwarding to the Recipient Lock-In Committee and the Administrative Law Judge with a Statement of Facts about recipient cases.

3.3.31.3.6

Provide the capability to extract and format provider, recipient and standard report data. All fields and potential values must be selectable to determine what records or cases will be selected. All fields must be selectable for output presentation, and all fields must be selectable to determine the report sort sequence.

3.3.31.3.7

Provide the capability to extract from the recipient database the demographic, eligibility and other information needed about a recipient under review.

3.3.31.3.8

Provide the capability to provide a formal response to a referral or complaint.

3.3.31.3.9

Provide the capability to generate the SURS monthly and quarterly status reports.

3.3.31.3.10

Provide the capability to generate reviewer reports so each reviewer can generate their individual reports in order to monitor their own progress. The reports should also contain alerts to notify the reviewer of pending and upcoming activities.

3.3.31.3.11

Provide the capability to produce all types of standard management reports as requested by OHCA staff including, but not limited to, the standard reports necessary to complete reviews, reviewer status reports, monthly and quarterly status reports, and management reports monitoring progress and activity of case reviews.

3.3.31.3.12

Provide the capability to review the summary profile report for the provider or recipient under review and document significant report items from the profile.

3.3.31.3.13

Provide the capability to compile a report to summarize reasons why provider was selected, provider's service record, the information collected during review and findings compiled following analysis of all data associated with the case.

3.3.31.3.14

Provide the capability to generate reports of all active and closed cases.

3.3.31.3.15

Provide the capability to generate reports based on differences in performance measures and case outcomes.

3.3.31.3.16

Provide the capability to automatically generate a list of potential primary care providers, based on the claim history detail of the recipient, 14 days after the recipient deadline for selecting a primary care provider.

3.3.31.3.17

Provide the capability to generate confirmation of PCP Letters to be mailed to the primary care providers.

3.3.31.3.18

Provide the capability to notify recipient of his or her restriction to a primary care provider and/or pharmacy, and update the recipient database with the restriction data.

- o Provide the capability to prepare documents/letters notifying recipient that he/she will be restricted, including the Notice of Restriction, and the Recipient Choice Form.
- o Provide the capability for review staff and medical consultants to determine the disposition of a case and to generate letters to providers requesting that they put an end to any improper practice that has been discovered.
- o Provide the capability to send providers written notification letters regarding the disposition of the case. The disposition will vary by type of provider, type of audit, and specific circumstances of the findings and final recommendation.
- o Provide the online update capability for capturing results from meetings including but not limited to Medical Advisory Committee (MAC) and CEO Appeals, and the capability of systematically updating related SURS Case with pertinent data from these captured results.

3.3.31.3.19

Provide the capability for scheduling, tracking and documenting meetings within the SURS Case Tracking system.

3.3.31.3.20

Provide update capability to document SUR cases with results of onsite audits conducted at provider's facilities. This capability should also include the ability to export information from a Portable Computer or by direct online entry to the SUR Case Tracking system. Information to be documented includes but is not limited to reviewer's notations on: specific claims, claims detail history report, photocopied medical records, SURS Worksheet, and so forth. Any photocopied documents obtained from a provider while conducting an onsite audit will require the documents to be imaged and added to the specific SURS Case Review for the provider being audited.

3.3.31.3.21

Provide the capability to document the physical characteristics and focused observations of a provider's facility to the specific SURS case. This capability should also include the ability to export information from a Portable Computer or by direct online entry to the SUR Case Tracking system. Information to be documented includes information required in order to be eligible as a provider under the Oklahoma Medicaid Program.

3.3.31.3.22

Provide the capability of linking all SURS Case documents to a specific SURS Case by using the unique identifier. Each document within a SURS Case is required to be cross-referenced with the specific service listed on the SURS Claims Detail, SURS Worksheet, Medical Record, etc. This is intended to provide an internal tracking within a SURS Case Review to allow a case to stand independently so anyone could establish the trail of the reviewer's process and decisions made.

3.3.31.3.23

Provide the capability of maintaining Performance Measures by individual SURS reviewer and/or collectively for the entire SURS unit within the SUR Case Tracking system. Performance Measures include but are not limited to: number of cases reviewed, number of claims included in the universe, the number of actual claims reviewed in the sample, the total dollars reimbursed for cases included in the universe, the total dollars reimbursed for actual claims reviewed in the sample, and total dollars identified as overpayments for claims reviewed included in sample size. Also include as Performance Measures such items as the Total dollars requested to be recouped within each step of the Due Process (Reconsiderations, MAC Appeal, and CEO Appeal). Performance Measures should include the ability to report by Quarter, Calendar Year or Fiscal Year by individual SURS reviewer or collectively for the entire SURS unit.

3.3.31.3.24

Provide the ability to capture and utilize data pertaining to SUR employees such as experience level, areas of expertise, etc., to assure the appropriateness of case assignment through the automated assignment process.

3.3.31.3.25

Provide the ability with as much systematic and automatic capabilities possible in the documentation of all activities throughout the entire case review process. Include abilities such as: documenting case status, correspondence development and supervisor approval, summarization of findings, imaging of all hardcopy documents obtained throughout the case review process, linking and cross-referencing of services to associated notations and documents, etc.

3.3.31.3.26

Provide the online capability to allow reviewers to update any of the case information in their caseload. This capability should also allow supervisors/managers to set flags and overrides.

3.3.31.3.27

Provide the ability with as much systematic and automatic capabilities possible in the documentation of all activities throughout the entire management review and approval process. This includes the ability to make notations to the case, instructions to the SUR reviewer of necessary modifications or action, approval or rejection by the supervisor, etc.

3.3.31.3.28

Provide the capability to capture information pertaining to Medical Standards. Information to be captured includes but is not limited to requestor name and address, source name and address, title of the published medical standards produced by the organization, the effective date of standards, and the date the material is requested and received.

3.3.31.3.29

Provide online capability for capturing and updating information included in provider/recipient questionnaires.

3.3.31.3.30

Provide the capability for tracking appeals and hearings through out the due process period. This includes but is not limited to all correspondence, meetings, hearings, findings and notifications. This should include the ability to link pertinent information and document any related SUR Case.

3.3.31.3.31

Provide the online capability of developing and producing correspondence, notifications, and so forth, pertaining to all steps of Due Process including MAC Appeals and CEO Appeals, meetings, hearings, and so forth. This should include the ability to link pertinent information and document any related SUR Case.

3.3.31.3.32

Provide the online capability of documenting decisions of the Medical Advisory Committee (MAC), State Medicaid Director and the Chief Executive Officer of the Oklahoma Health Care Authority. This includes the decision, action to be taken, dates, etc. This should include the ability to link pertinent information and document any related SUR Case.

3.3.31.3.33

Provide the online capability to capture the date and associated information related to cases filed with the Circuit Court Administrative Review or Court of Appeals. This includes the decision, action to be taken, dates, and so forth. This should include the ability to link pertinent information and document to any related SUR Case.

3.3.31.3.34

Provide the online capability to capture the date and associated information related to Implemented Settlement Agreements. This includes the decision, action to be taken, dates, settlement amount, and so forth. This should include the ability to link pertinent information and document to any related SUR Case.

3.3.31.3.35

Provide the online capability for capturing and tracking dates and associated information pertaining to research, responses to Freedom of Information Requests, referrals from other agencies, complaints about providers/recipients and other requests for information or investigation. This should include the ability to link pertinent information and document to any related SUR Case.

3.3.31.3.36

Provide the online capability for documenting consultant recommendations on recipient or provider case reviews. This should include the ability to link pertinent information and document to any related SUR Case.

3.3.31.3.37

Provide the online capability for maintaining recipient information for recipients in the Recipient Restriction Program (Lock-in to a Primary Care Provider and/or Pharmacy). This includes but is not limited to dates of lock-in period, primary care provider and/or pharmacy.

3.3.31.3.38

Provide the capability for online review and determination (Pay or Deny) or suspended claims for recipients restricted under the Recipient Restriction Program. This should include the ability to link pertinent information and document to any related SUR Case.

3.3.31.3.39

Provide the capability to add referrals to the Selection Universe as part of the auto-assignment process for selection and assignment of SUR Case Reviews.

3.3.31.3.40

Provide the capability for online access and inquiry to the SUR Case Tracking system to obtain information pertaining to a specific case or several cases. Information should be limited to the security level of the inquirer. A separate screen should be developed to allow for a central entry point that would control access and allow for the use of selection to focus the inquiry. This should also include the ability to access the system remotely (Offsite) through use of portable computer with modem access.

3.3.31.3.41

Provide the online capability for capturing and tracking dates and associated information pertaining to implemented actions on case reviews through out the review process including processes such as reconsiderations, appeals, settlements, and so forth. This should include the ability to link pertinent information and document to any related SUR Case.

3.3.31.3.42

Provide the online capability for capturing and tracking dates and associated information pertaining to implemented actions on case reviews through out the review process including processes such as reconsiderations, appeals, settlements, and so forth.

This should include the ability to link pertinent information and document any related SUR Case.

3.3.31.3.43

Provide the capability that includes the automatic and/or manual assignment of SUR Cases requiring re-evaluation where results from previous SUR Review resulted in a finding requiring re-evaluation to be scheduled of a provider or recipient.

3.3.31.3.44

Provide the online capability for capturing and tracking dates and associated information pertaining to implementing and monitoring provider Suspension/Termination Proceedings. This should include the ability to link pertinent information and document to any related SUR Case.

3.3.31.3.45

Provide the online capability for notifying the provider, capturing and tracking dates and associated information pertaining to any SUR case reaching final recommendation stage regarding the disposition and the specific circumstances of the findings and final recommendation. This includes all phases of the SUR Review process, Due Process, Circuit Court, Suspension/Termination, etc. This should include the ability to link pertinent information and document to any related SUR Case.

3.3.31.3.46

Provide the online capability for capturing and tracking dates and associated information pertaining to the notification of disposition. This should include the ability to link pertinent information and document to any related SUR Case.

3.3.31.3.47

The contractor is required to maintain support tables required and utilized in the development of the SUR Case Tracking system and throughout the contract period as specified by the Oklahoma Health Care Authority.

3.3.31.3.48

The contractor is required to maintain in support tables members of Medical Advisory Committee, Medical Consultant and other identification and demographic data as specified by the Oklahoma Health Care Authority.

3.3.31.4 Interfaces

The MMIS SUR Case Tracking function must accommodate the following external interfaces:

- o laptops utilized by field staff, and
- o the internet.

3.3.32 STAFF PERFORMANCE TRACKING

OHCA requires the capability to track staff performance. This tracking ability requires that the contractor provide the functionality and tools to accomplish this objective.

3.3.32.1 Inputs

The MMIS Staff Performance Tracking function must accept the following inputs:

- o employee demographic and identifying information,
- o performance criteria and performance measures, and
- o business processing information.

3.3.32.2 Processing

The MMIS Staff Performance Tracking function must have the following processing capabilities:

3.3.32.2.1

Provide the ability for user management to create/maintain performance measures on-line, by unit, by business process, and compare them to actual performance results.

3.3.32.2.2

Record and track business processing information for OHCA staff assigned by clerk ID.

3.3.32.2.3

Provide the ability to assign performance measures to specific business processes by organizational unit.

3.3.32.2.4

Record relevant information about the business process being tracked such as claim number(s), deposit number, provider, recipient, staff identification number.

3.3.32.2.5

Record relevant information to measure and assess the performance of each business process being tracked.

3.3.32.2.6

Provide the ability to group tasks/activities within business processes by category, such as research, telephone time, and so forth.

3.3.32.2.7

Maintain an employee calendar/schedule to include current workload, vacations, and training or other time commitments.

3.3.32.2.8

Manually and automatically assign tasks and activities within business processes to staff based on user-defined criteria and the unit supervisor. Provide supervisor override of automatically assigned tasks.

3.3.32.2.9

Provide the capability to define the criteria to be used for assigning tasks and activities to staff.

3.3.32.2.10

Notify supervisors/managers of automated assignments and tasks that could not be automatically assigned.

3.3.32.2.11

Provide the ability to change data on employees, or terminate system access for those employees who have ended employment with OHCA.

3.3.32.2.12

Ability to generate and track referrals to OHCA units for necessary actions and follow up.

3.3.32.3 Outputs

The MMIS Staff Performance Tracking function must provide the following outputs:

- o generate reports based on differences in performance measures and actual processing results,
- o generate reports on pending and over due actions by organizational unit,
- o generate reports on performance completed by organizational unit and actions,
- o tracking reports generated by claim number, provider, recipient, contact, staff identification number, and source of inquiry such as provider, legislature, or governor's office,
- o reports by type of transaction, by staff, with elapsed time to complete processing action such as adjustments, eligibility, claims inquiry, and
- o user defined reports by unit, by staff, by periods of time.

3.3.32.4 Interfaces

The MMIS Staff Performance Tracking function has no external interfaces.

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