Request for Proposals

ISSUED BY

The New Mexico Human Services Department



For the provision of

HHS 2020 Medicaid Enterprise Financial Services

RFP # 20-630-8000-0001

Human Services Department

P.O. Box 2348

Santa Fe, New Mexico  87504-2348

David R. Scrase, MD, Cabinet Secretary

ISSUE DATE: June 27, 2019

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# I.  INTRODUCTION

## A.  PURPOSE OF THIS REQUEST FOR PROPOSALS

The State of New Mexico (NM) Human Services Department (HSD) is undertaking replacement of its existing Medicaid Management Information System (MMIS) through a MMIS Replacement (MMISR) Enterprise Solution. The MMISR Solution will comprise multiple technology-based modules and Business Process Outsource (BPO) services contracts. For this procurement, the State's definition of BPO is outsourcing the operations and responsibilities of a specific business process to a BPO service provider with oversight by the State. These BPO services are separate business functions and are responsible for performing processes or parts of processes and done to save costs or gain productivity.

The purpose of this Request for Proposals (RFP) is to solicit proposals for a Contractor to configure, provide and operate the Financial Services (FS) module of the MMISR Solution to meet the State's business needs. The State is seeking a FS Contractor with the depth and range of experience needed to successfully deliver this complex Project and whose approach reflects the creativity and insight born of that experience. Offeror shall demonstrate experience, knowledge, innovation, and the capacity necessary to perform the services described in this RFP.

## B.  SUMMARY SCOPE OF WORK

This section summarizes the work that will be required of the FS Contractor; however, it is not an exhaustive list of services expected.

The selected FS Contractor will provide services to: (1) perform work under the contract resulting from this RFP; (2) work with the Centers for Medicare and Medicaid Services' (CMS) approved Independent Verification and Validation (IV&V) Contractor, and the HHS 2020 Enterprise Project Management Office (EPMO), as well as the state staff dedicated to the Project; (3) perform planning and leadership related to configuration of all FS; (4) work with the MMISR System Integrator (SI) and other BPO Contractors to ensure FS integration with the MMISR Solution; and (5) support attainment of CMS Certification for the MMISR Solution as a whole.

The State seeks a Contractor who understands the CMS Medicaid Information Technology Architecture (MITA) and who can help the State achieve its goal of MITA Maturity Level 4. By pursuing MITA Maturity Level 4, the State expects to achieve

automation to the fullest extent, including the use of business rules to automate decision making; compliance with established industry standards; and improvements in timeliness, accuracy and customer satisfaction. The State recognizes that these benefits are available at MITA Maturity Level 3, and that a major differentiator between Level 3 and Level 4 is the development and implementation of regional/interstate standards and interfaces. The State supports the development of such standards and interfaces, will participate in regional and national efforts to define them, and expects its Contractors across the Medicaid Enterprise to participate as well.

The selected Contractor will work collaboratively with the HHS 2020 EPMO and other State staff, IV&V, other Contractors and Stakeholders associated with the MMISR Solution, including all other selected Contractors.

The selected Contractor will configure, provide and operate all FS components of the MMISR Solution to meet the State's business needs. The FS Contractor will perform project management services necessary to implement and operate FS components for the MMISR Solution, integrating these services with the HHS 2020 EPMO project management processes and standards.

The Contractor will perform services introduced in this section and described in more detail in the full Scope of Work (APPENDIX G). The specific Requirements that the Contractor is subject to are found in APPENDIX H.

Pursuant to §10-16-13 NMSA 1978 Prohibited Bidding: No state agency shall accept any bid (proposal) from a person who directly or indirectly participated in the preparation of specifications on which the competitive bidding was held.


## C. SCOPE OF PROCUREMENT


The procurement (consistent with §13-1-150 Multi-term Contracts), will result in a single four (4) year contract with up to four (4) optional one (1) year extensions at the discretion of the Department, not to exceed eight (8) years in total. The Contract will have fixed price deliverables.

As part of HSD's commitment to maximizing the benefits of a modular MMISR Solution, which includes no longer being dependent on a single New Mexico MMIS Contractor, each Offeror may win no more than two MMISR procurements as the prime contractor. The selected FS Contractor *may* be a subcontractor on other MMISR contracts. The selected Contractor can perform as the Prime Contractor on any other module except for SI and can serve as a subcontractor in other modules.

A conflict of interest may exist when an Offeror holds a Centennial Care Managed Care

Organization (MCO) contract and a contract for the MMISR Quality Assurance, Benefit Management Services and/or Financial Services BPOs with the State. This includes an Offeror that is a MMISR Contractor and/or a Subcontractor. To avoid the conflict, HSD, at its sole discretion, has the right to deny approval of the Offeror to enter into a MMISR contract.

The Contract will begin upon final execution from the Department of Finance and Administration (DFA) Contracts Review Bureau (CRB). At HSD discretion, the contract may be amended as needed to meet the requirements of this procurement or any future related Federal or State requirements for Medicaid, that would enable the Department and the Enterprise to meet strategic goals.

## D. PROCUREMENT MANAGER

The Department has designated a Procurement Manager who is responsible for the conduct of this procurement and whose name, address, telephone number and email address are listed below.

<div align="center">

Jade Hunt, Procurement Manager
New Mexico Human Services Department
Medical Assistance Division
39A Plaza la Prensa
Santa Fe, NM 87507

Phone: (505) 827-7710
Email:   JadeN.Hunt@state.nm.us

</div>

All deliveries via express carrier should be addressed and delivered to as follows:

<div align="center">

Jade Hunt, Procurement Manager, c/o Gary O. Chavez,
Chief Procurement Officer (CPO)
New Mexico Human Services Department
Administrative Services Division
1474 Rodeo Road
Santa Fe, NM 87505

</div>

Any inquiries, requests, or additional material regarding this procurement must be submitted to the Procurement Manager in writing via email. The NM State email system does not accept compressed files (zip files) and electronic mailboxes may have file size limitations. Please request confirmation of receipt as needed. Offerors may contact ONLY the Procurement Manager regarding the procurement. Other state employees or

contractors do not have the authority to respond on behalf of the Department.

## II.    MMISR APPROACH

The MMISR Project is part of NM HSD's Health and Human Services (HHS) 2020. HHS 2020 is an Enterprise vision for transforming the way HHS services and programs are delivered to New Mexico citizens. HHS 2020 is not limited to technology; it encompasses a re-evaluation of processes and organization structures used to manage and deliver program services, efforts to work across organizational boundaries to more effectively, manage and deliver all HHS services in the State and transition from current operating models to outcomes-based focus for our work. The goal of the MMISR Solution is to move away from a monolithic system approach and instead to implement a modular MMISR Solution with the information, infrastructure, tools and services necessary to efficiently administer NM Medicaid and Health and Human Services (HHS) programs. The MMISR Solution will use a combination of technology and BPO service procurements as the foundation for the HHS 2020 Framework. Due to MMISR certification and auditing requirements, the State will retain oversight and will require Contractor's adherence to Service Level Agreements (SLAs) for BPO processes and services. The services and processes performed by the Contractor must meet CMS Certification and increase the Enterprise's MITA Maturity Level.


HSD plans to achieve this vision via a series of procurements. Each procurement will require that the selected Contractor comply with accepted standards that promote interoperability across the HHS 2020 Framework and that support successful Service Oriented Architecture (SOA) compliant integration with other MMISR modules and services. To that end, the State has engaged an SI Contractor to provide a unifying role across these procurements. The SI Contractor will provide the core infrastructure used to transfer and enable storage of data from all the Contractors and throughout the MMISR Solution. Additionally, the SI Contractor is responsible for planning, testing, migrating, and managing successful integration across modules and services, and for setting interoperability standards.

HSD intends for the BPO modules to function as "black boxes", in that the inner workings of the Contractor's enabling technology are not specified by the State, but the module is viewed in terms of functionality, business process efficiency, performance against SLAs, and data inputs and outputs, enabling the State to take advantage of commodity services in the marketplace to achieve rapid use of key services needed to support Medicaid. The HSD BPO procurement strategy encompasses SLAs and associated Liquidated Damages (LDs) (see Appendix K – HHS 2020 Performance Measures), in compliance with CMS, State and other requirements, including those associated with the SI Solution and the

MMISR Solution as a whole and on exchange of data in agreed-upon formats and frequencies.

The MMISR Process Flows found in the Procurement Library present flow diagrams that illustrate, at a high level, the interactions and relationships among the MMISR modules and services.

A. **The MMISR Modules and Services Procurements**

a. **System Integrator** – Through the SI procurement, HSD acquired the core technologies and associated services needed to support, implement, facilitate and manage the HHS 2020 Framework with which other modules shall integrate, including:

1) SOA enablement, Enterprise Service Bus (ESB), schema management, data quality management (DQM), policy enforcement, security implementation, management and governance;

2) Core shared services Master Data Management (MDM), including Electronic Document Management (EDM), address verification, client information verification, notification engine, Master Client Index (MCI), Master Provider Index (MPI) and others depending upon Contractors' recommendations, and SOA tooling to support business process automation (e.g., Workflow, Business Rules and Business Process Management/Orchestration including Operational Data Store [ODS]);

3) Reusable and repeatable system migration capability (including data conversion as required to migrate from legacy systems to the HHS 2020 ecosystem);

4) Security implementation and management, identity proofing, system integrity, system fraud prevention, and Single Sign-on; and

5) Integration Governance (e.g., security, monitoring, management and platform administration).

b. **Data Services (DS)** – Through the DS procurement, HSD acquired a Contractor and services focused on designing, implementing, operating and continually improving the structures, processes and data needed to support HSD and HHS 2020 current and future reporting and analytic requirements. The DS Contractor will develop data structures (e.g., multiple linked data stores, data marts, data lakes, an Enterprise Data Warehouse (EDW) or equivalent) while leveraging the infrastructure and tools provided by the SI Contractor. The DS procurement resulting in a Contractor to design, implement, operate and continually improve Business Intelligence (BI) as part

of a set of SOA services needed to support current and future reporting and analytics requirements for the State.

The DS Contractor will focus initially on defining and implementing the processes, analytics and technology tools and structures required to establish foundational integrated data services that support reporting and analytics. However, DS goals also include providing insightful analytics to support population health management (i.e., an outcomes-focused approach to designing, delivering and managing services with the ability to run NM-specific experience against national databases) and to enable HHS State-wide reporting and analytics through an integrated data services and technology platform. The DS Contractor also will deliver timely and accurate reports, analytics and related work products.

The DS Contractor will be responsible for analyzing data requirements, both current and projected; working with the State to define and implement a data governance approach; using the MDM Solution of the SI Contractor for HHS 2020 data assets; providing data analytic and BI tools; and working with the State to plan an approach to achieve increasing levels of data maturity for HHS 2020.

c. **Quality Assurance (QA)** – HSD is contracting with a BPO Contractor to provide the following Enterprise components of the QA Business Services using a CMS-compliant platform and processes:

1) Program Integrity (PI) support, including Third-Party Liability (TPL), Fraud and Abuse Detection Services (FADS), audit coordination and compliance;

2) Recovery Audit Contractor (RAC)- Management of Recovery and Audit responsibilities;

3) Quality Reporting; and

4) Coordination of efforts and projects with the HSD Office of Inspector General (OIG) and the Medicaid Fraud Control Unit (MFCU) of the Office of the Attorney General (OAG).

The QA Contractor also will provide services necessary to perform to the QA contract and to interact with the State and with other HHS 2020 module and BPO Contractors to effectively support HHS 2020 and the MMISR Solution.

d. **Financial Services (FS)** – Through this FS procurement, HSD will contract with a BPO Contractor to provide comprehensive financial services (e.g., accounting, payment, billing); Enterprise claims processing (including pharmacy claims, non-

medical claims and other payment types), Self-Directed Home and Community Based Services; Pharmacy Benefit Management; Drug Rebate; Data Exchange and Reporting; and General Requirements, using a CMS-compliant platform and processes for multiple Enterprise programs. The FS Contractor also will provide services necessary for managing the FS contract, for interacting with the State and other HHS 2020 Contractors to effectively support HHS 2020 and MMISR and for providing to the SI and DS Contractors the data elements essential to Federal reporting requirements.

e. **Benefit Management Services (BMS)** – Through the BMS procurement, HSD will contract with a BPO Contractor to provide the following services for BMS using a CMS compliant platform and processes:

1) Member Management;
2) Delivery and assistance with a care and case management tool to provide the data tracking necessary for effective care and case management within and across HHS 2020 agencies;
3) Utilization Management/Utilization Review including Prior Authorization (and other authorizations, Referrals, Budget Management, Individual Support Plans and Services);
4) Provider Management, including enrollment; and
5) Benefit Plan Management.

The BMS Contractor also will provide the project management services necessary to satisfactorily perform the BMS contract and to interact with the State and with other HHS 2020 module Contractors to effectively support HHS 2020 and the MMISR Solution.

f. **Unified Public Interface (UPI)** – A key element of the HHS 2020 Framework is a unified interface serving all Stakeholders, in keeping with the vision of presenting a more customer-centric view of HHS services and processes. HSD seeks to develop, implement and operate a UPI serving NM citizens, Providers, State agencies and employees, and other Stakeholders. The goal of the UPI is to offer a "one-stop shop" that embraces a "no wrong door" approach to customer service.

To achieve this goal the two principal UPI parts.

1) Consolidated Customer Service Center (CCSC) – The goal for the CCSC is to provide a single, integrated contact center serving all HSD programs, to increase efficiency and to make it easier for our customers and Providers to obtain needed information and/or actions. HSD is negotiating a contract with

the selected CCSC Offeror. The resulting BPO service contract will encompass:

a) CCSC set-up/tailoring to meet HSD-specific contact center needs, including technology, processes, training and staff;

b) Provide the required services to efficiently resolve or route, to the appropriate entity, all client inquiries;

c) CCSC operation, reporting and continuous improvement; and

d) Services necessary to perform to the CCSC contract and to interact with the State, HHS 2020 module Contractors and BPO Contractors to effectively support HHS 2020 and the MMISR Solution.

2) <u>Unified Web Portal and Mobile Technology</u> – The goal for the Unified Web Portal and Mobile Technology encompasses both a unified web portal and the use of social media, mobile technology and other user-friendly technologies to improve User ease of access and to enhance the State's ability to readily and effectively reach customers, Providers and other Stakeholders. Work associated with this component includes:

a) Development of a comprehensive concept and design to effectively serve all Stakeholders, via web portal(s), mobile technology and other user-friendly technologies;

b) Implementation, operation and maintenance of the unified portal(s) and other recommended technologies; and

c) Services needed to manage this component and to interact with the State and with other HHS 2020 module Contractors and BPO Contractors to effectively support HHS 2020 and the MMISR Solution.

HSD released a competitive procurement in 2015 for MMISR Independent Verification and Validations (IV&V) services and selected a Contractor (CSG) that began operations in August 2016. The MMISR IV&V Contractor will perform IV&V services throughout MMISR implementation and CMS Certification in accordance with the requirements of CMS and NM Department of Information Technology (DoIT). All MMISR module and BPO prime Contractors will be required to interact and collaborate with the IV&V Contractor.

*Table 1 RFP Release Timeline*

| Module or BPO | RFP Release Date | Proposals Due |
|---|---|---|
| System Integrator | February 20th, 2017 | April 19th, 2017 |
| Data Services | April 17th, 2017 | June 21st, 2017 |
| Quality Assurance | March 16th, 2018 | May 16th, 2018 |
| Consolidated Customer Service Center | November 12th, 2018 | March 21st, 2019 |
| Financial Services | June 27th, 2019 | August 26th, 2019 |
| Benefit Management Services | July 10th, 2019 | September 27th, 2019 |
| Unified Portal | TBD | TBD |

## III. CONTRACTOR ROLE

This section summarizes the work for the MMISR Solution FS Contractor. The FS Contractor will play a critical role in MMISR Solution success. See APPENDIX G for a more detailed scope of work and APPENDIX H for FS requirements.

The FS module shall integrate with the SI Solution which will comprise a highly reliable, loosely coupled, secure SOA-compliant integration platform for all of HHS 2020 that will provide systems migration capability, core shared services and an ongoing operational monitoring and management capability. The FS Contractor shall adhere to all standards established by the SI Contractor and approved by the State related to integration, interoperability, security and transmission of data. The Contractor shall exchange data using the ESB and shall acknowledge the data belongs to the State.

The contract resulting from this RFP also will require the Contractor to perform a range of services essential to successful implementation, integration, certification, management

and operation of the MMISR Solution. The FS Contractor shall provide BPO Services. The FS Contractor shall be knowledgeable to manage, process and execute compliance activities and functions for the Enterprise.

At a high level, the selected Contractor will:
- Configure, provide and operate the FS module through the contract life to meet the State's business needs;
- Perform Project Management and Contract Management activities for all FS functions while integrating with the HHS 2020 EPMO's management processes and standards;
- Collaborate with Stakeholders from HSD, other State agencies and organizations, other MMISR Contractors, Federal partners, the IV&V Contractor and others as required to make the MMISR Solution a success;
- Participate in FS business process changes while establishing Continuous Process Improvement (CPI) activities that can continue and will continue through the life of the Project;
- Provide all the technology and services identified in this RFP;
- Provide updates and related testing of installations at no cost to the State; and
- Meet certification requirements and perform certification activities as stated in Section 15 of Appendix G.

HSD is seeking Offerors who can demonstrate added value and experience delivering the services required to meet FS requirements while integrating with the SI standards and processes. The proposed FS Offerors should take into consideration the information presented in this RFP and available in the Procurement Library https://webapp.hsd.state.nm.us/Procurement/.

Offerors proposals shall demonstrate the Offeror's ability and experience to:

- Apply lessons learned from other large enterprise-driven FS efforts;
- Consider and understand the risks associated with its chosen MMISR approach and how to mitigate the risks;
- Integrate with SI platform, processes and standards;
- Deliver FS that are efficient, easily maintained, extendable, and easy to operate and update throughout its life;
- Integrate the FS requirements that affect interoperability within the MMISR Solution and as part of the HHS 2020 Framework;
- Deliver FS that are in the best interest of the State, and that actively assists the State in improving MITA Maturity Levels across the Enterprise;
- Exercise competence and experiential strength in applying well-defined

methodologies and processes to manage and deliver the Project successfully; and

- Apply and foster creativity in understanding the State's goals for this Project and for HHS 2020 and applying that understanding to the recommended FS and MMISR Solution (as defined in Appendix G-Statement of Work and Appendix H-Requirements).

## IV.    DEFINITION OF TERMINOLOGY

This section contains definitions of terms used throughout this procurement document, including appropriate abbreviations:

"**Agency**" means the Human Services Department.

"**ASPEN**" means New Mexico's Automated System Program and Eligibility Network.

"**Authorized Purchaser**" means an individual authorized by a Participating Entity to place orders against the Contract resulting from this procurement.

"**Award**" means the final execution of the contract document.

"**Business Days**" means days the State of New Mexico is open for business (i.e., Monday through Friday except for State Personnel Board approved State and Federal holidays).

"**Business Hours**" means 7:30 AM through 5:30 PM Mountain Time (MT), Monday through Friday.

"**Close of Business**" means 5:30 PM MT.

"**CMS**" means the Federal Center for Medicare and Medicaid Services, an agency of the US Department of Health and Human Services.

"**Contract**" means any agreement for the procurement of items of services, construction, or tangible personal property.

"**Contractor**" means the FS Contractor for the MMISR Solution who has been contracted as a result of this procurement.

"**Days**" means business days.

"**Department**" means one of the principal divisions of the State government, headed by a secretary who is a member of the governor's cabinet. HSD is the department that contracts for this project.

"**Desirable**" means the terms "may", "can", "should", "preferably", or "prefers" to identify a discretionary item or factor.

"**Determination**" means the written documentation of a decision of a procurement officer, including findings of fact required to support a decision. A determination becomes part of the procurement file to which it pertains.

"**Electronic Document Management**" means document imaging, scanning and management.

"**Electronic Visit Verification (EVV)**" means, as defined in NMAC 8.308.12.7.I, a telephone and computer-based system that electronically verifies the occurrence of HSD selected services visits and documents the precise time the service begins and ends.

"**Enterprise**" means the full spectrum of NM HHS systems and agencies (departments/divisions) engaged in this Project. At the present time the Enterprise applies to ALTSD, CYFD, DOH and HSD.

"**Evaluation Committee**" means a body appointed to evaluate Offerors' proposals.

"**Evaluation Committee Report**" means a report prepared by the Procurement Manager and the Evaluation Committee for contract award. It will contain written determinations resulting from the procurement.

"**FFS**" means Fee-For Service, a payment model where services are paid for separately.

"**Finalist**" means an Offeror who meets all mandatory specifications of this RFP and whose score on evaluation factors is sufficiently high to merit further consideration by the Evaluation Committee.

"**Framework**" means the fundamental structure to support the development of the HHS 2020 Solution. The Framework acts as the architectural support for the modules, services and applications, ESB, Web services, service layers, commonly shared Core Services, etc.

"**HHS**" means Health and Human Services and includes all State agencies delivering HHS-related services: Department of Health (DOH), HSD, Aging and Long-Term Services Department (ALTSD), Children Youth and Families Department (CYFD).

"**Hourly Rate**" means the proposed fully loaded maximum hourly rates that include travel, per diem, fringe benefits and any overhead costs for Contractor personnel and if appropriate, subcontractor personnel.

"**HSD**" means the New Mexico State Human Services Department.

"**IP**" means integrated platform.

"**IT**" means information technology.

"**IV&V**" means Independent Validation and Verification as defined in Federal regulations

and by the New Mexico Department of Information Technology (DoIT).

**"Learning Management System"** means software application for the administration, documentation, tracking, reporting, and delivery of educational courses, training, programs, or learning and development programs.

"**Mandatory**" means the terms "must", "shall", "will" and "required" identify a required item or factor. Failure to meet a mandatory item or factor will result in rejection of an Offeror's proposal.

"**Minor Technical Irregularities**" means anything in a proposal that does not affect the price, quality, quantity or any other mandatory requirement.

**"MITA"** means Medicaid Information Technology Architecture (MITA) initiative sponsored by the Center for Medicare and Medicaid Services (CMS) and governed by the MITA Governance Board is intended to foster integrated business and information technology (IT) transformation across the Medicaid enterprise to improve the administration of the Medicaid program.

**"MITA SS-A"** means the MITA State Self-Assessment.

"**MMIS**" means the New Mexico Medicaid Management Information System that helps manage the State's Medicaid program and Medicaid business functions.

"**MMISR**" means the MMIS Replacement system and Project, as explained in the RFP.

**"MT/MDT"** means Mountain Time/Mountain Daylight Time.

**"NM"** means New Mexico.

**"Off Shore"** means any country outside of the United States.

"**Offeror**" means any person, corporation, or partnership that chooses to submit a proposal.

"**Price Agreement**" means a definite or indefinite quantity contract that requires the Contractor to furnish items of tangible personal property, services or construction to a State agency or a local public body that issues a purchase order, if the purchase order is within the quantity limitations of the contract, if any.

"**Procurement Manager**" means any person or designee authorized by a State agency or local public body to enter into or administer contracts and to make written determinations with respect thereto.

"**Procuring Agency**" means the New Mexico Human Services Department.

"**Project**" when capitalized, refers to the MMIS Replacement effort, and it incorporates the

HHS 2020 Framework, modules and services as defined in this RFP. It also includes all the work required to make the systems and services a reality for HSD and its partners. When "project" is used in a lower-case manner, it refers to a discrete process undertaken to solve a well-defined goal or objective with clearly defined start and end times, defined tasks and a budget that is separate from the overall Project budget. A Project terminates when its defined scope or goal is achieved, and acceptance is given by the project's sponsor. The Project will terminate when the Framework is fully implemented, has been certified by CMS, and meets all the conditions and requirements established by the State.

**"Provider"** means an individual, institution, facility, agency, physician, health care practitioner, non-medical individual or agency, or other entity that is licensed or otherwise authorized to provide any of the Covered Services in the State for HHS 2020 Enterprise Agencies. Providers include individuals and vendors providing services to Members.

"**Request for Proposals**" means all documents, including those attached or incorporated by reference, used for soliciting proposals.

"**Responsible Offeror**" means an Offeror who submits a responsive proposal and that has furnished, when required, information and data to prove that its financial resources, production or service facilities, personnel, service reputation and experience are adequate to make satisfactory delivery of the services or items of tangible personal property described in the proposal.

"**Responsive Offer**" means an offer that conforms in all material respects to the requirements set forth in the RFP. Material respects of an RFP include, but are not limited to price, quality, quantity or delivery requirements.

**"SCS"** means CMS' Seven Conditions and Standards.

**"Service-Level Agreements (SLAs)"** means an agreement that defines the level of service expected from the service provider.

**"Solution"** means any combination of design, software, services, tools, systems, processes, knowledge, experience, resources, expertise or other assets that the State, the MMIS and the respective modular contractors use or provide to meet the business needs of the Project.

"**SPD**" means State Purchasing Division of the New Mexico State General Services Department.

"**Staff**" means any individual who is a full-time, part-time, or independently contracted employee with an Offeror's company.

**"Stakeholders"** means internal and external individuals, agencies, organizations, departments that are integral to the Enterprise by having an interest in or a need being met

by the HHS 2020 Enterprise MMISR project for the health and human service programs they manage. Stakeholders include at a minimum, State Departments, Providers, Members, and Advocacy groups.

"**State (the State)**" means the State of New Mexico.

"**State Agency**" means any department, commission, council, board, committee, institution, legislative body, agency, government corporation, educational institution or official of the executive, legislative or judicial branch of the government of this state. "State agency" includes the Purchasing Division of the General Services Department and the State Purchasing Agent but does not include local public bodies.

"**State Purchasing Agent**" means the Director of the Purchasing Division of the New Mexico General Services Department.

"**Users**" means persons who use the HHS 2020 Enterprise system, which includes Members, Clients, Recipients, Beneficiaries, Participants, Providers, HHS Enterprise staff. Internal users of the HHS 2020 Solution will include State staff across the Enterprise (e.g., ALTSD, CYFD, DOH, HSD) based upon security profiles. External users will include BPO staff, Providers, advocacy groups, Members, MCOs, and the general public, based upon security profiles.

# V.    MMISR PROCUREMENT LIBRARY

An MMISR Procurement Library has been established and can be accessed at https://webapp.hsd.state.nm.us/Procurement/.Offerors are encouraged to review the materials contained in the Procurement Library by selecting the link provided in the electronic version of this document through your own internet connection or by contacting the Procurement Manager and scheduling an appointment. The procurement library contains the information listed below:

The RFP is posted on the NM HSD website:
http://www.hsd.state.nm.us/LookingForInformation/open-rfps.aspx

NM Procurement regulations and RFP instructions:
http://www.generalservices.state.nm.us/statepurchasing/resourcesandinformation.aspx

NM 2015 MITA 3.0 State Self-Assessment, on the NM HSD procurement library website:
https://webapp.hsd.state.nm.us/Procurement/

Program-related Documents in the Procurement Library: The Procurement Library https://webapp.hsd.state.nm.us/Procurement/  contains reference documents related to this procurement, including but not limited to:

1. HHS 2020 Roles and Responsibilities
2. HHS 2020 Background Information NM HHS and Medicaid
3. HHS 2020 Work Flows
4. HHS 2020 Stakeholder Relationship Diagrams
5. HHS 2020 User Views
6. HHS 2020 Data Flows
7. HHS 2020 Acronyms
8. HHS 2020 Terms and Definitions
9. HHS MMIS Activity Data
10. HHS 2020 CMS Seven Conditions and Standards
11. HHS 2020 Overview of the NM Medicaid Program
12. HHS 2020 Legacy MMIS Interfaces
13. HHS2020 Data Needs for Reporting
14. HHS 2020 Security Privacy and Standards
15. HHS 2020 Omnicaid Turnover Plan
16. HHS 2020 Legacy Enterprise Partner Interfaces
17. HHS 2020 Process Views
18. HHS 2020 MITA Business Area to Module
19. HHS 2020 Organizational Chart
20. HHS 2020 HHS 2020 Vision and Architecture
21. HHS 2020 Security Standards
22. HHS 2020 Recovery Data
23. HHS 2020 DOH Documents
24. HHS 2020 CYFD Documents

Below is a list of documents that Offerors are encouraged to review in addition to the list of items in the Procurement Library. Offerors can access the documents by selecting the link provided in the electronic version of this document through their own internet connections:

42 CFR Part 433 (c): https://www.ecfr.gov/cgi-bin/text-idx?SID=f100ecfeaa4b4f7032c97c20d7746886&amp;node=sp42.4.433.c&amp;rgn=div6

45 CFR Part 95 (f): https://www.ecfr.gov/cgi-bin/text-idx?SID=735a4beac7b39103a5c80483d3ffa209&amp;node=sp45.1.95.f&amp;rgn=div6

State Medicaid Manual Part 11: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html

CMS Seven Conditions and Standards: https://www.medicaid.gov/Medicaid-CHIP-

Program-Information/By-Topics/Data-and-Systems/Downloads/EFR-Seven-Conditions-and-Standards.pdf

CMS MMIS Certification Toolkit Version 2.3 and Medicaid Enterprise Certification Toolkit (MECT) 2.3 MMIS Module Checklist Set: https://www.medicaid.gov/medicaid/data-and-systems/mect/index.html

Privacy and Security Standards – NIST Special Publications: http://csrc.nist.gov/publications/PubsSPs.html

CMS MITA:  https://www.medicaid.gov/medicaid/data-and-systems/mita/index.html

HIPAA and ACA Administrative Simplification Overview: https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/HIPAA-ACA/index.html

Electronic Visit Verification (EVV) 21st Century Cures Act: https://www.medicaid.gov/medicaid/hcbs/guidance/electronic-visit-verification/index.html

## VI.     CONDITIONS GOVERNING THE PROCUREMENT
This section of the RFP presents the schedule, description and conditions governing the procurement.

### A.      SEQUENCE OF EVENTS

The Procurement Manager will make every effort to adhere to the following schedule:

*Table 2 Sequence of Events*

| Action | Responsible Party | Due Date* |
|---|---|---|
| 1. Issue RFP | HSD | June 27, 2019 |
| 2. Distribution List Confirmation | HSD | July 10, 2019 |
| 3. Pre-proposal Conference | HSD | July 10, 2019 |
| 4. Deadline to Submit Questions | Potential Offerors | July 17, 2019 |
| 5. Response to Written Questions | Procurement Manager | July 31, 2019 |

| 6. Submission of Proposal | Potential Offerors | August 26, 2019 |
|---|---|---|
| 7. Proposal Evaluation | Evaluation Committee | August 27, 2019 – September 9, 2019 |
| 8. Selection of Finalists | Evaluation Committee | September 10, 2019 |
| 9. Best and Final Offer | Finalist Offerors | September 16, 2019 |
| 10. Oral Presentation(s) | Finalist Offerors | September 19, 2019 – September 20, 2019 |
| 11. Finalize Contractual Agreement | HSD/Finalist Offerors | October 31, 2019 |
| 12. Approval of Contract (Federal & State) | CMS/DoIT | December 31, 2019 |
| 13. Prepare, Negotiate, and Finalize Contract | HSD/Finalist Offerors | January 1, 2020 |
| 14. Contract Award | HSD/Finalist Offerors | January 1, 2020 |
| 15. Protest Deadline | HSD | 15 calendar days after contract award notice |

* Dates subject to change based on number of responses and final approval from Federal partners.

## B. EXPLANATION OF FS EVENTS

The following paragraphs describe the activities listed in the sequence of events shown in Section VI. A, above.

1. **Issue RFP**

The RFP and amendments, if any, may be downloaded from the following address: http://www.hsd.state.nm.us/LookingForInformation/open-rfps.aspx.

2. **Distribution List**

Potential Offerors must hand deliver, return by email, or return by registered or certified mail the "Acknowledgement of Receipt of Request for Proposals Form" that accompanies this document (APPENDIX A) to have their organization placed on the procurement distribution list. An authorized representative of the organization must sign and date the form, which the Potential Offeror then returns to the Procurement Manager by 3:00 pm MT as stated in Section VI, A. SEQUENCE OF

EVENTS.

The procurement distribution list will be used to distribute amendments to the RFP, in accordance with 1.4.1.19 New Mexico Administrative Code (NMAC) and to distribute written responses to questions. Failure to return the Acknowledgement of Receipt form shall constitute a presumption of receipt and the potential Offeror's organization name shall not appear on the distribution list.

3.  **Pre-proposal Conference**

A pre-proposal conference will be held beginning at 2:00PM MT in the ASD Large Conference Room Address, 1474 Rodeo Rd. Santa Fe, New Mexico 87505, as stated in Section VI, A. SEQUENCE OF EVENTS. Attendance by Potential Offers at the pre-proposal conference is optional. Potential Offeror(s) are encouraged to submit written questions to the Procurement Manager in advance of the conference (see Introduction, Section D). The identity of the organization submitting question(s) will not be revealed. Additional written questions may be submitted at the conference. All written questions will be addressed in writing on the date listed in the SEQUENCE OF EVENTS. The State will keep a public log of the names of potential Offeror(s) who attended the pre-proposal conference.

4.  **Deadline to Submit Questions**

Potential Offerors may submit written questions or comments to the Procurement Manager related to the intent or clarity of this RFP until 5:00PM MT, as indicated in Section VI, A. SEQUENCE OF EVENTS. *All written questions and comments must be addressed to the Procurement Manager as declared in the Introduction, Section D, and submitted via electronic mail (e-mail) as an attachment in Microsoft Word format*

5.  **Response to Written Questions**

As indicated in the SEQUENCE OF EVENTS, the Procuring Agency will distribute written responses to written questions to all Potential Offerors whose organization name appears on the procurement distribution list. Questions which can be answered through review of information in the Procurement Library will not be included in responses. The Procuring Agency will send an e-mail copy of questions and responses to all Offerors who provide Acknowledgement of Receipt Forms (described in VI.B.2) before the deadline. Questions and responses also will be posted to the HSD website.

6.  **Submission of Proposal**

ALL OFFEROR PROPOSALS MUST BE RECEIVED BY THE PROCUREMENT MANAGER OR DESIGNEE NO LATER THAN 3:00 PM MT on the date stated in Section VI, A. SEQUENCE OF EVENTS. The State will not accept proposals received after this deadline. The Procuring Agency will record the date and time of receipt on each proposal.

Proposals must be addressed and delivered to the Procurement Manager at the

address listed in the Introduction, Section D. Proposals must be sealed and labeled on the outside of the package to clearly indicate that they are in response to the RFP #. The State will not accept proposals submitted by facsimile or other electronic means.

The Procuring Agency will keep a public log of the names of all Offeror organizations that submitted proposals. Pursuant to Section 13-1-116 New Mexico State Administrative (NMSA) Code 1978, the contents of proposals will not be disclosed to competing Potential Offerors during the negotiation process. The negotiation process is deemed to be in effect until the contract pursuant to this RFP is awarded. In this context "awarded" means the final required State agency signature on the contract(s) resulting from the procurement has been obtained.

7. **Proposal Evaluation**

A State-selected Evaluation Committee will evaluate proposals. The evaluation process will take place as indicated in the SEQUENCE OF EVENTS, depending upon the number of proposals received. During this time, the Procurement Manager may initiate discussions for the purpose of clarifying aspects of the proposals with Offerors who submit responsive or potentially responsive proposals. However, proposals may be accepted and evaluated without such discussion. Offerors SHALL NOT initiate discussions, under the risk of violating procurement rules and being disqualified.

8. **Selection of Finalists**

The Procurement Manager will notify the Finalist Offerors selected by the Evaluation Committee in accordance with the schedule in Section VI. A., SEQUENCE OF EVENTS, or as soon as possible. The Procurement Agency will determine a schedule for oral presentations and demonstrations, if required, at this time.

9. **Best and Final Offers**

Finalist Offerors may be asked to submit revisions to its proposals for the purpose of obtaining best-and-final offers in accordance with the schedule in Section VI. A., SEQUENCE OF EVENTS, or as soon as possible. Best-and-final offers may also be clarified and/or amended at finalist Offerors' oral presentations and demonstrations.

Prior to presentations, Finalists will be required to submit their best and final offers. Finalists will be required to present their proposals and their key staff to the Evaluation Committee. The presentations will be held in Santa Fe, New Mexico at a specific location to be determined. An agenda will be provided by the Department.

Based on its evaluation of proposals, the Department will determine the final agenda, set up schedule, and presentation schedule. The proposal presentations may not add new or additional information and must be based on the submitted proposals.

Finalists are expected to present their approaches to the work required as indicated in this RFP. Finalists are encouraged to demonstrate their understanding of the Department's requirements, their ability to meet those requirements, and their experience related to similar engagements. Finalists are also requested to articulate

their proposed services as discussed in their proposals.

## 10. Oral Presentations

Finalist Offerors may be required to make an oral presentation, at a location to be determined, in accordance with the schedule in Section VI. A., SEQUENCE OF EVENTS, or as soon as possible. Scheduling of oral presentations and the time limitations of the presentations will be at the Evaluation Committee's discretion.

## 11. Finalize Contractual Agreements

Any contractual agreement(s) resulting from this RFP will be finalized with the most advantageous Offeror(s) in accordance with the schedule in Section VI A., SEQUENCE OF EVENTS, or as soon as possible thereafter. This date is subject to change at the discretion of the relevant Agency procurement office. In the event that mutually agreeable terms cannot be reached with the apparent most advantageous Offeror in the time specified, the State reserves the right to finalize a contractual agreement with the next most advantageous Offeror(s) without undertaking a new procurement process.

## 12. Approval of Contract (Federal and State)

The final contract is subject to CMS review and approval prior to formal execution. The contract will be officially awarded only after CMS has granted its approval.

## 13. Prepare, Negotiate and Finalize Contract

The Contract will be finalized based on the most advantageous offer to the Department as stated in Section 11- Finalize Contractual Agreements. In the event that mutually agreeable terms cannot be reached within the Department's schedule, the Department reserves the right to finalize a Contract with the next most advantageous offer without undertaking a new procurement process.

Offerors are advised that state contracts may require a retainage of up to 20% for work performed and payable upon completion of various operations and maintenance deliverables at contract year end.

Offerors are advised that New Mexico imposes a "gross receipts tax" on certain goods and services which must be paid by government entities based on the location of services provided. Amounts of these taxes vary based on changes approved by local governing bodies, the state legislature, or if the Offeror is an out of state business entity. Offerors proposed fees must include tax.

Offerors are advised to consider tax aspects in pricing their proposals for the full contracted period. The Offeror who is selected as the finalist will be required to obtain a NM Vendor number from the Department of Finance and Administration (DFA).

The negotiated agreement will be reviewed by the Department for technical and legal requirements prior to submission for final signature.

The negotiated agreement will be reviewed by other State and Federal entities as

needed, prior to final approval.

The finalized agreement will be processed for final budget processing and routing for signature. The contract will be made effective upon final approval by the State Purchasing Agent.

During contract negotiation, terms related to a performance bond will be finalized.

The Department may include warranty provisions in the final agreement.

Because of the use of Federal funds, this procurement does not qualify for a NM Resident Business Preference or a NM Veteran's Business Preference per NMSA 1978 §13-1-21.

Offerors are advised that this procurement does not require any individuals, organizations, or other parties to limit their participation to one Offeror only. Such individuals, organizations, or other parties may participate in proposals submitted by multiple Offerors to this procurement.

Offerors are advised that the Department may require Offeror to execute a separate HIPAA Business Associate Agreement with final contract award.

Offerors are advised that the work required under this procurement requires compliance with Federal regulations as they apply to Protected Health Information (PHI), Personally Identifiable Information (PII), and Federal Tax Information (FTI).

## 14. **Contract Award**

After review of the Evaluation Committee Report and of the signed contractual agreement, the Agency procurement office will award in accordance with the schedule in Section VI. A., SEQUENCE OF EVENTS, or as soon as possible thereafter. This date is subject to change at the discretion of the relevant Agency procurement office.

The contract shall be awarded to the Offeror (or Offerors) whose proposal(s) are most advantageous to the State of New Mexico and HSD, taking into consideration the evaluation factors set forth in this RFP. The most advantageous proposal may or may not have received the most points. The award is subject to appropriate Department and State approval.

## 15. **Protest Deadline**

Any protest by an Offeror must be timely and in conformance with Section 13-1-172 NMSA 1978 and applicable procurement regulations. The fifteen (15) calendar-day protest period shall begin on the day following contract award and shall end at 5:00 pm MT on the 15th calendar day after contract award. Protests must be written and must include the name and address of the protestor and the RFP number. Protests also must include a statement of the grounds for protest, including appropriate supporting exhibits and must specify the ruling requested from the party listed below. The protest must be delivered to the HSD Protest Manager:

Office of General Counsel
Rodeo Building
1474 Rodeo Rd.
Santa Fe, New Mexico 87505
Mailing Address: P.O. Box 2348
Santa Fe, New Mexico 87504-2348


Protests received after the deadline will not be accepted.


**C.**     **GENERAL REQUIREMENTS**


1. **Acceptance of Conditions Governing the Procurement**

In the letter of transmittal, Potential Offerors must indicate their acceptance of the Conditions Governing the Procurement section of this RFP. Submission of a proposal constitutes acceptance of the Evaluation Factors contained in Section VI of this RFP.


2. **Incurring Cost**

The Potential Offeror shall solely bear any cost they incur in preparing, transmitting and/or presenting any proposal or material submitted in response to this RFP. The Offeror also shall solely bear any cost the Offeror incurs for set up and demonstration of any proposed equipment and/or system.


3. **Prime FS Contractor Responsibility**

The FS Contractor selected through this RFP will be deemed the Prime FS Contractor and is completely responsible for the FS Contract performance whether or not subcontracts are used. Any contractual agreement that may result from this RFP shall specify that the prime Contractor is solely responsible for fulfillment of all FS requirements of the contractual agreement with a State agency that may derive from this RFP. The State agency entering into a contractual agreement with a Contractor will make payments to only the prime Contractor for this RFP.


4. **Subcontractors/Consent**

The use of subcontractors is allowed. The prime FS Contractor shall be wholly responsible for the entire performance of the FS contractual agreement whether or not subcontractors are used. Additionally, the FS prime Contractor must receive written approval from the agency awarding any resultant contract before any subcontractor is used during the term of this agreement. The State retains the option to request replacement of any subcontractor at its discretion.


5. **Amended Proposals**

An Offeror may submit an amended proposal before the deadline for receipt of

proposals. An amended proposal must be a complete replacement for a previously submitted proposal and must be clearly identified as such in the transmittal letter. The Agency personnel will not merge, collate, or assemble proposal materials. Amended proposals will not be accepted after the submission deadline.

6. **Offeror's Rights to Withdraw Proposal**

Offerors will be permitted to withdraw their proposals at any time prior to the deadline for receipt of proposals. The Offeror must submit a written withdrawal request signed by the Offeror's duly authorized representative and addressed to the Procurement Manager.

The approval or denial of withdrawal requests received after the deadline for receipt of the proposals is governed by the applicable procurement regulations.

7. **Proposal Offer Firm**

Responses to this RFP, including proposal prices for services, will be considered firm for one hundred twenty (120) calendar days after the due date for receipt of proposals or ninety (90) calendar days after the due date for the receipt of a best-and-final offer, if the Offeror is invited or required to submit one.

8. **Disclosure of Proposal Contents**

Proposals will be kept confidential until negotiations and the award are completed by the Agency. At that time, all proposals and documents pertaining to the proposals will be open to the public, except for material that is clearly marked proprietary or confidential. The Procurement Manager will not disclose or make public any pages of a proposal on which the potential Offeror has stamped or imprinted "proprietary" or "confidential" subject to the following requirements:

    a)  Proprietary or confidential data shall be readily separable from the proposal to facilitate eventual public inspection of the non-confidential portion of the proposal.

    b)  Confidential data is restricted to:
        i.  Confidential financial information concerning the Offeror's organization;
       ii.  Data that qualifies as a trade secret in accordance with the Uniform Trade Secrets Act (UTSA), Sections 57-3A-1 to 57-3A-7 NMSA 1978.

PLEASE NOTE: Offerors **shall not designate** the price of products offered or the cost of services proposed as proprietary or confidential information.

If a request is received for disclosure of data for which an Offeror has made a written request for confidentiality, State Purchasing Division (SPD) or the Agency shall examine the Offeror's request and make a written determination that specifies which portions of the proposal may be disclosed. Unless the Offeror takes legal

action to prevent the disclosure, the proposal will be so disclosed. The proposal shall be open to public inspection subject to any continuing prohibition on the disclosure of confidential data.

9. **No Obligation**

This RFP in no manner obligates the State of New Mexico or any of its Agencies to use any Offeror's services until a valid written contract is awarded and approved by appropriate authorities.

10. **Termination**

This RFP may be canceled by the State at any time and any and all proposals may be rejected in whole or in part when the Agency determines such action to be in the best interest of the State of New Mexico.

11. **Sufficient Appropriation**

Any contract awarded as a result of this RFP may be terminated if sufficient appropriations or authorizations do not exist. Such terminations will be affected by sending written notice to the Contractor. The Agency's decision as to whether sufficient appropriations and authorizations are available will be accepted by the Contractor as final.

12. **Legal Review**

The Agency requires that all Offerors agree to be bound by the General Requirements contained in this RFP. Offerors must promptly submit any concerns in writing to the attention of the Procurement Manager.

13. **Governing Law**

This RFP and any agreement with an Offeror that may result from this procurement shall be governed by the laws of the State of New Mexico.

14. **Basis for Proposal**

Only information supplied in writing by the Agency through the Procurement Manager or in this RFP should be used as the basis for preparation of Offeror proposals.

15. **Contract Terms and Conditions**

The Contract between the Agency and a Contractor will follow the format specified by the Agency and will contain the terms and conditions set forth in Appendix I, "Contract Terms and Conditions", of the attached sample contract. However, the Agency reserves the right to negotiate with a successful Offeror provisions in addition to those contained in this RFP.

HSD discourages exceptions requested by Offerors to contract terms and conditions in the RFP (Sample Contract). If, in the sole assessment of HSD (and its Evaluation

Team), a proposal appears to be contingent on an exception, or on correction of what is deemed by an Offeror to be a deficiency, or if an exception would require a substantial proposal rewrite, a proposal may be rejected as nonresponsive.

The sample contract in APPENDIX I is HSD's generic contract.

Sample Contract Termination provisions can be found in Section 6 of the attached sample contract found in APPENDIX I.

## 16. **Offeror Terms and Conditions**

Should an Offeror object to any of the Agency's terms and conditions, as contained in this Section or in the appendices, the **Offeror must propose specific, alternative language in writing and submit it with its proposal**. Contract variations received after the award will not be considered. The Agency may or may not accept the alternative language. Offerors agree that requested language must be agreed to in writing by the Agency to be included in the contract. If any requested alternative language submitted is not so accepted by the Agency, the attached sample contract with appropriately accepted amendments shall become the contract between the parties. General references to the Offeror's terms and conditions or attempts at complete substitutions are not acceptable to the Agency and will result in disqualification of the Offeror's proposal.

Offerors must briefly describe the purpose and impact, if any, of each proposed change, followed by the specific proposed alternate wording. Offerors must submit with the proposal a complete set of any additional terms and conditions that they expect to have included in a contract negotiated with the Agency.

## 17. **Contract Deviations**

Any additional terms and conditions that may be the subject of negotiation will be discussed only between the Agency and the Offeror selected and shall not be deemed an opportunity to amend the Offeror's proposal.

## 18. **Offeror Qualifications**

The Evaluation Committee may make such investigations as necessary to determine the ability of the potential Offeror to adhere to the requirements specified within this RFP. The Evaluation Committee will reject the proposal of any Potential Offeror who is not a Responsible Offeror or who fails to submit a responsive offer as defined in Sections 13-1-83 and 13-1-85 NMSA 1978.

## 19. **Right to Waive Minor Irregularities**

The Evaluation Committee reserves the right to waive minor irregularities. The Evaluation Committee also reserves the right to waive mandatory requirements in instances where all responsive proposals failed to meet the same mandatory requirements and the failure to do so does not otherwise materially affect the procurement. This right is at the sole discretion of the Evaluation Committee.

### 20. Change in Contractor Representatives

The Agency reserves the right to require a change in Contractor representatives if the assigned representative(s) is (are) not, in the opinion of the Agency, adequately meeting the needs of the Agency.

### 21. Notice of Penalties

The Procurement Code, Sections 13-1-28 through 13-1-199 NMSA 1978, imposes civil, misdemeanor and felony criminal penalties for its violation. In addition, the New Mexico criminal statutes impose felony penalties for bribes, gratuities and kickbacks.

### 22. Agency Rights

The Agency, in agreement with the Evaluation Committee, reserves the right to accept all or a portion of a potential Offeror's proposal.

### 23. Right to Publish

Throughout the duration of this procurement process and contract term, Offerors and Contractors must secure from the agency written approval prior to the release of any information that pertains to the potential work or activities covered by this procurement and/or agency contracts derived from this procurement. Failure to adhere to this requirement may result in disqualification of the Offeror's proposal or removal from the contract.

### 24. Ownership of Proposals

All documents submitted in response to the RFP shall become property of the State of New Mexico.

### 25. Confidentiality

Any confidential information provided to, or developed by, the Contractor in the performance of the contract resulting from this RFP shall be kept confidential and shall not be made available to any individual or organization by the Contractor without the prior written approval of the Agency.

The Contractor(s) agrees to protect the confidentiality of all confidential information and not to publish or disclose such information to any third party without the procuring Agency's written permission.

### 26. Electronic Mail Address Required

A large part of the communication regarding this procurement will be conducted by electronic mail (e-mail). Offeror must have a valid e-mail address to receive this correspondence. (See also Response to Written Questions).

### 27. Use of Electronic Versions of this RFP

This RFP is being made available by electronic means. In the event of conflict

between a version of the RFP in the Offeror's possession and the version maintained by the Agency, the Offeror acknowledges that the version maintained by the Agency shall govern. Please refer to the version found on the HSD website is at: http://www.hsd.state.nm.us/LookingForInformation/open-rfps.aspx

## 28. **New Mexico Employees Health Coverage**

If the Offeror has, or grows to, six (6) or more employees who work, or who are expected to work, an average of at least twenty (20) hours per week over a six (6) month period during the term of the contract, Offeror must agree to have in place and agree to maintain for the term of the contract, health insurance for those employees if the expected annual value in the aggregate of any and all contracts between Contractor and the State exceeds two hundred fifty thousand dollars ($250,000) dollars.

Offeror must agree to maintain a record of the number of employees who have (a) accepted health insurance; (b) decline health insurance due to other health insurance coverage already in place; or (c) decline health insurance for other reasons. These records are subject to review and audit by a representative of the State.

Offeror must agree to advise all employees of the availability of State publicly financed health care coverage programs by, at a minimum, providing each employee with the following web site link to additional information: https://www.bewellnm.com/

For Indefinite Delivery, Indefinite Quantity (IDIQ) contracts (price agreements without specific limitations on quantity and allowing an indeterminate number of orders to be placed against it); these requirements shall apply the first day of the second month after the Offeror reports combined revenue (from State and, if applicable, from local public bodies if from a State price agreement) of two hundred fifty thousand dollars ($250,000).

## 29. **Campaign Contribution Disclosure Form**

Offeror must complete, sign and return the Campaign Contribution Disclosure Form, APPENDIX E, as a part of its proposal. This requirement applies regardless whether a covered contribution was made or not made for the positions of Governor and/or Lieutenant Governor or other identified official. Failure to complete and return the signed unaltered form will result in disqualification.

## 30. **Pay Equity Reporting Requirements**

If the Offeror has ten (10) or more employees OR has eight (8) or more employees in the same job classification, Offeror must complete and submit the required reporting form (PE10-249) if awarded a contract. Out-of-state Contractors who have no facilities and no employees working in New Mexico are exempt if the contract is directly with the out-of-state Contractor and is fulfilled directly by the out-of-state Contractor and is not passed through a local Contractor.

For contracts that extend beyond one (1) calendar year or are extended beyond one (1) calendar year, Offeror must also agree to complete and submit the required form

annually within thirty (30) calendar days of the annual bid or proposal submittal anniversary date and, if more than one hundred eighty (180) calendar days has elapsed since submittal of the last report, at contract completion.

Should Offeror not meet the size requirement for reporting at contract award, but subsequently grow such that they meet or exceed the size requirement for reporting, Offeror must agree to provide the required report within ninety (90) calendar days of meeting or exceeding the size requirement.

Offeror must also agree to levy these reporting requirements on any subcontractor(s) performing more than ten percent (10%) of the dollar value of this contract if said subcontractor(s) meets, or grows to meet, the stated employee size thresholds during the contract term. Offeror must further agree that, should one or more subcontractor not meet the size requirement for reporting at contract award but subsequently grow such that they meet or exceed the size requirement for reporting, Offeror will submit the required report for each such subcontractor within ninety (90) calendar days of that subcontractor meeting or exceeding the size requirement.

## 31. **Disclosure Regarding Responsibility**

*RFP proposal should include all disclosures.* Any prospective Contractor and any of its Principals who enter into a contract greater than sixty thousand dollars ($60,000.00) with any State agency or local public body for professional services, tangible personal property, services or construction agrees to disclose whether the Contractor, or any principal of the Contractor's company:

Is presently debarred, suspended, proposed for debarment, or declared ineligible for award of contract by any Federal entity, State agency or local public body;

Has within a three (3) year period preceding this offer, been convicted in a criminal matter or had a civil judgment rendered against them for:

    a) the commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) contract or subcontract;

    b) violation of Federal or State antitrust statutes related to the submission of offers; or

    c) the commission in any Federal or State jurisdiction of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, violation of Federal criminal tax law, or receiving stolen property;

Is presently indicted for, or otherwise criminally or civilly charged by any (Federal, State or local) government entity with the commission of any of the offenses enumerated in paragraph A of this disclosure;

Has been notified, preceding this offer, of any delinquent Federal or State taxes in an amount that exceeds three thousand dollars ($3,000) of which the liability remains unsatisfied. Taxes are considered delinquent if the following criteria apply:

    a) The tax liability is finally determined. The liability is finally

determined if it has been assessed. A liability is not finally determined if there is a pending administrative or judicial challenge. In the case of a judicial challenge of the liability, the liability is not finally determined until all judicial appeal rights have been exhausted.

b) <u>The taxpayer is delinquent in making payment</u>. A taxpayer is delinquent if the taxpayer has failed to pay the tax liability when full payment was due and required. A taxpayer is not delinquent in cases where enforced collection action is precluded.

Have within a three (3) year period preceding this offer had one or more contracts terminated for default by any Federal or State agency or local public body.

a) Principal, for the purpose of this disclosure, means an officer, director, owner, partner, or person having primary management or supervisory responsibilities within a business entity or related entities.

b) The Contractor shall provide immediate written notice to the State Purchasing Agent or other party to this Agreement if, at any time during the term of this Agreement, the Contractor learns that the Contractor's disclosure was at any time erroneous or became erroneous by reason of changed circumstances.

c) A disclosure that any of the items in this requirement exist will not necessarily result in termination of this Agreement. However, the disclosure will be considered in the determination of the Contractor's responsibility and ability to perform under this Agreement. Failure of the Contractor to furnish a disclosure or to provide additional information as requested will be grounds for immediate termination of this Agreement pursuant to the conditions set forth in Paragraph 7 of this Agreement.

d) Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render, in good faith, the disclosure required by this document. The knowledge and information of a Contractor is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

e) The disclosure requirement provided is a material representation of fact upon which reliance was placed when making an award and is a continuing material representation of the facts during the term of this Agreement. If during the performance of the contract the Contractor is indicted for, or otherwise criminally or civilly charged by any government entity (Federal, State or local) with commission of, any offenses named in this document, the Contractor must provide immediate written notice to the State Purchasing Agent or other party

to this Agreement. If it is later determined that the Contractor knowingly rendered an erroneous disclosure, in addition to other remedies available to the Government, the State Purchasing Agent or Central Purchasing Officer may terminate the involved contract for cause. Still further the State Purchasing Agent or Central Purchasing Officer may suspend or debar the Contractor from eligibility for future solicitations until such time as the matter is resolved to the satisfaction of the State Purchasing Agent or Central Purchasing Officer.

## 32. **No Resources Provided by NM HSD to the MMISR FS Contractor**

NM HSD will not provide the selected Contractor with supplies, clerical support, computers, hardware, workspace and/or other resources related to fulfilling the Contract that results from this procurement. State acknowledges its cost responsibility for future Contractor and State staff supplies. The State will provide the Contractor access to its MMIS and to other MMISR Contractors as needed.

## 33. **Equal Employment Opportunity**

HSD is committed to equal employment opportunity (EEO) and to compliance with Federal antidiscrimination laws. We also comply with New Mexico law, which prohibits discrimination or harassment against employees or applicants for employment based on race, age forty (40) and over, color, religion, national origin, ancestry, sex (including pregnancy, childbirth and related medical conditions), sexual orientation, gender identity, spousal affiliation, National Guard membership, status as a smoker or nonsmoker, genetic information, HIV status, physical or mental handicap, or serious medical condition.

HSD will not tolerate discrimination or harassment. The Contractor will be required to submit a statement confirming compliance with EEO rules as part of its contract.

## 34. **New Mexico Preference Not Applicable**

Because of the use of Federal funds, this procurement does not qualify for a NM Resident Business Preference or a NM Veteran's Business Preference per NMSA 1978 §13-1-21.

## D. RESPONSE FORMAT AND ORGANIZATION

### 1. NUMBER OF RESPONSES
Each Offeror shall submit only one (1) proposal in response to this RFP.

### 2. NUMBER OF COPIES
Each Offeror shall deliver:

- **Binder 1**: one (1) original and six (6) identical hard copies of their Technical proposal and required additional forms and material. The original and each copy shall be in separate, labeled binders. Any confidential information in the proposal shall be clearly identified and easily segregated from the rest of the proposal. Binder 1 MUST NOT include any cost information.

In addition, the entire proposal including all materials in Binder 1 (not Binder 2) shall be submitted on a single CD. <u>Contents of Binder 2 must be submitted on a separate CD</u>. Proposals submitted on CD must include THREE versions: (1) a version in secure PDF; (2) a version in unsecured Microsoft WORD and/or Excel to enable the Department to organize comparative review of submitted documents; and (3) a redacted PDF for release to public under Inspection of Public Records Act requests. Electronic versions of the proposal must not exceed 10 MB per file, not for the entire proposal submission. Security policies do not allow the State to receive electronic copies via a USB drive.

Within each section of the proposal, Offerors should address the items in the order in which they appear in this RFP. All forms provided in this RFP must be thoroughly completed and included in the appropriate section of the proposal. All discussion of proposed costs, rates or expenses must occur only in Binder #2 on the cost response form.

- **Binder 2**: one (1) original and six (6) copies of their Cost proposal. The original and each copy shall be in separate, labeled binders.

- One (1) electronic version, in addition to the one stated in the Binder 1 of the proposal containing ONLY the Technical proposal. This copy MUST NOT contain any cost information. Acceptable formats for the electronic version of the proposal are Microsoft Word, Excel and PDF.
- One (1) electronic version of the Cost proposal. Acceptable formats for the electronic version of the proposal are Microsoft Word, Excel and PDF.

Any and all confidential or proprietary information shall be clearly identified and shall be segregated in the electronic version, mirroring the hard-copy submission(s).

Any proposal that does not adhere to the requirements of this Section may be deemed non-responsive and may be rejected on that basis.

3. **PROPOSAL FORMAT**

This section describes the required format, content and organization for all proposals.

Hard copy proposals shall be submitted typewritten, Times Roman twelve (12) (tables, header, footer, original RFP requirement text, and proposal graphics may be in 10-pt font), on standard eight and a half (8½) by eleven (11) inch paper (larger paper is permissible only for charts, spreadsheets, etc.) and shall be placed in the binders with tabs delineating each section. The original FS RFP requirement text must be included in Offerors' proposal responses and cannot exceed the three hundred (300) page limit. The requirement response must be in 12-point font. Response must be no more than three hundred (300) pages in length excluding the title page, table of contents, tabs, pricing, resumes, financial statements, the mandatory State required forms, detailed work plan, detailed implementation schedule and examples of documents. The Offeror is expected to include in the 300 page limit a summary work plan with milestones and a summary implementation schedule. For ease of review, Offerors are encouraged to place examples in an optional separate binder.

## 1. Proposal Content and Organization

Canned or promotional material may be used if referenced and clearly marked; however, use of promotional material should be minimized. The proposal must be organized and indexed (tabbed) in the following format and must contain, at a minimum, all listed items in the sequence indicated. Additional items may be submitted as attachments following the mandatory items listed for Binder 1.

**Binder 1**: Technical proposal. No cost information in Binder 1.

1. Table of Contents
2. Signed Letter of Transmittal Form (APPENDIX C)
3. Two Page Summary of Offeror's Approach
4. List of References
5. Financial Stability Documents
6. Performance Bond Capacity Statement
7. Signed Campaign Contribution Disclosure Form (APPENDIX E)
8. Signed New Mexico Employee Health Coverage Form (APPENDIX F)
9. Signed Pay Equity Statement
10. Signed Eligibility Statement
11. Response to Specifications (APPENDIX G and Vision for FS)
12. Response to Specifications (APPENDIX H, Experience & Personnel to include Organizational Experience (narrative) and Staffing Model)
13. Additional items (including Required Sample Documents if not included in separate binder)

**Binder 2**: Cost proposal

Completed Cost Response (see APPENDIX B)

In each section of the proposal, Offerors should address the items in the order in which they appear in this RFP. All forms provided in this RFP must be thoroughly completed and must be included in the appropriate section of the proposal. All discussion of proposed costs, rates or expenses must occur only in Binder 2 on the Cost Response Form. Offerors are to provide, as part of their budget narrative accompanying their Cost Response (found in APPENDIX B), their estimated implementation schedule for services and the assumptions made in developing the proposed schedule. After final integration testing, all Offerors are expected to be prepared for at least a six (6) month parallel run with the incumbent MMIS Contractor.

## 2. Letter of Transmittal

Offeror's proposal must be accompanied by the Letter of Transmittal Form located in APPENDIX C, which must be completed and signed by an individual person authorized to obligate the company. The letter of transmittal MUST:

a. Identify the submitting business entity;
b. Identify the name, title, telephone number and e-mail address of the person authorized by the Offeror organization to contractually obligate the business entity providing the Offer;
c. Identify the name, title, telephone number and e-mail address of the person authorized to negotiate the contract on behalf of the Offeror organization (if different than 2.b);
d. Identify the names, titles, telephone numbers and e-mail addresses of persons to be contacted for clarification and/or questions regarding proposal content;
e. Identify subcontractors (if any) anticipated to be used in performing any resultant contract;
f. Describe the relationship with any other entity that will participate in performing an awarded contract;
g. Identify the following with a check mark and signature where required:
    1) Explicitly indicate acceptance of the Conditions Governing the Procurement (see Section VI. C.1);
    2) Acknowledge receipt of any and all amendments to this RFP; and
h. Be signed by the person identified in paragraph 2.b above.

## VII.    RESPONSE SPECIFICATIONS

APPENDIX G describes the services to be delivered through this procurement. Offerors must provide their methodology, plan and approach to the services specified in APPENDIX G, and their Vision for FS.

APPENDIX H contains the requirements to which Offerors must respond. Offerors must respond to all requirements and questions in the manner described in APPENDIX H. Offerors must adhere to the State's required proposal format, page limitations and required content. Failure to adhere to these requirements may result in the proposal deemed nonresponsive and rejected.

A.   **COST**

Offerors must complete the Cost Response as noted in APPENDIX B. Cost will be evaluated by appropriateness and best value for the State. All charges listed in the Cost Response must be justified and evidence of need documented in a cost proposal response narrative in the detailed budget submitted with the proposal. Offeror shall acknowledge that it will provide full, secure access to all of its work products and tools. As the Offeror's services are part of the MMISR Solution, it will be available to the State, Stakeholder partners, State contractors and other modular Contractors without transaction fees or charges throughout all stages of development and operations.

B.   **OTHER REQUIREMENTS**

Submit the following items in Binder 1 following the responses to Mandatory Specifications. Please include a labeled tab for each item.

1. **Letter of Transmittal Form**
   The Offeror's proposal **must** be accompanied by the Letter of Transmittal Form in APPENDIX C. The form must be complete and **must** be signed by the person authorized to obligate the Offeror's organization.

2. **List of References**
   Offerors shall provide three (3) references from similar large-scale Projects performed for private, State or large local government clients within the last three (3) years. *Offerors are required to send the Reference Questionnaire Form, APPENDIX D, to each business reference listed. The business reference, in turn, is requested to submit the completed Reference Questionnaire Form, APPENDIX D, directly to the Procurement Manager, as described in Section D of the Introduction.* It is the Offeror's responsibility to ensure the completed forms are received on or before the proposal submission deadline for inclusion in the evaluation process.

   References for which the Reference Questionnaire Form is not received, or for which the Form is incomplete, may adversely affect the Offeror's score in the

evaluation process. The Evaluation Committee may contact any or all references for validation of information submitted. Additionally, the Agency reserves the right to consider any and all information available to it (outside of the reference information required herein) in its evaluation of Offeror responsibility per Section VI, Paragraph C.18.

Within their proposals, Offerors must submit a list of references with the following information for each reference:

- Client name;
- Project description;
- Project dates (starting and ending);
- Staff assigned to referenced engagement who will be designated for work on FS module services;
- Project outcomes, lessons learned and/or value delivered; and
- Client Project manager name, telephone number, fax number and e-mail address.

3. **Financial Stability Documents**
   Offerors must submit copies of the most recent year's independently audited financial statements and the most current 10-K, as well as financial statements for the preceding three (3) years, if they exist. The submission must include the audit opinion; the balance sheet; statements of income, retained earnings and cash flows; and the notes to the financial statements. If independently audited financial statements do not exist, Offeror must state the reason and submit instead sufficient information (e.g., Dun and Bradstreet report) to enable the Evaluation Committee to assess the Offeror's financial stability. If potential offeror is privately held and/or does not have a 10-K filed with the Securities and Exchange Commission (SEC), another form of a financial stability document should be submitted, such as a current Financial Audit Statement.

4. **Performance Bond Capacity Statement**
   Offeror must have the ability to secure a Performance Surety Bond in favor of the Agency to insure the Contractor's performance under the contract awarded pursuant to this procurement. While each engagement will be different, the option to require a Performance Surety Bond must be available to the Agency at time of contract award. **A letter or statement of concurrence must be submitted in the Offeror's proposal.**

5. **Campaign Contribution Disclosure Form**
   The Offeror must complete an unaltered Campaign Contribution Disclosure Form (see APPENDIX E) and submit a signed copy with their proposal. This must be accomplished whether or not an applicable contribution has been made.

6. **Employee Health Coverage Form**
   The Offeror must agree with the terms indicated in APPENDIX F. Offeror must complete the unaltered form and submit with Offeror's proposal a copy signed by the person authorized to obligate the Offeror's firm.

7. **Pay Equity Reporting Statement**
   The Offeror must agree with the reporting requirements defined in Appendix I, Article 22. This report is due at contract award. Offeror must include a statement of concurrence with this requirement in their proposal. Out-of-state Contractors that have no facilities and no employees working in New Mexico are exempt if the contract is directly with the out-of-state Contractor, is fulfilled directly by the out-of-state Contractor and is not passed through a local Contractor. However, such out-of-state Offerors must still submit a statement of concurrence that reads as follows: **"Offeror concurs with the Pay Equity Reporting as defined in Appendix I, Article 22. Offeror would come under the definition of out-of-state Contractor if Offeror should be successful."**

8. **Eligibility Statement**
   **Provide a statement confirming the following:** It is the Contractor's responsibility to warrant that the Contractor and its principals are eligible to participate in all work and transactions; have not been subjected to suspension, debarment, or similar ineligibility determined by any Federal, State or local governmental entity; that the Offeror is in compliance with the State of New Mexico statutes and rules relating to procurement; and that the Contractor is not listed on the Federal government's terrorism watch list as described in Executive Order 13224. Entities ineligible for Federal procurement are listed at http://www.generalservices.state.nm.us/statepurchasing/Debarment_Notices.aspx.

C. **ORAL PRESENTATION**
   Finalists will be the Offerors with the highest scores based on evaluations of responses to Sections A, B and C above. The number of Finalists will be determined at the discretion of the Evaluation Committee. If selected as a finalist, the Offeror may be required to present an overview of its proposal to the Evaluation Committee to give the Evaluation Committee the opportunity to interview proposed Key Personnel, to ask questions, to seek clarifications on the Offeror's proposal and to better assess Offeror's ability to fulfill the requirements outlined in the scope of work.

# VIII.    EVALUATION

## A. EVALUATION POINT SUMMARY

Table 3 summarizes evaluation factors for this RFP and their associated point values. These weighted factors will be used in the evaluation of Offeror proposals.

*Table 3 Evaluation Point Summary*

| Table 3- Evaluation Point Summary **Factors** | Score | |
|---|---|---|
| Technical Responses | 140 | |
| Vision for FS | | 30 |
| Statement of Work (Appendix G) | | 110 |
| Requirements (Appendix H) | 330 | |
| Financial Processing | | 60 |
| Claims Processing | | 60 |
| Self-Directed Home and Community Based Services | | 40 |
| Pharmacy Benefit Management | | 50 |
| Drug Rebate | | 50 |
| Data Exchange and Reporting | | 35 |
| General Requirements, including Project Management | | 35 |
| Experience & Personnel | 90 | |
| Organizational Experience (narrative) | | 50 |
| Staffing Model | | 40 |
| Required Sample Documents | 20 | |
| Cost Proposal | 280 | |
| Cost Response Form #1 | | 120 |
| Cost Response Form #2 | | 120 |
| Cost Response Form #3 | | 40 |
| References | 40 | |

| Table 3- Evaluation Point Summary **Factors** | Score |
|---|---|
| Oral Presentation (Finalists Only) | 100 |
| Total | 1000 |

**B. EVALUATION FACTORS**

Responses will be scored on a point system with one-thousand (1,000) total points including orals. Offerors with the highest total points prior to oral presentations will be considered Finalists. The number of Finalist Offerors will be determined at the discretion of the Evaluation Committee. Finalists will be asked to provide an Oral Presentation with a possible score of one hundred (100) points. The award for this contract will go to the Finalist deemed to be the most advantageous and to offer the best value to the State for this work.

1. **Technical Responses (140 points)**
Points will be awarded based on the thoroughness, innovation, and clarity of the Offeror's response, the breadth and depth of the engagements cited, and the perceived validity of the response. APPENDIX G describes services to be delivered through this procurement. Offerors must provide a 2-3 page summary of its methodology, plan, approach to the services being delivered, and the vision for FS. These responses are to be placed in Binder 1.

2. **Requirements (330 points)**
Points will be awarded based on the thoroughness and clarity of the Offeror's response, the breadth and depth of the engagements cited, and the perceived validity of the response. These responses are to be placed in Binder 1.

3. **Experience and Personnel (90 points)**
Offerors shall provide a narrative describing their Organizational Experience and proposed Staffing Model describing the scope and responsibilities of each Key Personnel position, with the name, title, skill set, experience and location by phase and to include a resume for each position proposed.

4. **Required Sample Documents (20 points)**
Points will be awarded based on the thoroughness and clarity of the Offeror's response, the breadth and depth of the engagements cited and the perceived validity of the response. Offerors are encouraged to place examples in a separate binder. Sample documents should include at a minimum test plans, processes for CRs, system reports, existing claims edits.

- Accounting Processing

- Claims Processing
- Self-Directed Home and Community Based Services
- Pharmacy Benefit Management
- Drug Rebate
- Data Exchange and Reporting

5. **Cost (280 points)**
The evaluation of each Offeror's cost proposal (the total of four years of detailed budgets) will be conducted using the following formula. This response is to be placed in Binder 2.

$$\frac{\text{Lowest Responsive Offer Total Cost for each sub-factor}}{\text{This Offeror's Total Cost for each sub-factor}} \times \text{Available Award Points for each sub-factor}$$

Provide costs and detailed budget explanations in a table format as shown in Appendix B.

6. **References (40 points)**
Offerors shall provide three (3) references from similar large-scale Projects performed for private, State or large local government clients within the last three (3) years in Binder 1, with business information for each.

7. **Oral Presentation (Finalists only, 100 points)**
The Evaluation Committee may require oral presentations by the highest-scoring Finalists or Finalist. Points will be awarded based on the quality and organization of information presented, how effectively the information was communicated, the professionalism of the presenters, and the technical knowledge of the proposed staff. Prior to oral presentations, the Agency will provide the Finalist Offerors with a presentation agenda.

C. **OTHER REQUIREMENTS**
Provide the following in tabbed sections in Binder 1:

1. **Letter of Transmittal (Appendix C)**
Pass/Fail only. No points assigned.

2. **References (40 points) (Appendix D)**
Offeror submits a list of three (3) references in Binder 1, with business information for each. Offerors are required to send the Reference Questionnaire Form, APPENDIX D, to each business reference listed. The business reference, in turn, is requested to submit the completed Reference Questionnaire Form, APPENDIX D, directly to the Procurement Manager, as described in the Introduction Paragraph D. Points will be awarded based on

evaluation of the responses to a series of questions asked of the references concerning quality of the Offeror's services, timeliness of services, responsiveness to problems and complaints and the level of satisfaction with the Offeror's overall performance.

3. **Financial Stability – Financials (Section VII. B .3)**
Pass/Fail only. No points assigned.

4. **Performance Bond Capacity Statement (Section VII. B .4)**
Pass/Fail only. No points assigned.

5. **Campaign Contribution Disclosure Form (Appendix E)**
Pass/Fail only. No points assigned.

6. **New Mexico Employee Health Coverage Form (Appendix F)**
Pass/Fail only. No points assigned.

7. **Pay Equity Reporting Statement (Appendix I, Article 22)**
Pass/Fail only. No points assigned.

8. **Eligibility Statement (Section VII. B .8)**
Pass/Fail only. No points assigned.

## D. EVALUATION PROCESS

1. All Offeror proposals will be reviewed for compliance with the requirements and specifications stated in the RFP. Proposals deemed non-responsive by the State will be eliminated from further consideration.
2. The Procurement Manager may contact the Offeror for clarification of the response as specified in Section VI. B.7.
3. The Evaluation Committee may include other sources of information to perform the evaluation as specified in Section VI. C.18.
4. Responsive proposals will be evaluated on the factors in this Section VIII which have been assigned a point value. The responsible Offerors with the highest scores will be selected as Finalist Offerors. The Finalist Offeror whose proposal is most advantageous to the State, taking into consideration the evaluation factors in Section VIII, will be recommended for award (as specified in Section VI. B. 11). Please note, however, that, regardless of overall score, a serious deficiency in the response to any one factor may be grounds for rejection.

## IX. SUMMARY LISTING OF APPENDICES:

**APPENDIX A - ACKNOWLEDGEMENT OF RECEIPT FORM**

**APPENDIX B - COST RESPONSE FORMS**

**APPENDIX C - LETTER OF TRANSMITTAL FORM**

**APPENDIX D - REFERENCE QUESTIONNAIRE FORM**

**APPENDIX E - CAMPAIGN CONTRIBUTION DISCLOSURE FORM**

**APPENDIX F - NEW MEXICO EMPLOYEES HEALTH COVERAGE FORM**

**APPENDIX G - DETAILED STATEMENT OF WORK**

**APPENDIX H - OFFEROR AND CONTRACTOR REQUIREMENTS**

**APPENDIX I - SAMPLE CONTRACT**

**APPENDIX J - RFP CROSSWALK TO CMS DRAFT RFP TEMPLATE**

**APPENDIX K – FS PERFORMANCE MEASURES**

## X.    APPENDICES:

## APPENDIX A – Financial Services Acknowledgement of Receipt Form

In acknowledgement of receipt of this Request for Proposals, the undersigned agrees that s/he has received a complete copy, beginning with the title page and table of contents, and ending with APPENDIX K.

The acknowledgement of receipt should be signed and returned to the Procurement Manager no later than 3:00 pm MT on July 10, 2019 (see contact information at end of form). Only potential Offerors who elect to return this form completed with the indicated intention of submitting a proposal will receive copies of all Offeror written questions and of the written responses to those questions, as well as RFP amendments if any are issued.

FIRM: ___

REPRESENTED BY: _____

TITLE: _____

PHONE NO.: _____ E-MAIL: _____ FAX NO.: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

SIGNATURE: _____ DATE: _____

This name and address will be used for all correspondence related to the Request for Proposal. Firm does/does not (circle one) intend to respond to this Request for Proposal.

<div align="center">

Jade Hunt, Procurement Manager
New Mexico Human Services Department
Medical Assistance Division
39A Plaza la Prensa
Santa Fe, NM 87504-2348
Phone: (505) 827-7710
Email:  JadeN.Hunt@state.nm.us

</div>

**APPENDIX B - COST RESPONSE FORM #1**
New Mexico Human Services Department

FINANCIAL SERVICES

Design, Development, and Implementation (DDI)

Provide an all-inclusive price for the design, development, and implementation for all Financial Services Module components, including project management, hardware, and software services. Offerors should price below all the Financial Services Module components in meeting the requirements of this RFP as a Fixed Price. As noted in the chart, total costs must include applicable New Mexico Gross Receipts Tax (NM GRT). The cost of each specific deliverable will be negotiated at time of contract but shall equal the proposed project components price. Offerors are to provide, as part of their budget narrative, their estimated work schedule and the assumptions made in developing the proposed schedule.

Pricing also must include license maintenance (renewals, updates, required technical support) for all Financial Services Module components. Note than New Mexico expects the costs proposed for ongoing operations to include regular and required updates and changes or enhancements to all Financial Services Module components. These will not be separately reimbursable.

| Pricing Components | Year 1 Costs | Year 2 Costs | Year 3 Costs | Year 4 Costs |
|---|---|---|---|---|
| Financial Processing | | | | |
| Claims Processing | | | | |
| Self-Directed Home and Community Based Services (SDHCBS) | | | | |
| Pharmacy Benefit Management | | | | |
| Drug Rebate | | | | |
| Data Exchange and Reporting | | | | |
| General Requirements | | | | |
| Total costs must include applicable NMGRT. | | | | |

| Total: | | | | |
|--------|---|---|---|---|
| | | | | |

FINANCIAL SERVICES

Maintenance and Operations (M&O)

Provide an all-inclusive price for the maintenance and operations of all Financial Services Module components, including project management, hardware, and software services for ongoing operations. Offerors should price below all the Financial Services Module components in meeting the requirements of this RFP as a Fixed Price. As noted in the chart, total costs must include applicable New Mexico Gross Receipts Tax (NM GRT). The cost of each specific deliverable will be negotiated at time of contract but shall equal the proposed project components price. Offerors are to provide, as part of their budget narrative, their estimated work schedule and the assumptions made in developing the proposed schedule.

Pricing also must include license maintenance (renewals, updates, required technical support) for all Financial Services Module components. Note than New Mexico expects the costs proposed for ongoing operations to include regular and required updates and changes or enhancements to all Financial Services Module components. These will not be separately reimbursable.

| Pricing Components | Year 1 Costs | Year 2 Costs | Year 3 Costs | Year 4 Costs |
|---|---|---|---|---|
| Financial Processing | | | | |
| Claims Processing | | | | |
| Self-Directed Home and Community Based Services (SDHCBS) | | | | |
| Pharmacy Benefit Management | | | | |
| Drug Rebate | | | | |
| Data Exchange and Reporting | | | | |
| General Requirements | | | | |

**APPENDIX B - COST RESPONSE FORM #3**
New Mexico Human Services Department

FINANCIAL SERVICES

Pricing for Optional Contract Extension Years

Provide an all-inclusive price for optional contract extension years for the entire Financial Services Module. Pricing also must include license maintenance (renewals, updates, required technical support) for all Financial Services Module components as well as regular and required updates and changes or enhancements to all Financial Services Module components for ongoing operations. These will not be separately reimbursable.

| Optional Years for Financial Services Module | Optional Year 1 | Optional Year 2 | Optional Year 3 | Optional Year 4 |
|---|---|---|---|---|
| Ongoing Operations<br><br>Total costs must include applicable New Mexico Gross Receipts Tax (NMGRT).<br><br>Total: | | | | |

# APPENDIX C -Letter of Transmittal Form

RFP#: _____

Offeror Name: _____

EACH ITEM #1 to #7 MUST BE COMPLETED IN FULL. FAILURE TO RESPOND TO ALL SEVEN ITEMS WILL RESULT IN THE DISQUALIFICATION OF THE PROPOSAL.

1. Identity (name) and mailing address of submitting organization:

_____

_____

_____

2. For the person authorized by the organization to contractually obligate on behalf of this Offer:

Name _____

Title _____

E-Mail Address _____

Telephone Number _____

3. For the person authorized by the organization to negotiate on behalf of this Offer:

Name _____

Title _____

E-Mail Address _____

Telephone Number _____

4. For the person authorized by the organization to clarify/respond to inquiries regarding this Offer:

Name _____

Title _____

E-Mail Address _____

Telephone Number _____


5. Use of subcontractors (select one):

_____ No subcontractors will be used in the performance of any resultant contract OR

_____ The following subcontractors will be used in the performance of any resultant contract:

_____
_____
_____

(Attach extra sheets, if needed)


6. Describe any relationship with any entity (other than subcontractors listed in item 5 above) that will be used in the performance of any resultant contract:

_____
_____
_____

(Attach extra sheets, if needed)


7. ___On behalf of the submitting organization named in item #1, above, I accept the Conditions Governing the Procurement as required in Section VI C.1.

___     I concur that submission of our proposal constitutes acceptance of the Evaluation Factors presented in Section VI.B of this RFP.

___     I acknowledge receipt of any and all amendments to this RFP.


_____   _____

Authorized Signature and Date

(must be signed by the person identified in item #2, above)

## APPENDIX D - Financial Services Reference Questionnaire Form

As part of the RFP process, the State of New Mexico requires Offerors to submit three (3) business references. The purpose of these references is to document Offeror's experience relevant to the scope of work in an effort to establish Offeror's responsibility.

Offeror is required to send the following reference form to each business reference listed. The business reference, in turn, is requested to submit the Reference Questionnaire directly to:

Jade Hunt, Procurement Manager
HHS 2020 – MMISR FINANCIAL SERVICES RFP #20-630-8000-0001
Medical Assistance Division
39A Plaza la Prensa
Santa Fe, NM 87504-2348
Phone: (505) 827-7710
Email: JadeN.Hunt@state.nm.us

For inclusion in the evaluation process, completed Reference Questionnaires must be received by the Procurement Manager not later than the RFP submission deadline. The form and information provided will become a part of the submitted proposal. Letters or other forms of reference, other than the Reference Questionnaire, will not be accepted. The business references provided may be contacted for validation of content provided therein.

RFP # 20-630-8000-0001 REFERENCE QUESTIONNAIRE FOR:

<Offeror Name>

This form is being submitted to your organization for completion as a business reference for the company listed above. This form is to be returned to the State of New Mexico Human Services Department via facsimile or e-mail:

Jade Hunt, Procurement Manager
HHS 2020 – MMISR FINANCIAL SERVICES RFP #20-630-8000-0001
Medical Assistance Division
39A Plaza la Prensa
Santa Fe, NM 87504-2348
Phone: (505) 827-7710
Email:   JadeN.Hunt@state.nm.us

The form must be received by the Procurement Manager no later than 3:00PM MT, **August 26, 2019** and **must not** be returned to the company requesting the reference.

For questions or concerns regarding this form, please contact the State of New Mexico Procurement Manager listed above. When contacting us, please be sure to include the RFP number listed at the top of this page.

| Organization Providing Reference: | |
|---|---|
| Contact Name and | |
| Contact Telephone Number | |
| Contact E-mail Address | |

QUESTIONS:

1. In what capacity have you worked with this company in the past? Describe the work this company or companies did for you.

COMMENTS:

2. How would you rate this company or company's knowledge and expertise?

(**3** = Excellent; **2** = Satisfactory; **1** = Unsatisfactory; **0** Unacceptable)

 COMMENTS:

3. How would you rate the company' or companies' commitment to schedule and flexibility relative to changes in project scope and/or timelines?

(**3** = Excellent; **2** = Satisfactory; **1** = Unsatisfactory; **0** = Unacceptable)

COMMENTS:

4. What level of satisfaction did you have with the deliverables produced by the company or companies?

(**3** = Excellent; **2** = Satisfactory; **1** = Unsatisfactory; **0** = Unacceptable)

COMMENTS:

5. How would you rate the dynamics/interaction between the company or companies and your staff?

(**3** = Excellent; **2** = Satisfactory; **1** = Unsatisfactory; **0** = Unacceptable)

COMMENTS:

6. Who were the company's or companies' principal representatives involved in your project and how would you rate them individually? Please comment on the skills, knowledge, behaviors or other factors on which you based the rating for each.

(**3** = Excellent; **2** = Satisfactory; **1** = Unsatisfactory; **0** = Unacceptable)

Name: _____Rating: ____

Name: _____Rating: ____

Name: _____Rating: ____

Name: _____Rating: ____

COMMENTS:

7. How satisfied are you with the services or the products developed by the company or companies?

(**3** = Excellent; **2** = Satisfactory; **1** = Unsatisfactory; **0** = Unacceptable)

COMMENTS:

8. With which aspect(s) of this company or companies' services are you most satisfied?

COMMENTS:

9. With which aspect(s) of this company or companies' services were you least satisfied?

COMMENTS:

10. Would you recommend this company or companies services to your organization again? Do you recommend this company to the State of New Mexico?

COMMENTS:

**APPENDIX E - Campaign Contribution Disclosure Form**

Pursuant to NMSA 1978, § 13-1-191.1 (2006), any person seeking to enter into a contract with any state agency or local public body for professional services, a design and build project delivery system, or the design and installation of measures the primary purpose of which is to conserve natural resources must file this form with that state agency or local public body. This form must be filed even if the contract qualifies as a small purchase or a sole source contract. The prospective contractor must disclose whether they, a family member or a representative of the prospective contractor has made a campaign contribution to an applicable public official of the state or a local public body during the two years prior to the date on which the contractor submits a proposal or, in the case of a sole source or small purchase contract, the two years prior to the date the contractor signs the contract, if the aggregate total of contributions given by the prospective contractor, a family member or a representative of the prospective contractor to the public official exceeds two hundred and fifty dollars ($250) over the two-year period.

Furthermore, the state agency or local public body shall void an executed contract or cancel a solicitation or proposed award for a proposed contract if: 1) a prospective contractor, a family member of the prospective contractor, or a representative of the prospective contractor gives a campaign contribution or other thing of value to an applicable public official or the applicable public official's employees during the pendency of the procurement process or 2) a prospective contractor fails to submit a fully completed disclosure statement pursuant to the law.

THIS FORM MUST BE FILED BY ANY PROSPECTIVE CONTRACTOR WHETHER OR NOT THEY, THEIR FAMILY MEMBER, OR THEIR REPRESENTATIVE HAS MADE ANY CONTRIBUTIONS SUBJECT TO DISCLOSURE.

The following definitions apply:

"Applicable public official" means a person elected to an office or a person appointed to complete a term of an elected office, who has the authority to award or influence the award of the contract for which the prospective contractor is submitting a competitive sealed proposal or who has the authority to negotiate a sole source or small purchase contract that may be awarded without submission of a sealed competitive proposal.

"Campaign Contribution" means a gift, subscription, loan, advance or deposit of money or other thing of value, including the estimated value of an in-kind contribution, that is made to or received by an applicable public official or any person authorized to raise, collect or expend contributions on that official's behalf for the purpose of electing the official to either statewide or local office. "Campaign Contribution" includes the payment of a debt incurred in an election campaign, but does not include the value of services provided without compensation or

unreimbursed travel or other personal expenses of individuals who volunteer a portion or all of their time on behalf of a candidate or political committee, nor does it include the administrative or solicitation expenses of a political committee that are paid by an organization that sponsors the committee.

"Family member" means spouse, father, mother, child, father-in-law, mother-in-law, daughter-in-law or son- in-law.

"Pendency of the procurement process" means the time period commencing with the public notice of the request for proposals and ending with the award of the contract or the cancellation of the request for proposals. "Person" means any corporation, partnership, individual, joint venture, association or any other private legal entity.

"Prospective contractor" means a person who is subject to the competitive sealed proposal process set forth in the Procurement Code or is not required to submit a competitive sealed proposal because that person qualifies for a sole source or a small purchase contract.

"Representative of a prospective contractor" means an officer or director of a corporation, a member or manager of a limited liability corporation, a partner of a partnership or a trustee of a trust of the prospective contractor.

DISCLOSURE OF CONTRIBUTIONS:

Name(s) of Applicable Public Official(s) if any: _____

(Completed by State Agency or Local Public Body)

| Item | Description |
|---|---|
| Contribution Made By | |
| Relation to Prospective Contractor: | |
| Name of Applicable Public Official | |
| Date Contribution(s) Made | |
| Amount(s) of Contribution(s) | |
| Nature of Contribution(s) | |
| Purpose of Contribution(s) | |

(Attach extra pages if necessary)

_____  _____
Signature        Date

_____
Title (position)

-OR—

NO CONTRIBUTIONS IN THE AGGREGATE TOTAL OVER TWO HUNDRED FIFTY DOLLARS ($250) WERE MADE to an applicable public official by me, a family member or representative.

_____        _____
Signature        Date

_____
Title (Position)

## APPENDIX F - New Mexico Employees Health Coverage Form

1.   For all contracts solicited and awarded on or after January 1, 2008: If the Offeror has, or grows to, six (6) or more employees who work, or who are expected to work, an average of at least 20 hours per week over a six (6) month period during the term of the contract, Offeror agrees to have in place, and agree to maintain for the term of the contract, health insurance for those employees and to offer that health insurance to those employees no later than July 1, 2010, if the expected annual value in the aggregate of any and all contracts between Contractor and the State exceed $250,000 dollars.

2.   Offeror agrees to maintain a record of the number of employees who have (a) accepted health insurance; (b) declined health insurance due to other health insurance coverage already in place; or (c) declined health insurance for other reasons. These records are subject to review and audit by a representative of the State.

3.   Offeror agrees to advise all employees of the availability of State publicly financed health care coverage programs by providing each employee with, as a minimum, the following web site link to additional information https://www.bewellnm.com/

4.   For Indefinite Quantity, Indefinite Delivery contracts (price agreements without specific limitations on quantity and providing for an indeterminate number of orders to be placed), these requirements shall apply the first day of the second month after the Offeror reports combined revenue (from state and, if applicable, from local public bodies if from a state price agreement) of $250,000.


Signature of Offeror:


Date_____

**APPENDIX G – DETAILED STATEMENT OF WORK**

This APPENDIX contains the Statement of Work (SOW) for this FS procurement. The Statement of Work is a companion document to the requirements found in APPENDIX H and should be read and interpreted as a statement of both expectation and as an explanation of the Project described in Part 1 of this RFP and of the requirements found in APPENDIX H. The Scope of Work described herein outlines the responsibilities and Project obligations of the selected FS Contractor. Prior to preparing their proposals in response to this procurement, Offerors are required to review the SI, DS, QA and CCSC RFPs as well as the questions and answers (Q&A's) and addendums for the respective RFPs as may be found in the Procurement Library.

The FS Contractor ("Contractor") will play a critical role in the overall success of the MMISR Project. The FS Contractor must provide all required essential business components: Financial Processing, Claims Processing, Self-Directed Home and Community Based Services, Pharmacy Benefit Management; Drug Rebate; and providing the reports available from its service (e.g., transactional reporting, such as audit trails, aging reports, adjudication cycle reports, Remittance Advices, warrant and EFT reporting) and the data the DS requires for reports and financial dashboards. The FS Contractor's solution must support the maintenance of all files required for claims adjudication although other BPOs or organizations may be responsible for replicating these updates (e.g., the BMS contractor for provider and reference file updates and ASPEN for most client eligibility updates and third party liability coverage).

CMS, the primary funding entity for the MMISR Project, has identified in the MECT certain System Review Criteria (SRCs) that are applicable for MMIS certification. The Contractor must deliver the services as outlined in this SOW and meet the SRCs for each FS component as detailed in APPENDIX H.

The FS module must be SOA compliant and fully capable of integration via Application Programming Interfaces (APIs) with the SI Solution, which consists of a highly reliable, loosely coupled, secure SOA-compliant integration platform (IP) for all of HHS 2020. The FS module will integrate with the SI's ESB that is capable of end-to-end connections to all other MMISR modules, shared services and legacy systems including integration of client eligibility and authorization data from multiple sources. The Systems Migration Repository (SMR) will translate legacy data into data fields and formats (XML) for consumption by the modules. The ESB will provide access to data within legacy systems that continue to function after SMR conversion. The FS Contractor will be required to adhere to all standards established by the SI Contractor and approved by the State on integration, interoperability, security, Single Sign On (SSO) and transmission of data. The

Contractor must exchange data using the SI's ESB and acknowledge the data belongs to the State.

The FS Contractor must acknowledge its affirmative obligation to work with other modules: e.g., with QA to share information and data on denied claims and claims paid against authorization levels: BMS to identify claims issues relating to provider enrollment and client services utilization; and with DS to make available all information regarding claims, encounters, financials for all Federal and State reporting, and DS dashboards. The FS Contractor must provide data and assist the DS vendor in the development of the Financial Dashboards the State requires. The Contractor must provide all data in the format required by the State that is necessary for auditing.

The Contractor's business services must have the processes, tools and skills to deliver on all the FS components. The State is seeking a Contractor which understands how to apply proven approaches for efficient delivery of timely and accurate services and minimize duplication of services. The State is seeking a Contractor who can efficiently deliver a broad range of extremely high-quality business services in a complex environment from contract award through MMISR certification by CMS and into on-going Maintenance and Operations (M&O).

Offerors are encouraged to propose innovative business services and vision for FS that meet or exceed the requirements of this RFP. All Offerors are encouraged to demonstrate added value in their proposals by recommending innovative concepts and solutions which may not have been specifically addressed in this RFP.

## 1. Services and Approach

The Contractor's project and contract management practices must reflect accepted best practices (e.g., Project Management Body of Knowledge, Continuous Process Improvement), complemented by insight gained from successful work on services and technology projects of similar size and complexity for other health care customers. The Contractor's project and contract management approach should be practical, results-oriented and readily implemented. At a minimum, the Contractor is required to propose compatible processes and tools to perform all the project and contract management activities that are outlined in this APPENDIX G and in the Requirements found in APPENDIX H of this RFP. All project management activities must be coordinated with the HHS 2020 EPMO, and when so directed by the State's PMO. Contractor's tools must be compatible with those used by the State in table G1.

HSD is seeking a Contractor that has demonstrable and proven business services using a service-delivery approach to accomplish the following:

1. Effectively address and support the HHS 2020 Vision and the MMISR modular technology and business services approach while identifying risks or trade-offs and making informed recommendations and related processes with cost-effective implementation, maintenance and operation. Offeror's service approach must demonstrate a commitment to the CMS SCS and to sustainability, flexibility and scalability, extensibility and maximized reuse and interoperability;
2. Apply experience with FS, requirements compliance and project management including providing examples of exit criteria for determining that a phase is complete;
3. Manage parallel delivery timelines and resources (including all subcontractors) to effectively work as a cohesive team to meet State and Federal requirements;
4. Ensure that the FS be planned, tested and executed to enable successful completion within an aggressive time frame; and
5. Deliver and manage business services that will comply with CMS Certification requirements and enable the State to improve MITA Maturity Levels across the Enterprise.

**1.1 Complete BPO Services**
Offerors are responsible for providing all FS components and related services to successfully meet all the requirements of this BPO procurement. Offerors shall propose services that are responsive to both the goals and the intent of the HHS 2020 Vision and Framework.

Offerors must describe in their proposals the tools and services that are being offered including the capacity to handle the claims processing volumes and related business activities and services associated with FS which are being provided. Offerors should describe the immediate as well as future benefits which will be provided.

HSD may, as planning evolves, request the FS Contractor to extend support to other HHS 2020 Project initiatives, e.g., the CYFD Comprehensive Child Welfare Information Systems (CCWIS), the Child Support Enforcement System Replacement (CSESR), and Medicaid buy-in processing to the extent that these initiatives align with and benefit from the HHS 2020 Framework.

Offerors must describe in their proposals the number, types and experience of Subject Matter Experts (SMEs) that are being proposed. SMEs must have the experience, knowledge and expertise to provide FS and training to the State. SMEs are expected to support end Users and may be asked to assist in performing associated tasks across the Enterprise. SMEs must have expertise in their respective FS components (e.g., Health Insurance, Medicaid).

**1.2 Subcontractors**

The use of subcontractors is acceptable with prior approval by HSD. The Prime Contractor will be directly accountable for the quality of the FS components as well as the associated services delivered throughout the contract life. The Prime Contractor is solely responsible for performance under the contract resulting from this RFP. The State retains the option to request replacement of any subcontractor at its discretion. All work, including any work performed by subcontractors, must be performed onshore. No offshoring of work, including storage of data, is permitted by either the Prime Contractor or its subcontractors.

## 2. FS Contractor Role

The Contractor must deliver FS that comply with the requirements found in APPENDIX H and that are responsive to this Statement of Work (APPENDIX G). At a minimum, this includes: performing in accord with the expectations found in Section 1 above; provide effective Project Management; comply with the Project Management standards established by the HHS 2020 EPMO; support and participate in Data Governance; ensure the security and integrity of data; and deliver and operate all FS components. The Sections that follow provide additional information and guidance on the Statement of Work. The Contractor must provide the services and tools to meet the needs of the Enterprise Stakeholders (e.g., HSD, DOH, ALTSD, CYFD).

### 2.1 The BPO Services

The Contractor must configure, provide and operate all required FS for the following components:

1. Financial Processing:

   - Payment Processing;

   - Financial Transactions;

   - Billing and Collections;

   - Accounting Detail and Interfaces; and

   - Audits.

2. Claims Processing:

   - Ingesting via electronic files, paper claims, and claims entered via web portal;

   - Adjudicating FFS and other Enterprise program claims according to edit criteria developed in conjunction with the State and other modules;

- Maintaining a system of edits and audits that meet all national and state standards and able to be dispositioned according to both high level and very detailed level classifications (e.g., disposition by claim type vs disposition by provider specialty);

- Ingesting encounter 835's from the MCOs, matching and updating the original encounter with the MCO's disposition status (e.g., paid, denied, suspended) and pricing any that the MCO reflects as paid;

- Sending encounters dispositioned by the MCOs to the ESB for submission to the DS;

- Payment of invoices and non-traditional claims for non-Medicaid services;

- Calculating and processing capitated Per Member Per Month (PMPM) payments to MCOs;

- Mass adjusting claims and encounters as instructed, with the capability to associate adjusted/voided claims to the request and reason for the action;

- Pricing FFS claims based upon Enterprise specific rules;

- Assigning Account Code based upon Enterprise specific rules;

- Capturing and using attachments;

- Capturing and integrating data (including EVV); and

- Approving claims and related transactions for payment or recoupment as changes are identified.

3. Self-Directed Home and Community Based Services:

- Service & support plans and authorized budgets;

- Employer, employee and vendor enrollment;

- Timesheet and invoice processing and payment; and

- Customer support, training and reporting.

4. Pharmacy Benefit Management:

- Providing a National Council for Prescription Drug Programs (NCPDP) Point of Sale service that adjudicates pharmacy claims in accordance with NCPDP standards and transmits real-time responses for Point of

Sale (POS) claims 24/7 in full compliance with NCPDP messages and codes as well as an adjudication service for batch (i.e., encounter) and paper claims;

- Maintaining drug data and parameters needed to correctly price drug claims from drug update services, ensuring that the service(s) used are synchronized with the Managed Care Organizations, and drug data updates from CMS, which includes the Unit Rebate Master File and the Labeler Name and Address File which includes current Drug Efficacy Study Implementation (DESI) drug information and supports the State's ability to receive Federal Financial Participation (FFP) for covered outpatient drugs supplied by manufacturers that have a current, signed rebate agreement with the Secretary of Health and Human Services; Utilizing client and provider data and prior authorization obtained from other modules;

- Applying Third Party Liability (TPL) obtained from other modules at point of service;

- Pricing claims using a robust service of pricing customizations and prior authorization based on multiple designs, provider reimbursement rates, "lesser-of" application, generic vs brand differential, and dispensing fee application, including pricing any encounters that have been adjudicated as paid by the MCOs; and

- Maintaining a Drug Utilization Review (DUR) data and Prospective DUR edits that meet standard NCPDP edits and standards set by the State and DUR board.

5. Drug Rebate:

- Providing a drug rebate process that follows the uniform rules prescribed by CMS, utilizing claims data from the claims processing service and rebate data from CMS;

- Administering drug rebate in a manner that maximizes drug rebate recoveries that includes the following:

  - Complete and accurate invoicing;

  - Complete and accurate payment reconciliation; and

  - Minimization or elimination of manufacturer dispute and unresponsiveness

- Entering manufacturer/invoice information, issuing invoices to manufacturers and resolving disputes with manufacturers, including

technical assistance and interfaces with the Managed Care Organizations and other third parties, including insuring timely receipt and accuracy of rebate information:

- Providing services that are capable of functions currently performed manually by HSD'S Administrative Services Division, to include but not be limited to:

  - Entering payments into the Drug Rebate service appropriately according to the Manufacturer and Invoice;

  - Maintaining contact with labelers regarding payment;

  - Processing daily and weekly interface files from the Drug Rebate service into the Statewide Human Resources Accounting Reporting (SHARE) System which is the State's financial and reporting system, to include requesting drug rebate reports, and reconciliation of detail data to journal entry, approval and posting of journal entry; and

  - Maintaining a current record of amounts billed and payments received from manufacturers for each quarter with a means of relating payments received to the specific invoiced amounts.

- Providing drug rebate data to Data Services for construction of the CMS 64 and other management reporting; and

- Producing transactional reports and any reports on activity that are already part of the offeror's Drug Rebate services.

6. Data Exchange and Reporting:

- Providing all claims data to other modules that require it for their respective processes or services as directed, and routinely to the Data Services module which is responsible for all State and Federal reporting;

- Providing transactional reporting, such as audit trails, aging reports, adjudication cycle reports, remittance advices, warrant and EFT reporting, etc. along with any reports that are inherent to the FS' service/system; and

- Ingesting the necessary Enterprise Data to verify eligibility, authorizations, provider enrollment, third party liability, and service utilization and sharing claims data to other modules as directed for their use to properly and accurately implement all FS services, processes and features.

The selected Contractor will be required to perform all work necessary to achieve

successful implementation and operation of the full FS module. The Contractor must:

1. Perform FS project management in compliance with the HHS 2020 PMO standards and processes;

2. Collaborate and coordinate with the Enterprise partners, module Contractors, IV&V and HHS 2020 EPMO;

3. Complete planning related to all FS;

4. Configure, provide and operate all FS to meet the State's business needs in accord with contractual timelines;

5. Take all necessary steps to bring all FS to an operational status and continue operational services for the contract period;

6. Ensure adherence to the MECT, MITA (comprised of Business, Information and Technology Architectures) and successive versions and the SCS; and

7. Coordinate with other modules and manage the FS project in conjunction with other modules to ensure enterprise wide implementation.

The Contractor's proposed services must comply with and support all applicable Federal, State or other regulations, guidance and laws, including at a minimum, the standards and protocols listed in Addendum 14 HHS 2020 Security Privacy and Standards and Addendum 21 HHS 2020 Security Operational Guidelines in the Procurement Library https://webapp.hsd.state.nm.us/Procurement/.

**2.2 FS Components**
The Contractor's services must comply with specifications found in this SOW and the requirements found in APPENDIX H of this RFP. The State seeks a FS Prime Contractor with the expertise to deliver services that integrate all functionality of the FS module with the HHS 2020 Framework even if subcontractors are utilized for components.

The Contractor must perform all the business services necessary to deliver the FS components and related services and interact with the State and HHS 2020 modules and BPO Contractors to effectively support HHS 2020 and the MMISR Project. For the purpose of this procurement, the State's definition of a BPO includes outsourcing that involves the contracting of the operations and responsibilities of a specific business process to a BPO service provider with oversight by the State. These BPO services are separate business functions and are responsible for performing processes or parts of processes and done to save costs or gain productivity. Due to the certification and auditing requirements for which the MMIS is accountable, the State will retain oversight

and require adherence to Service Level Agreements (SLAs) for the BPO components, processes and services.

As the State is looking to transform the way business is done and for the Contractor to position the State for the future, the Offeror must describe their approach for each component and related services. While this SOW has defined base functionality and requirements for the Financial Services Components, the State seeks proposals that include innovative and modern approaches to the implementation of all Financial Services components.

The Offeror must describe their approach to reducing costs including but not limited to:

- Automate existing manual processes;

- Implement workflows for monitoring automatic determinations and escalation as appropriate;

- Integrate data and processes across Agencies;

- Reduce duplication of efforts;

- Provide the State with the expertise to evaluate data and make strategic recommendations for increased efficiencies; and

- Implement alerts and notifications and integrate with SI notification engine.

The Offeror must describe their approach to position the State for the future including but not limited to:

- Increased meaningful Stakeholder engagement;

- Identification of innovation beyond that which is specifically requested in this RFP;

- Increased healthcare interoperability and integration with regional and national entities;

- Provision of services with configurable rules-based tools; and

- Scalable services.

Offerors should note that FS components are logically separated into accounting functions, claims functions, pharmacy benefit management, training and technical assistance, and data exchange functions. Offeror services do not have to necessarily have the same logical separation but should note that the State expects claims processing to

supply payment authorizations to the accounting function and that the accounting function will manage payables and receivables from multiple sources (e.g., claims, Pharmacy Benefit Management [PBM], other agencies), to include such things as netting and recoupment before initiating a payment or recoupment. In claims processing, if "payment" is referenced it does not imply generation of warrants or other payments in the claims function; rather it is considered either payment authorization, valuation and/or pricing of a claim or similarly edited and audited transactions. The use of "claim" is not intended to be limited to only traditional medical claims. "Claim" includes at a minimum payment transaction for MiVia, self-directed care timesheets, electronic visit validations, vouchers, invoice, incentives, capitation, State Residential Facilities, Case Management, payments for DOH or ALTSD programs, value-based purchase invoices, non-member specific invoices, Personal Care Adult, Children Foster Care placements, Personal Care allowance, equine therapy, synar services, State facilities, and other Enterprise partner non-traditional payments.

### 2.2.1 Financial Processing

The State is seeking a fiscal agent that can deliver Financial Processing services in a quality and timely manner for enterprise programs. These services, critical to the HHS 2020 Enterprise, must provide functionality which processes, records, calculates, collates and manages all Enterprise financial transactions as indicated by the State. Such functionality includes but is not limited to:

- Assign of appropriate accounting codes and dispositions to all financial transactions; accumulation of necessary balances for claims and transaction processes;
- Adjust accounts as appropriate;
- Managed accounts receivable (AR) and accounts payable (AP);
- Bill third parties on behalf of the Enterprise;
- Perform collections, recoupments and recoveries, coordinating with the QA contractor for TPL and RAC recoveries;
- Facilitate cost settlements;
- Calculate and perform disbursements and payments;
- Distribute receipts or payments to appropriate accounts;
- Impose and collect fees;
- Establish and complete fixed and dynamic financial cycles;
- Work with the Enterprise to establish FS policies and procedures;
- Record, track, monitor and account for fund or monetary receipts;
- Perform all appropriate reconciliations and trial balances;
- Process and disburse refunds as appropriate;
- Support the acceptance and disbursement of payments using Electronic

Funds Transfer/Electronic Data Interchange (EFT/EDI) and other payment/disbursement mechanisms identified by the Enterprise;

- Provide financial reporting as appropriate;

- Manage grants as appropriate;

- Generate 1099's and other tax reporting; and

- Process, maintain and transmit all financial transactions as required by the Enterprise.

The Contractor must conduct all financial processing in accordance with State and Federal regulations, policies and procedures; accounting standards and best practices; and the requirements and guidelines established by the respective responsible Enterprise entity. The Contractor must collaborate with the State, Enterprise and External Stakeholders to develop financial management policies and procedures to ensure all financial transactions relevant to Enterprise programs are appropriately and timely processed in accordance with Federal, State and Program law, regulations and guidelines, using configurable business rules whenever possible.

Financial reporting is expected to occur in two places. Because the services will be sharing data with DS, all mandated Federal and State reporting will be done in DS. However, other reports that can be produced in FS without the need for data from other Enterprise systems (e.g., 1099, aged receivables) must be done in FS. The Contractor must provide all FS performance reports as well as standard reports available through the proposed solution.

### 2.1.2.1 Payment Processing

The contractor must execute a financial (payment) cycle no less than once per week and must include capitation payments in at least one weekly financial (payment) cycle per month. At the State's direction, the Contractor must adjust the frequency and/or schedule of financial cycles. Via the SI, the Contractor must send an Automated Clearing House (ACH) file to the State's bank in order support Electronic Funds Transfer (EFT) and a payment file to the State for printing of paper warrants (checks) for those entities that are not set up for EFT.

The services must be able to support, free-of-charge to payees, multiple methods of disbursements and payments while maintaining strict internal security and quality controls in accordance with Federal and State laws, regulations and Enterprise guidelines. Types of payments should include warrants, electronic transfers, inter-agency transfers, ACH, electronic benefit transfer (EBT) and others as required by the Enterprise. Before payments are made they must be reconciled, analyzed for irregularities, suspicious payments, determined they be of appropriate type (e.g., no EFT to payees who have no bank on file or who have not passed testing), and pass other validations as required by

the Enterprise. Payments that do not pass must be forwarded for resolution and approval to appropriate Enterprise Users.

### 2.1.2.2 Financial Transactions

The Contractor must process all financial transactions (e.g., cost settlement, Graduate Medical Education/Indirect Medical Education [GME/IME], Sole Community Provider, Gross level managed care payouts, Indian Health Services [IHS] reconciliations, Tribal 638s reconciliations, Value Based Payments [VBP], Gross level recoveries) based on configurable business rules or, where appropriate, allow authorized Enterprise users to directly enter or modify financial transactions. Financial transactions must be uniquely identifiable and carry appropriate cost centers, account codes and financial reason codes that clearly identify the purpose of the transaction as well as related claims IDs when the financial transaction is related to identified claims and links to supporting documentation. All transactions must be able to be fully reversed if needed. The Contractor must be able to fully interface with the state entities responsible for financial accounting, reporting and generation of warrants and EFTs. The Contractor must also interface with other modules as required and other members of the enterprise that may need to pay using financial transactions.

These include, but not limited to the following functional areas:

- Accumulation of balances – FS must cover, at a minimum, adjustments for services reimbursed by other carriers as appropriate, service utilization when there are annual, life-time, plan, budget or other Enterprise identified limits, disposition and flagging of balance accumulation, unreimbursed assistance, and other accruals or accumulations as necessary for financial operations. FS must retain detailed information about the creation, processing, dispositions and reasons behind accumulations and accruals and their source transactions.

- Adjustments – FS must adjust or void any financial transactions when indicated by the Enterprise or through the discovery of errors or through another authorized system or user process. The services must recalculate and adjust any dependent accounts, accumulations or accruals, payments, collections or other dependent financial objects resulting from the adjustment.

- Collections, recoupments, recoveries – FS must identify, initiate, manage and act on collections, recoupments and recoveries generated by the services or received from Enterprise partners or their authorized Enterprise Users. Among these partners is the QA contractor, which is responsible for initiating TPL and RAC

recoveries and working with FS to update claim and financial records to reflect this activity. The FS must accept transactions (e.g., receipt records, AR or AP creation requests) from Enterprise partners and post to the appropriate accounts based on Enterprise business rules. When indicated by the Enterprise, the services should pursue the collection of funds through various mechanisms from payment or disbursement offsets, billing requests, and can apply various methodologies (gross, percentage, partial, resolution hierarchies) to resulting transactions. FS should be able to hold, suspend, or forego various recoupment or recovery methodologies based on Enterprise business rules or authorized Enterprise User intervention.

- Distribution – FS must be able to distribute collections, recoupments, recoveries or other receipts to multiple Enterprise accounts and initiate appropriate inter-departmental fund transfers to fulfill the distribution request.

- Disbursement and payment requests – FS must calculate appropriate disbursement and payment requests per payee based on singular or multiple AP subsidiary account balances. Balances must account for and generate, as appropriate, Enterprise approved AP and AR transactions and payment methodologies necessary to implement recoupments, recoveries, fees, Third-Party Liability (TPL) or other Enterprise authorized modifications in an order prioritized by Enterprise business rules. Zero balance payments must be posted and appropriately dispositioned as such for other operational processes. Negative balance "payments" must be appropriately classified as a new AR subsidiary account or as a unique entry to an existing AR, or to an appropriate contra account as necessary, and the dispositions or reasons appropriately identified. Automated reconciliation of net payments must be done prior to submitting the request and any resulting adjustments to expenses, revenues and funds or other Enterprise accounts must be calculated, for posting upon payment; and the detail linked to the payment request.

- Enterprise mandated and dynamic financial cycles – FS must support the processing of multiple financial cycles per Enterprise business rules to facilitate timely payments, accounting cycles (e.g., monthly, quarterly, State fiscal year, Federal fiscal year, calendar year) or other cycles identified by the Enterprise. Financial cycles must be able to prioritize unique transactions based on Enterprise business rules and allow for dynamic cycles where necessary for payments, billing or other approved off-cycle process requests. Process dates, dispositions and reason codes must be recorded for each transaction as appropriate.

- Fees – FS must be able to impose fees of on AR subaccounts for various reasons and maintain the disposition and reason of each fee transaction. Fee assessment must be based on Enterprise configurable rules for timing, value, imposition and collection. Fees must associate with valid time-spans. Authorized Enterprise Users and systems must be able to adjust fees and fee methodologies at the rule and individual assessment level and can impose, suspend, hold, void or distribute fees across ARs in a user-friendly fashion. Fees must be able to have multiple disposition and reason codes as necessary.

- Other Transaction Processing – FS must accept and transmit financial transactions with other Enterprise systems and collate such information into the FS's transaction store and maintain lineage, reasons, dispositions and other information necessary to integrate such information for an Enterprise view of financial information. Such information will come through the IP from SHARE, QA, BMS, Enterprise Stakeholders, Enterprise systems, external systems and Enterprise Users. Transactions will take IP standardized formats that may include X12 or other standard formats. The services must accept and send all financial data in the formats required by the SI.

- Reconciliation –. FS must account for multiple Enterprise accounting systems, balancing accounts, trial balances and reports within the services and across Enterprise financial systems (e.g., SHARE). In coordination with other Enterprise financial system Users, FS must create resulting adjusting entries to the accounts within the services' purview and provide suggested adjusting entries to Enterprise partners. Reconciliation activities must support the quality improvement process by reducing adjustments by implementing appropriate Enterprise business rules.

- Refund processing–. FS must calculate approved payment requests for refund processing as part of an automatic or manual financial cycle, as directed by the Enterprise. Associated refund transactions must be created for AR subsidiaries and AP subsidiaries created or the appropriate transaction posted to existing subsidiaries. FS should provide access to the Enterprise for AR/AP detail with drilldown to supporting transactions and documentation.

To process Enterprise User transactions, the Contractor must work with Enterprise Users to develop appropriate electronic form and workflow services provided by the IP. Transactions of this nature include adjustments, payment requests for non-claim transactions such as Disproportionate Share Hospital (DSH) payouts, advanced payments, incentive payments or other Enterprise required transactions and include

the ability to analyze, reconcile and adjust such payments in a rolling fashion for up to seven (7) years.

Contractor's services must be able to automatically, or by authorized User intervention, create and manage AR and AP accounts and subsidiary accounts and associate them with reasons (e.g., recoupment, recovery, TPL), dispositions, demographic information (e.g., Provider, Vendor, Carrier, Member), the responsible entity (e.g. individual, corporation), comments, hierarchies of resolution, and other data as necessary and required by the Enterprise.

### 2.1.2.3 Billing and Collections

The services must be able to generate bills to third parties to include Members, Providers, and other third-party entities as identified by the Enterprise. Among these entities are incarceration facilities, including but not limited to county detention centers that must be billed for Short Term Medicaid for Incarcerated Individuals (STMII) claims. The QA module will be responsible for billing insurance carriers for TPL. TPL billings will result in payments that will be recorded in the FS with appropriate cost centers and reason codes. Billings will be in a form appropriate to the program and business process to include electronic transactions (e.g., X12), paper or electronic invoices, or other formats as indicated by the Enterprise. FS must be able to generate, suppress or re-generate billings based on changes to AR or AP, and per Enterprise business rules, or based on authorized User intervention, as appropriate. All billings must be appropriately accounted for in accounts receivable and must be tagged with appropriate dates and accounting codes. All billings must be linked back to the original documentation or other transactions (e.g., claims, recoupments, recoveries, collection activities) to include any payments withheld to satisfy a liability and the remaining balance for which the billing is generated.

The services must be able to receive, track, monitor and maintain payment receipts from any third-party including Providers, Members, insurance carriers, drug manufacturers, incarceration facilities, and other Enterprise identified and approved entities. The FS Contractor is responsible for receiving payments. These payments must be logged and sent to the State for deposit no later than the next business day. For payments that are received directly by the State, ASD will make the deposit and communicate the payment details to the FS contractor to update the system. The FS solution must provide a central receipt log that automatically associates receipts with existing accounts receivable and provides a mechanism for Enterprise Users to easily associate receipts to multiple source documents at both the header and detail level when the system is unable to forge the appropriate linkages

automatically. This log must be available to authorized Enterprise Users regardless of what business unit receives the payment.

## 2.1.2.4 Accounting Detail and Interfaces

The Contractor must capture all claim-level and gross-level payments and other financial transactions and provide information to the Administrative Services Division (ASD) through electronic transactions to update SHARE, the State's accounting system. Each transaction will must associate with the proper cost center and/or accounting codes to enable the State to associate budgets and expenditures with cost categories.

Transactions must map back to the State's chart of accounts for assets, liabilities, revenues, expenses and funds by funding source (e.g., grants, general funds, special appropriations) and maintain multiple additional accounting codes (e.g., Federal Categories of Service, Budget Categories, State Accounting Codes, Federal Medical Assistance Percentages (FMAP) and Federal Financial Participation (FFP) rates, transaction dispositions, transaction reasons) including the time-spans for which each code is valid. Sufficient information must be maintained for each transaction to allow for reporting under a cash basis, an accrual basis and a modified accrual basis.

The services must provide a mechanism for authorized Enterprise users to easily update, append and monitor all charts of accounts, accounting codes and code crosswalks and integrate with the Enterprise workflow system for transaction approvals. Each financial transaction processed must be assigned to one or more of these charted accounts, accounting codes, dispositions and reasons at the header and at line-item details as well as maintain appropriate dates for each transaction (e.g. date of service, paid date, processing date).

Contractor's services must maintain separation of transactions by Enterprise program as well as cost allocate each transaction to appropriate funding sources and retain such information at the header and line-item level. The services must follow industry best practices and standards per Generally Accepted Accounting Principles (GAAP) and those of the Government Accounting Standards Board (GASB) as relevant to New Mexico. New Mexico uses a modified accrual basis of accounting for all governmental funds. Revenues are recognized and susceptible to accrual when they become both measurable and available. Revenues susceptible to accrual are primarily amounts due from the Federal Government and other State agencies or entities. Expenditures are recognized in the period in which the associated liability is incurred.

## 2.1.2.5 Audits

The HHS 2020 is subject to a variety of external audits by other federal and state agencies. The Contractor must cooperate with and provide support for federal and State audits. As directed by the State, the Contractor must reconcile claims and financial activity with the auditing agency and process claim adjustments and financial transactions to correct identified errors.

The Contractor shall provide support, at no additional cost, for hearings, legal cases, audit, inquiries, and other studies as required, including testifying, attending meetings or other scheduled events, responding to subpoenas as directed by the State, and providing other documentation as required.

The State of New Mexico, the State Auditor, the U.S. Procuring Agency of Health and Human Services, the U.S. Comptroller General, the U.S. Government Accountability Office, or their authorized representatives will, at all reasonable times, have the right to enter the Contractor's premises or such other places where duties under this Agreement are being performed to inspect, monitor, or otherwise evaluate (including periodic systems testing) the work being performed. The Contractor shall provide reasonable access to all facilities and assistance to the State and federal representatives.

The Contractor must perform an in-depth electronic data processing (EDP) audit of internal controls in accordance with the Auditing Standards Board's "Statements on Standards for Attestation Engagements No. 16" (SSAE 16) and provide the Procuring Agency with a formal written report of this audit. The EDP auditor shall be an independent auditing firm other than the CPA firm engaged as the CONTRACTOR's corporate auditor. The selection of and contract with the EDP auditor shall be subject to the approval of the Procuring Agency.

### 2.2.2    Claim Processing

The State is seeking financial services that include ingesting and adjudicating Enterprise claims. Contractor's services must provide functionality for the receipt, processing, editing, auditing and pricing of claims of multiple types from many different entities  For this RFP, claims are a legal obligation for the State to pay for goods, services, voucher or other program obligations received from any Provider, Vendor, Contractor, Member, other organization or other entity for program-related services and claims received for managed care members for which the State doesn't reimburse directly but rather through capitation paid to the MCO. Medical and non-medical claims will be received for processing from multiple entities (e.g., Individual or Group Provider, Coordination of Benefits Agreement [COBA] Contractor, Mi Via self-directed) and may be in a number of different formats including HIPAA 837 transactions, MiVia, self-directed care timesheets, electronic visit validations, invoices, and paper claims for payment.

The services must automatically create claims transactions based upon configurable criteria and timelines when a traditional "claim" is not submitted (e.g., Capitation, State Residential Facilities, Case Management, Health Department payments, value-based purchase invoices, non-member specific invoices, Personal Care Adult, Children Foster Care placements, Personal Care allowance, program vouchers, equine therapy, synar services, State facilities, other Enterprise partner non-traditional payments).

Some Enterprise services require tax calculations and actions. Provider 1099 data, as required by the IRS, must be provided to the Enterprise. W2 tax calculations and reporting is also required for some Providers. For example, Personal Care Attendants (PCA) are considered an employee of the Member for whom they provide services and the FS must perform tax functions on behalf of the Member.

In addition to claims processing, the Contractor must calculate and process the capitation (PMPM) payments to MCO. Capitation payments are calculated based upon a combination of data provided by ASPEN, the eligibility and Enrollment system and data regarding the client's authorization for long term care services that will come directly to the FS. The cohort chosen for a client uses multiple cohort factors (e.g., health plan, category of eligibility, age, gender, geographic area, Medicare status, long term care) and can vary over time. The FS must be able to issue and recoup capitation payments as Member changes are identified. The FS must be able to report any Member months that cannot be capitated due to any inconsistency in the enrollment data vs the cohort factors and re-issue retroactive Member months when the inconsistency is resolved.

The Financial Services module must receive all claims regardless of the payer (FFS, MCO, or Enterprise program). Submitters will be instructed to submit claims for clients in managed care in separate files that show the appropriate MCO as the intended payer (i.e., a submitter could be sending 4 files, one for each MCO as payer and one for NM HSD FFS as payer). For FFS claims the FS Contractor will process through the entire claims processing cycle (e.g., ingest, adjudicate against FFS edits, price, apply account code assignment, trigger 835). For MCO claims (claims submitted by providers, clearinghouses, and subcontractors to the MCO for clients enrolled in managed care), the FS Contractor must store within the FS solution the incoming claim without processing. Incoming MCO files will be simultaneously sent to the appropriate MCO which is responsible for adjudicating the claims and returning to the ESB an 835 showing their adjudication results.  A copy of the 835 will be sent to the FS which must ingest, match and update the original MCO claim with the MCO's disposition status (e.g., paid, denied, suspended), the MCO Paid Date, the MCO amounts paid, any COB applied and any interest or fees included, and any error reason codes for denied status claim/lines. The FS must also price any that the MCO reflects as paid. The FS must send encounters with the disposition status of paid or denied as noted on the 835 by the MCOs to the ESB for submission to the DS. The FS is expected to monitor and track MCO claims and if the MCO 835 Encounter is not returned and matched to the original claim within a specified timeframe, defined by the State (not less than 30 days) the FS will send the original claim to the ESB for submission to the DS a status of 'pending' or 'no response'.

Claims processing is critical functionality to the overall MMISR Solution. Because claims payment is sometimes dependent upon other modules for the information required for processing, the Contractor services must be fully integrated with the Enterprise. To process a claim correctly, the services must utilize Provider, Member, PA, TPL, and reference data, in addition to the claims business rules engine (BRE) for edits.

Claims processing must:
- o Accurately capture, adjudicate and provide an audit trail to track Enterprise claims within established time parameters (see SLAs in Appendix K).
- o Provide an EDI for acceptance and transmission of all electronic HIPAA claims, capitation reports, remittances and claims inquiry established in accordance with Enterprise rules re: the level of validation.
- o Provide EDI editing that contains State-directed edits that will cause claims to be rejected.
- o Accept electronic crossover claims, from Medicare system, adjudicate and provide an audit trail to track.
- o Accept attachments and other materials related to claims transactions as required for review and approval. Offeror's services must be able to accept electronic attachment codes as well as physical attachments, in a variety of formats (e.g., word document, scanned image, excel) and associate them to one or more claims for later retrieval and viewing.
- o Adjudicate and edit FFS claims against date-defined criteria by Enterprise-defined business rules for service coverage, policy procedures, and payment parameters such as:
  - ▪ Ensuring Members are properly enrolled and eligible.
  - ▪ Ensuring Providers are properly enrolled and eligible to perform the service.
  - ▪ Appling a hierarchy for claims adjudication when a Member is enrolled in multiple benefit plans which cover the service and coordinate payment across benefits plans based upon configurable rules.
  - ▪ Ensuring the claim is processed based upon a hierarchy across multiple Enterprise programs which may pay for the service.
  - ▪ Ensuring the service is included in the Member's Enterprise program benefit plan.
    - • The FS must support a variety of Enterprise benefit program plans and delivery of services. Each program should have its own eligibility criteria, provider network, reimbursement rules, medical policy, cost

sharing and benefit structure.

- Enterprise (e.g., DOH, CYFD, BHSD, ALTSD, HSD) programs include unique benefit plans (e.g., Children's Special Health Care Services, MiVia, Self-Directed Care, MCO carveout) with their own policies and rules.

▪ Ensuring PA is approved for the services requiring a PA.

▪ Denying payments, or portions thereof, when services are covered under other Enterprise programs, Managed Care, or other liable entity (e.g., Medicare, Veterans Administration [VA], TPL, Casualty Claim)., in addition to payment denial when such services are not covered under the respective program for which payment is sought.

▪ Allowing payment exceptions based upon configurable rules, (e.g., emergency, no provider network capability, carveout) to Providers outside the network.

▪ Denying payments, or portions thereof, when Member has one or more cost sharing amounts due (e.g., patient responsibility, room and board contribution, copay, deductible, coinsurance) and calculate balances.

▪ Maintaining and editing against limited benefits over periods of time (e.g., one [1] appendectomy per lifetime, one dental cleaning per six [6] months) as defined by the Enterprise.

▪ Editing against standard and required coding rules (e.g., The National Correct Coding Initiative [NCCI] in Medicaid [https://www.medicaid.gov/medicaid/program-integrity/ncci/index.html](https://www.medicaid.gov/medicaid/program-integrity/ncci/index.html)).

▪ Editing against Enterprise reference data files (e.g., Member data, Provider data, procedure code and modifier data, diagnosis code, benefit plans).

▪ Denying exact duplicate claim.

- Make accurate and timely payments to MCOs, Providers and others.
  o Payments amounts must be calculated based upon date specific configurable pricing rules which take into account multiple factors, such as:
    ▪ Program specific rates;
    ▪ Rate on file in accordance with State and Federal policy or billed amount, whichever is less;
    ▪ Percentage of rate on file or billed amount, whichever is less;
    ▪ Percentage of charges billed up to a maximum dollar amount;
    ▪ Percentage of Medicare rate;

- Program voucher rates;
- Medicare End Stage Renal Disease [ESRD] pricing;
- Anesthesia pricing using a formula;
- Diagnosis-related group [DRG] pricing, with or without outlier;
- Maximum allowable fee per service;
- Procedure code modifier pricing;
- FFP portion of maximum fee pricing;
- Manual pricing medical consultant-determined rate per service;
- Nursing home daily rate;
- Nursing home claim records on a specific case rate;
- Per diem rate, or a facility per diem rate;
- Nursing home Prospective Payment System (PPS);
- Facility specific per diem rate;
- Outpatient hospital rate per visit day;
- Outpatient PPS;
- Crossover claim pricing, including Part B cutback;
- Incentive payment pricing;
- Pay for performance;
- Individual waiver program pricing methodologies;
- Provider specific;
- Member specific; and
- Geographic area specific.

- Accumulate and provide claims and financial data to the Enterprise.
- Provide the Enterprise both the reports available with the FS service and the data DS requires to create reports.
- Generate remittance advice (RA) for distribution to providers in the format they prefer.
- Identify claims that have been, or are in the process of being, recouped both within the FS and other Enterprise modules (e.g., QA, BMS).
- Include an appeal process with workflow.
- The system must identify Members with TPL and process claims accordingly.
  - If the claim has TPL information and the Member record does not reflect TPL information, then the services must provide the TPL data to the Enterprise.
  - If the claim has TPL information and the Member record reflects TPL information, then FS must calculate the amount payable and provide the TPL cost avoided data to the Enterprise module responsible for collecting TPL data.
  - If the claim does not have TPL information and the Member record

reflects TPL information, then FS must deny the claim and provide the TPL cost-avoided data to the Enterprise assuming the service isn't a pay and chase service.

- o If the claim has indication of an accident, then the claim must be referred to the Quality Assurance module, which is responsible for casualty recovery.

- Maintain proper quality control and continuous process improvement to ensure that the rate of claims processing errors will not exceed 0.5% of the total number of claims processed in any month.
- Manage and use reference data (e.g., HIPAA defined code sets, diagnosis codes, procedure codes, revenue codes, rate/fee schedules) to pay claims.
- Generate clear and complete remittances to providers, clearinghouses, submitters, in electronic format as well as paper according to enterprise rules.
- Accept and store incoming claims submitted for members in managed care and match those claims to data returned by the MCO in an 835 after the MCO has adjudicated the claims, creating encounters to be sent to the DS reflecting the MCO's status, MCO Paid Date, MCO Paid Amounts, COB applied, any interest or fees added, and any exceptions that caused the claim/lines to deny.
- Price any claims adjudicated as paid by the MCO, recording the FFS pricing amount in addition to the amount identified as paid by the MCO in the encounter file going to the DS.

### 2.2.3    Self-Directed Home and Community Based Services

The State is seeking comprehensive services to support Self-Directed Home and Community Based Services (SDHCBS) programs that are flexible, configurable, and meet federal requirements for self-directed waiver programs. SDHCBS programs are intended to provide a community-based alternative to institutional care and facilitate greater client choice, direction and control over the services and supports they receive.

SDHCBS is an umbrella term that covers two programs:

- Mi Via is an FFS program for Medicaid clients who are eligible for the Developmental Disabilities (DD) or Medically Fragile (MF) waiver programs.
- Self-Directed Community Benefit (SDCB) is a managed care program for Medicaid clients who are eligible for the Centennial Care Community Benefit program; it is administered by the Centennial Care MCOs.

The FS Contractor is the Financial Management Agent (FMA) for both the Mi Via and SDCB programs. As FMA, the contractor enters employer (participant) and employee/vendor information, performs background and criminal record checks on

prospective employees, processes employee timesheets, mileage reimbursement requests and vendor invoices, and generates employee or vendor payments on behalf of the participant. In order to function as the FMA for the SDCB program, the FS contractor must enter into contracts with the Centennial Care MCOs. The cost of the contractor's FMA services for Centennial Care members who are eligible for the D&E waiver and elect to self-direct are borne by each member's MCO.

### 2.2.3.1    Service & Support Plans and Authorized Budgets

The contractor's proposed solution must allow for the web-based entry, approval, and modification, as needed, of service and support plans and budgets by authorized individuals. However, the contractor's staff is not responsible for the development and entry of such plans and budgets.

When a client is determined to meet certain SDCB or Mi Via requirements, and is eligible to self-direct, the client or a representative works with a support broker/ or consultant to develop a care plan that defines the services and supports requested by the client, their frequency and duration, their projected cost, and the type of provider who will furnish each service or related good. This plan conforms to the budget that has been established for the client, which is based on the client's Level of Care (LOC) or Intermediate Care Facility/Individuals with Intellectual Disabilities (ICF/IID) LOC, Assessment, and the amount and type of waiver services the client was receiving prior to requesting self-direction. The support broker/consultant enters the plan into the FS contractor's system. In addition to allowing update access to authorized personnel, the contractor's solution must allow clients to view their service and support plan and to signify their approval prior to it being finalized. The contractor's solution must also allow clients to view current utilization of the authorized budget by service in real-time.

### 2.2.3.2    Employer, Employee and Vendor Enrollment

The contractor's proposed solution must support the enrollment of employers, employees and vendors. The employer of record (EOR) is either the client or the client's representative, who may be a family member. The employee is the provider of services to the client. The FS contractor is responsible for the manual and automated activities involved in enrolling both employers and employees, including but not limited to processing federal and state forms (for example, IRS W-9 and USCIS I-9 Forms); entering data into the contractor's system; obtaining license information; fingerprinting prospective employees; and initiating background and criminal record checks. The FS contractor is also responsible for enrolling vendors that provide services and goods approved in the participant's service and support plan The State is seeking solutions that support the electronic exchange of information and forms wherever feasible and minimize the distribution of hard copy documents and forms.

### 2.2.3.3    Timesheet/Invoice Processing and Payment

As the FMA for Mi Via and SDCB, the contractor must handle all payroll functions on behalf of participants who hire direct service personnel, including collecting and processing timesheets of support workers, processing payroll, withholding, and filing of applicable employment-related taxes and insurance. In addition to processing timesheets, the contractor must process and pay invoices for services and related goods that are approved in the participant's service and support plan. An invoice may be for time expended by direct service personnel who are employed by an agency rather than the participant or may be for other approved goods or services. The contractor must also process and pay requests for mileage reimbursement.

As mandated by the 21st Century Cures Act, the State is implementing First Data's Electronic Visit Verification (EVV) system to document the location, time and duration of personal care services, including those rendered under Mi Via and SDCB. The Contractor must interface with the EVV to create timesheets for support workers employed directly by participants.

Under the current system, for a participant to purchase goods that are part of his or her plan, such as a personal computer or tablet from a retailer, an invoice is created, and a check made out to the retailer is cut to cover the cost. The contractor must propose a debit card solution to replace the cutting of checks; this solution must allow the participant to purchase goods that are part of the service and support plan and limit purchases to only such approved goods. The Contractor must also describe how it will audit debit card use to verify that only approved goods and services have been purchased.

The Contractor's solution must track, and report disbursements made on behalf of Mi Via and SDCB participants and provide each participant and support broker/consultant with a monthly report of expenditures and budget status.

### 2.2.3.4    Customer Support, Training and Reporting

The Contractor must provide initial and ongoing training to users of its SDHCBS solution, including State and MCO staff, providers, support brokers/consultants, and participants and their representatives. The Contractor must integrate its services with both components of the Unified Public Interface (UPI). For the Consolidated Customer Service Center (CCSC) component, this means establishing a call center to answer and resolve inquiries received via the CCSC. To support the Unified Web Portal component, the Contractor must make its SDHCBS web service available through the portal so that users have a single point of entry to interact with the Medicaid Enterprise.

The Contactor's solution must allow State and MCO Staff to run and generate

various reports via a user-friendly interface. Reports should include but are not limited to queries on participants, employees, EORs, vendors, and utilization of specific services.

### 2.2.4    Pharmacy Benefit Management

The State is seeking a Contractor who will be responsible for the day to day operational administration of Pharmacy Benefit Management (PBM.) services for New Mexico's Fee for Service population and will require coordination with Indian Health Services and Tribal 638s. In New Mexico, each MCO utilizes a PBM and is responsible for the MCO population that each MCO serves.  The services must be accessible either by a POS device or through the provider's own practice management system and provide online real-time adjudication of pharmacy claims twenty-four (24) hours per day, seven (7) days per week for provider billing purposes. The PBM services must provide the capability to process electronic point of sale and paper transactions. The PBM services must include the following capabilities but are not limited to prior authorization (PA), claim processing including rules and limit application, prospective drug utilization review (Pro-Dur), Third Party Liability (TPL) coordination of benefits and cost avoidance.

In order to process claims, the services must integrate with other MMIS modules through the ESB to obtain the necessary data regarding client eligibility, provider eligibility, other insurance resources, client benefit limitations, MCO enrollment status, and other data necessary for the PBM services to correctly process pharmacy claims.

The PBM services payment methodologies must allow for variable dispensing fees based on provider, refill status, product selection activity by comparing the prescribed National Drug Code (NDC) to the dispensed NDC; variable limitations on days' supply for defined groups of providers or recipients (e.g., Indian Health Service, Tribal 638s); all federal upper payment limits and restrictions, base line pricing, state maximum payment limits (SAC), other payment limitations as directed by HSD, and the ability to reimburse pharmacies as approved and applying various co-pay arrangements as defined or approved by HSD. The services must enforce limitations of program benefits based on client's categories of eligibility, participation in other programs such as hospice and Program of All-Inclusive Care for the Elderly (PACE), residence in an institution, or other circumstances that affect client benefits.

The PBM services must provide Prospective Drug Utilization Review (ProDUR) capability, using online real-time intervention at the point-of-sale with clinical edits to detect therapeutic duplication, drug/disease contraindication, drug/drug interaction, incorrect drug dosage, incorrect duration of drug treatment, clinical abuse or misuse, non-compliance/underutilization, excessive utilization, high cost, and not using first drug of choice. The services must be flexible enough to accommodate any future

changes that may be required by the State.

The PBM services must provide the capability to process prior authorization requests through electronic interface or by manual updates while enforcing prior authorization policies. The PBM services must interface with other services including, Providers, MMIS modules, Children's Medical Services, and other agencies to receive and provide prior authorization information, including entering the approved or denied authorizations into the PBM services. The services must also enforce prior authorization criteria as a requirement for payment as defined by the State.

PBM services must enforce payment policies for clients with insurance or other third-party liability; recognizing Fee for Service claims submitted for members identified to have third-party coverage according to State policies, and the ability to allow providers to submit a third party's carrier identification number and plan/policy numbers for insurance carriers not listed on the State roster.

PBM services must allow sufficient flexibility and adaptability to enforce Pharmacy Program policies, including allowing different dispositions for different client groups, and for encounter data.

The State expects the Contractor to provide full disclosure and pass-through, transparent pricing based upon the PBM's true cost, definition and classification of drugs in which the State receives the value of the PBM's negotiated discounts, rebates, credits or other financial benefits. The financial benefits must remain up to date and any changes obtained by the PBM services pursuit of financial value must concurrently flow to the State of New Mexico.

The State is seeking comprehensive PBM services that are flexible and configurable. At a minimum the PBM services must provide the following:

- Provide a NCPDP Point of Sale service that adjudicates pharmacy claims in accordance with NCPDP standards and transmits real-time responses for POS claims 24/7 in full compliance with NCPDP messages and codes as well as an adjudication system for batch (i.e., encounter) and paper claims;
- Maintain drug data and parameters needed to correctly price drug claims from drug update services, ensuring that the service(s) used are synchronized with the MCOs, and drug data updates from CMS, which includes the Unit Rebate Master File and the Labeler Name and Address File which includes current DESI drug information and supports the State's ability to receive Federal Financial Participation (FFP) for covered outpatient drugs supplied by manufacturers that have a current, signed rebate agreement with the Secretary

of Health and Human Services;

- Utilize client, provider and prior authorization obtained from other modules
- Apply third party liability obtained from other modules at point of service and when indicated via "pay and chase";
- Provide the capability to permit overrides for emergencies, life threatening illnesses, and other situations defined by HSD;
- Price claims using a robust service of pricing customizations and prior authorization based on multiple designs, provider reimbursement rates, "lesser-of" application, generic-vs.-brand differential, and dispensing fee application; and
- Maintain a Drug utilization review data (DUR) and Prospective DUR edits that meet standard NCPDP edits and standards set by the State and DUR board.

### 2.2.5    Drug Rebate

The Contractor must provide a fully functioning Drug Rebate services that performs all aspects of drug rebate including processing and invoicing which excludes actual receipt of payments from manufacturers. The services must be capable of payment tracking and reconciliation and dispute resolution. The services must provide online access to drug-rebatable claims (pharmacy and medical J-Code claims), the Centers for Medicare and Medicaid Services listing of Manufacturers with Drug Rebate Agreements, Centers for Medicare and Medicaid Services listing of quarterly rebate amounts, quarterly rebate invoiced amounts at the NDC Level, and other data as directed by HSD. The Drug Rebate services must at a minimum:

- Provide a drug rebate process that follows the uniform rules prescribed by the CMS, utilizing claims data from the claims processing service and rebate data from CMS;
- Administer drug rebate in a manner that maximizes drug rebate recoveries that include the following:
  - Complete and accurate invoicing;
  - Complete and accurate payment reconciliation; and
  - Minimization or elimination of manufacturer disputes and unresponsiveness.
- Enter manufacturer/invoice information, issuing invoices to manufacturers and resolving disputes with manufacturers, including technical assistance and interfaces with the MCOs and other third parties;
- Provide a service that is capable of functions currently performed manually by HSD's Administrative Services Division, to include but not be limited to:
  - Entering payments into the Drug Rebate service appropriately according to the manufacturer and invoice;

- Maintaining contact with labelers regarding payment and outstanding balances;

- Process daily and weekly interface files from the drug rebate service into SHARE, including requesting drug rebate reports, and reconciliation of detail data to journal entry, approval and posting of journal entry; and

- Maintain a current record of amounts billed and payments received from manufacturers for each quarter with a means of relating payments received to the specific invoiced amounts.

- Provide drug rebate data to Data Services for construction of CMS64 and other management reporting; and

- Produce transactional reports and any reports on activity that are already part of the offeror's Drug Rebate services.

The PBM services must produce reports and other output documents in electronic formats which may be customized to HSD needs, including reports for general program administration. In addition, the services must provide data via the ESB to DS for production of Federal and State reports.

PBM services must provide any financial data via the ESB to the respective systems or modules that may require such data needed for financial transactions.

The PBM services must maintain, operate and staff a Pharmacy Support Help Desk on site in New Mexico. The PBM services Support Help Desk is to be available twenty-four (24) hours per day, seven (7) days per week. The Support Help Desk must respond to inquiries concerning recipient eligibility, provider status, claim status, billing procedures, and remittance vouchers. All Pharmacy Support Help Desk staff must be trained in billing procedures and current New Mexico policy. The Contractor must provide periodic training to its Help Desk staff regarding updated procedure and policies.

### 2.2.6  Data Exchange and Reporting

The Offeror must provide mechanisms for securely exchanging Enterprise required data. The services must provide functionality for sharing claims and financial data, as well as ancillary data provided by MCOs, providers, carriers and other entities, with the Enterprise (e.g., for reporting, for operation of other modules, for contract performance evaluation, for display via the portal(s), for the CCSC components and customer contacts. Each module, including FS, is responsible for sharing data with the other modules through the SI ESB while complying with the standards (e.g., security, data format) established by the SI.

The FS module must provide the Enterprise with either the transactional reporting

and any existing reports available with its service and the data DS requires to create.

The FS Contractor will work with DS on the development of a Financial Dashboard to be implemented on the Internal Unified Portal. HSD is requesting that Offerors describe how their Solution's web application can be integrated using standards-based Presentation Layer Services (e.g., Web Services for Remote Portlets or WSRP 2.0) for consumption by the Unified Portal.

### 2.2.6.1    Providing Enterprise Data
The FS processes must:

- Provide any data specified by Enterprise Stakeholders including but not limited to:

  - Data to produce individual Recipient Explanation of Medical Benefits (REOMB), Explanation of Disbursements, Statements of Account, RA, Explanation of Benefits (EOB) and the supporting data;

  - Data for Enterprise key performance and service level reporting;

  - Data required by the CCSC to resolve member and provider inquiries;

  - Data required by the External UP to resolve member and provider inquiries;

  - Data require by the Internal UP for any financial purpose or process;

  - Claims and financial transaction data to the Enterprise; and

  - Reference data.

- COBA file creation including enrollee eligibility data and adjudicated claim data for the purposes of coordinating benefits (FS and MCO) in the format specified by CMS (https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/COBA-Trading-Partners/COBA-File-Formats-and-Connectivity/COBA-File-Formats-and-Connectivity-page.html).

- Provide data to the Enterprise using standard data formats established by the System Integrator (SI).

- Refer claims and transactions, as appropriate, to the Enterprise for Quality Assurance evaluation (e.g., PI, Utilization, TPL).

- Support Federal Reporting requirements by providing data to the Enterprise.

- Integrate with the IP workflow for data and processes that go across modules and stakeholders.

### 2.2.6.2    Using Enterprise Data
Under MMISR, a fair portion of necessary Enterprise data will be delivered through the IP to Financial Services from other Enterprise modules and systems such as Quality Assurance, Benefit Management Services, Data Services, ASPEN, Social Security Administration (SSA), SHARE etc. The Contractor

must provide services for Using Enterprise Data that provide functionality for acquiring and using data from the Enterprise to receive, process, edit, adjudicate and price claims/encounters or other program obligations for payment, recovery or and accounting purposes. The service must provide functionality to receive payment requests from other entities and perform the State defined accounting actions for the payment. Claims forwarded to the MCO for processing that are paid by the MCO must be priced within the FS module. The MCO will process and provide an 835 to the Enterprise.

Utilizing Enterprise Data processes, the Contractor must:

- Accept data from the Enterprise Framework using established standard data formats.
- Improve claims payment and other financial processes using Member's data including benefit information.
- Utilize reference data provided and managed by the State for use in Enterprise processes.

## 3. Financial Services Deliverables and Deliverables Processes

The Contractor must provide, at a minimum, the contract services, deliverables, project management and administrative responsibilities required for delivery in a timely and complete manner.

Deliverables must be provided in the agreed-upon format to the designated HSD point of contact as required. Before a deliverable can be considered complete it must be accepted in writing by HSD.

HSD must approve, in writing, any changes to milestones, deliverables or other material facets of the contract prior to implementation of such changes. HSD may require concurrence of the Federal partner(s) on such changes prior to their implementation.

Document deliverables for this contract must be provided in electronic media, using the Enterprise software standards listed in Table G1, unless otherwise approved in writing by HSD in advance. The Contractor must provide FS technical documentation as needed to update the Enterprise Performance Life Cycle (EPLC) deliverables for CMS. The CMS EPLC deliverables can be obtained at https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/XLC/Artifacts.html.

The Contractor must use Microsoft tools for reporting on internal project management activities and provide FS documentation and update NM DoIT Enterprise Project Management documents, found at http://www.doit.state.nm.us/docs/project_oversight/project_cert_timeline.pdf.

*Table G 1 Standards for FS Document Deliverables*

| OUTPUT | DOCUMENT STANDARDS |
|---|---|
| Word Processing | Microsoft Word 2013, or newer version |
| Spreadsheets | Microsoft Excel 2010, or newer version |
| Graphics | Microsoft Power Point or Visio 2010, or newer version |
| Schedule | Microsoft Project 2010, or newer version |

## 4. Financial Services Deliverables

For Deliverables, the Contractor must follow HSD's deliverable development and review process, which is intended to ensure a shared understanding of deliverable scope and content from inception through completion of a final product. This process comprises the steps outlined below.

Step 1: Deliverable Expectation Document (DED). Develop a concise, bulleted outline for the deliverable. The outline must include: (a) deliverable name; (b) deliverable purpose; (c) headings- generally to third or fourth level, sufficient to illustrate document structure and sequence in which information will be presented; (d) brief bullet statements at each heading level indicating what will be covered, sufficient to demonstrate the breadth and depth of content; (e) identification of anything that will be expressly excluded from the deliverable (that might be considered part of the topic being addressed); and (f) indication of any sections that will be covered strictly or heavily through the use of tables or graphics. The Contractor must collaborate with the State to reach a shared understanding of the intended Deliverable. Following this discussion, the Contractor must update the DED, if necessary, to reflect changes agreed upon with the State and then must submit the DED to HSD. Both HSD and the Contractor must sign the final DED to indicate agreement.

Should the Contractor discover, as analysis progresses, the need to revise the DED, the Contractor must propose the desired changes to HSD and must obtain agreement on a revised DED before providing the revised Deliverable.

Step 2: Key Content Reviews. In conjunction with DED development, the Contractor must identify key points in the analysis or deliverable development process at which they will conduct collaborative Key Content Reviews (KCRs). A KCR might be done, for example, to review a methodology that will be used to perform further analysis, to review evaluation criteria or weighting schemes, to review key findings, to review assumptions or constraints that will affect analysis. Fundamentally, a KCR is a short review done to keep the Contractor's efforts and the State's expectations aligned and to identify any divergence as early in the analytical and product development process as possible. The Contractor must include collaborative KCRs in

the Work Plan for each deliverable as agreed upon with the State.

Step 3: Perform Analysis and Develop Draft Deliverable. As work to develop a Deliverable is completed, the Contractor must develop a draft deliverable using the agreed-upon DED. After the draft deliverable is thoroughly reviewed, the Contractor must deliver the draft deliverable to the State for review.

Step 4: Review Draft Deliverable. The State will distribute the draft deliverable to the appropriate staff for review. HSD and/or other Stakeholder staff will review the deliverable independently, adding comments in the document. Once individual reviews are completed, the HSD project manager or designated representative will validate comments and provide to the Contractor.

The Contractor should anticipate that the State will require a walkthrough of deliverables part of the review process.

Step 5: Incorporate Comments. The Contractor must review the State comments and must create a Comment/Response Matrix with its responses; e.g., agree to incorporate requested changes, revise wording, or disagree with requested change (and rationale). If there are any changes or comments that the Contractor does not intend to address or does not understand, the Contractor must provide an updated matrix to the State in advance of updating the deliverable. State and Contractor representatives will discuss resolution of those items to arrive at an agreed-upon response to be incorporated in the draft deliverable.

Step 6: Finalize Deliverable. The Contractor must incorporate the agreed-upon changes into a final deliverable. Once the deliverable is thoroughly reviewed and revised as necessary, the Contractor must deliver the final version to HSD.

Step 7: Deliverable Acceptance. HSD staff will verify that all expected changes have been incorporated in the deliverable. Once all agreed-upon changes are verified, the HSD Project manager will notify the Contractor that the deliverable is complete and accepted.

The timeframes for the steps required in the deliverable review processes will be finalized in the contract resulting from this procurement. The State's standard review period for a draft Deliverable is fifteen (15) business days.

**4.1 Functional Business Requirements**

The Offeror must document the services and functionality that it will provide to meet the requirements of all FS as defined by the State. The State expects that assessment of requirements will be an iterative process that will be repeated throughout the Project lifecycle.

The Contractor must perform the work necessary to provide a final set of FS requirements necessary to configure, provide and operate all the proposed services to the State for review. The result shall integrate with the SI, all-inclusive requirements traceability matrix, which utilizes JAMA®. The requirements work must address the items listed in this Appendix G Statement of Work and the requirements listed in APPENDIX H. The Contractor is expected to follow the project requirements processes,

outlined below:

1. Conducting and documenting requirements review sessions as required, including updates and creation of final documents;

2. Conducting a gap analysis of requirements to validate the FS services that meet or exceed the State's requirements;

3. Uploading documents and supporting working documents (as requested by HSD), to the HHS 2020 Document Library; and

4. Adoption and utilization of the SI-defined transmission, security and integration requirements and processes throughout the life of the contract; and

5. Maintaining and sharing complete and timely system documentation for all functions performed.

**4.2 Integration Plan**

Offeror must define in proposal response its integration approach to comply with the MMISR schedule while being compliant with the standards and processes of the SI Contractor for loading or exposing data to the FS module and for sourcing data that must be supplied prior to productive use. The selected Contractor must prepare an Integration Plan that at a minimum must:

1. Identify new and existing data to be integrated, including a map that cites specific data sources and destinations for each field which shall take the form of an approved Data Sharing Agreement, in accordance with Data Governance directives and policies;

2. Define necessary conversion and conforming algorithms;

3. Define roles and responsibilities associated with data conversion/conformity and field population;

4. Identify new and existing data elements in the FS module that must be populated or exposed prior to productive use, including those elements that may not have been captured in HSD's legacy systems;

5. Provide a plan for ensuring the FS module is appropriately populated with all necessary data prior to productive use; and

6. Provide a plan for testing the converted/conformed and populated data in the FS module for accuracy and consistency.

## 5. Data Governance

In collaboration with the State, the Contractor must adhere to the HHS 2020 Data

Governance processes as defined by the Data Governance Council (DGC) to ensure that data available through and from all FS components is accurate, current and complete. The Contractor must participate in the DGC and adhere to all the DGC policies regarding data structure, definitions, values, exceptions, metrics and other directives. The Contractor must utilize the approved tools (e.g., Atlassian suite, Jama, Spark for Enterprise Architecture) in support of the DGC and its policies.

## 6. Security

Security is of primary concern. The State is required to ensure the protection of sensitive or confidential information of facilities and personnel. The Contractor must take all necessary steps to ensure that it and its staff are made aware of the security standards that are to be enforced across the framework and within all the FS components.

While performing work under this contract, the Contractor is responsible for compliance with:

- Addendum 14 - HHS 2020 – Security Privacy and Standards
- Addendum 21 - Security Standards

The Contractor shall integrate these activities with the security plan established by the State and SI Contractor. The Contractor must comply with and ensure compliance with all applicable business, Federal and State security, regulatory security and privacy requirements in addition to adhering to the security standards established by the SI Contractor.

The Contractor must ensure that any controls, required by CMS to attain certification, are satisfied.

## 7. Configure and Provide FS Components

The Contractor must configure, provide and operate all FS components such that the proposed business services provided are fully functioning using CMS-compliant technology and meeting the State's business requirements throughout the life of the contract.

### 7.1 Configuration

Utilizing industry standards, CMS-compliant technology and services, the Contractor must perform all work necessary to configure all the FS components. In addition, when performing this work, the Contractor must:

- Conduct configuration walkthroughs or reviews with State staff and other Contractors as needed or as requested; and
- Plan perform and document testing of all configuration to meet the State's requirements as defined in Appendix H Requirements.

**7.2 Provide FS Components**

The MMISR implementation will occur in phases, with contractors and components coming online on different schedules as opposed to a traditional single waterfall type "big bang" go-live. During this phased approach, some legacy activities will continue to be conducted by the incumbent MMIS fiscal agent. The Contractor must perform all tasks required to put its services into production in accordance with the Enterprise release schedule, including, but not limited to:

- Create a baseline project plan, using an agreed-upon configuration control tool and process, for each FS component's release and scheduled release date(s) approved by the State in coordination and documented with the SI Contractor's integration schedule;
- Verify operational readiness; and
- Provide training necessary to all Contractor and Stakeholder Users.

# 8. Testing

The Contractor must provide a comprehensive strategy and plan for the FS module, working in collaboration with Stakeholders, adhering to the Master Test Management Plan and other contractors where appropriate. This strategy must apply to development and implementation of the module in conjunction with other modules and the SI as well as ongoing change management post implementation. Work must include, but is not limited to:

1. Development of a detailed level analysis test plans and procedures that have been approved by the State to test all changes prior to their implementation;

2. Periodic testing of data restoration from back-up in accordance with State requirements;

3. Performing a disaster recovery test at least annually in accordance with State and CMS requirements;

4. Using automated load, stress, and volume testing software, repeating benchmark performance tests periodically and prior to any large change to the system that may impact performance;

5. Documenting problems identified through any of the tests and ensuring that timely and appropriate corrective action steps are taken to address problems and to mitigate probability of future reoccurrence;

6. Documentation of all test environments; and

7. Distinct SIT, QAT, UAT and additional testing instances as required by the State.

**8.1 Test Plan and Scripts**

The Contractor must define the approach for testing of the FS module and obtain State approval. The Contractor must, when developing test plans and scripts for the FS module:

1. Document and obtain State approval of the Test Plan that:

   a. Defines the overall testing process, including unit, system integration, User acceptance, field, regression, smoke, parallel and performance testing;

   b. Defines a mechanism for tracking test performance and completion;

   c. Defines procedures for managing the test environment, including change control;

   d. Defines procedures for assigning severity to problems encountered;

   e. Defines reporting content and schedule; and

   f. Defines entrance and exit criteria for each round of testing.

2. Create functional test scripts for full requirements traceability. These will be developed by the Contractor and will adhere to the State's quality assurance standards;

3. Generate appropriate de-identified test data, which may include live production data, that is sufficiently representative of production data to enable valid testing;

4. Prepare and maintain test environments throughout the testing process while ensuring all production data meets security standards in any testing environment;

5. Create and modify as needed automated test scripts that will provide end-to-end coverage of base functionality to be run for each release to ensure regression compatibility;

6. Schedule and coordinate testing;

7. Perform QAT and SIT;

8. Integrate and collaborate with the other modules, including SI, to Perform Security Testing (Static Application Security Testing, Dynamic Application Security Testing, etc.);

9. Support UAT for the FS (e.g., run batch jobs, advance system clocks, run queries to provide test data);

10. Document and make available test results;

11. Work closely with the SI Contractor to identify and correct issues that may involve other Contractors' modules;

12. Make all necessary fixes and complete retesting;

13. Analyze test results to identify trends or issues;

14. Report to the State on testing (e.g., issues, pass/fail rate, status against planned testing); and

15. Receive State approval of test results prior to implementation.

**8.2 Tested Software**
The Contractor must ensure that its Solution as configured is ready for business use. The State and its Stakeholders and its IV&V Contractor will participate in system testing and conduct User acceptance testing sufficient to ensure that all functions and components of the Contractor's Solution system are performing acceptably. The Contractor must provide documentation to the State for approval of completed testing. The State will perform and evaluate testing and if satisfactory, will certify the software as functionally ready for use.

**8.3 Load/Volume/Stress Testing Report**
The Contractor must conduct volume/stress testing as directed by the State and document the results of performance testing. Stakeholders will participate in volume/stress testing to ensure that the system can perform adequately with anticipated volumes of queries, reports and other transactions. The completed load/volume/stress testing must include and document:

1. The overall load/volume/stress testing process including frequency;

2. The load/volume/stress testing results;

3. Recommendations for optimizing system performance; and

4. Improvements made to tune the system for optimal performance.

## 9. Enterprise Project Management
Upon contract award, the selected Contractor must adopt and comply with the HHS 2020 Enterprise project management processes and standards. The Contractor's  project management activities must be coordinated with the HHS 2020 EPMO. Where noted below, the Contractor shall integrate with MMISR Project-wide processes and standards so that a single, effective approach to understanding, managing and communicating information about the project is possible by all Stakeholders. HSD hosts and maintains a secured SharePoint principal repository (the HHS 2020 Document Library) that encompasses documentation for HHS 2020. All documents related to procurements and to

subsequent service delivery will reside in the Document Library.

The Contractor must post to the HHS 2020 SharePoint Document Library all documents, including payment deliverables and work products related to the procurement and to the subsequent service delivery. The Contractor must post to the HHS 2020 Document Library all documents, defined in Appendix H, outlined in the schedule, and associated with work under this contract.

## 10. Staffing

The Contractor must provide the staff required to meet the State's requirements for providing all FS components. The Contractor must include a Certification lead and a lead for each business component. The Contractor must assign and utilize staff with the requisite skills to successfully execute all work required under the FS contract. The Contractor must ensure that all applicable background check requirements are satisfied for staff.

1.  The Contractor must manage staff performance throughout assignment to the Project and promptly address any issues, including issues raised by the State, regarding work quality, behavior, accessibility, etc.

2.  Every individual assigned to the Project must comply with HSD training requirements and follow HSD policies and procedures.

3.  The Contractor must report, at least quarterly, to HSD (using an HSD-provided template) key personnel assigned to the contract, including start date, role, location, and compliance with training requirements and access status (e.g., HSD security badge, email address).

4.  The Contractor must implement a consistent and thorough on-boarding process to introduce new staff to ensure that individuals are fully oriented to the environment, goals, status, tools, training requirements and security requirements needed to understand the Project, services, requirements, State and Contractor expectations.

5.  The Contractor must ensure staff complete HSD-required training in a timely manner and that they receive such all other training as may be needed to successfully perform its respective roles.

6.  The Contractor must implement a consistent transition process to ensure that when an employee or contractor leaves the Project all pertinent work materials are stored in the HHS 2020 Document Library, equipment is returned, an HSD Security Access Form is completed to ensure security access is revoked, their HSD badge is returned, and knowledge transfer is accomplished to minimize the adverse impact as staff transitions off the Project.

7.  All Contractor staff must comply with all applicable Federal and State security requirements.

8. No Contractor or subcontractor staff may access, view or receive State data from offshore.

## 10.1 Key Personnel

The term "Key Personnel" means Contractor's staff agreed upon by the State and the Contractor to be both instrumental and essential to the Contractor's satisfactory performance of services requirements. The Contractor must base its Key Personnel staffing model on its detailed project management plan and schedule. The Contractor must consider the changing needs of the Project by phase (as identified in the Medicaid Enterprise Certification Lifecycle) for Financial Services when developing the staffing model. Additionally, the Contractor must maintain a stable Key Personnel team for the duration of the contract.

Offeror must describe, in its proposal, the scope and responsibilities of each Key Personnel position(s), the name, title, skill set, experience and location by phase. Offeror's proposal submission must include a resume for each position proposed. Offeror shall propose a staffing plan and listing of Key Personnel positions, including Certification, that it believes is appropriate and necessary to implement its services.

While the State acknowledges that the Contractor may split staff across clients and projects, Offeror must provide assurance that the Project tasks, schedules and quality of work required of the Contractor, as described in this RFP, will not be negatively impacted by the sharing of Contractor staff across clients or projects.

**Additional Key FS Personnel Requirements**
Offeror must propose staff that meet the following requirements:

1. The Project Manager must be an employee of the Contractor at the time Offeror submits a proposal in response to this RFP;

2. All other Key Personnel included in Offeror's proposal must be current employees of the Offeror or of its identified subcontractor(s) or must have a signed statement of commitment from the individual to join the Offeror's organization not later than the planned contract start date;

3. All Key Personnel must be committed for the initial year of the contract performance period. The State may assess liquidated damages per business day for each business day beyond the thirty (30) calendar days allowed for replacement of a Key Staff position, until such time that the key staff is required for project purposes;

4. The Contractor must request no substitutions of Key Personnel within the first sixty (60) days of the contract unless such substitutions are made at HSD request or they are necessary due to sudden illness, death, resignation or other

reasons to which HSD may or may not approve; and

5.  Changes to proposed Key Personnel positions, staff and responsibilities are allowed only with prior written permission from HSD.

While the Contactor must make every effort to maintain a stable Key Personnel team for contract duration, Offeror must acknowledge that HSD has the right to refuse any replacement, substitution or reassignment of duties for Key Personnel. Prior to making any such changes, the Contractor must obtain written approval of the change from HSD. In all instances, qualifications of replacement staff must be comparable to or better than those of the individual that is being replaced or whose duties are being reassigned.

HSD retains the right to approve or disapprove proposed staffing and to require the Contractor to replace specified Contractor employees or those of subcontractors. All Contractor staff and the staff of subcontractors must perform their work in the United States; no off-shoring of any work under this contract is allowed.HSD retains the right to ask that any Contractor staff be removed from the Project.

## 10.2   Logistical Requirements

The State requires that the Contractor maintain a physical site located within seventy-five (75) miles of Santa Fe, New Mexico. At a minimum, staff in this location shall include the Project Manager and staff supporting resolution of suspended claims, non-pharmacy customer service functions, and coordination with other BPOS. The final location of the Contractor's New Mexico facility must be approved by the State.


Work Hours and HSD Broadband Connection

1.  Business hours for the State of New Mexico are Monday through Friday, 7:30 AM through 5:30 PM Mountain Time (MT) except for State holidays. Contractor staff shall be available throughout normal NM business hours.

2.  If needed, Contractor may request and, the State shall provide at Contractor's expense a broadband circuit to the Contractor, enabling connectivity to the HSD network. To ensure security vulnerabilities are not introduced from the Contractor to the HSD network.

3.  The Contractor shall comply with all HSD and DoIT security controls, including but not limited to, timely implementation of system patches, separation of any wireless network, maintaining up-to-date antivirus protection and implementing perimeter firewalls.

## 10.3   Financial Services Stakeholder Collaboration

The HHS 2020 and the MMISR Project involves a wide range of Stakeholders. While the SI Contractor is responsible for coordinating an integrated approach to Stakeholder

collaboration, the Contractor must collaborate with, participate in meetings with and otherwise coordinate with Stakeholders as required and necessary to complete work under the contract resulting from this procurement.

# 11. Training
The Contractor shall develop appropriate training documentation, in accordance with CMS EPLC requirements, for all FS components. The Contractor shall provide knowledge transfer to the Stakeholders as required.

## 11.1 Training Plan
The Contractor must define the innovative approach and schedule for end-user and technical systems operation/configuration/administration training. The Contractor's Training Plan must address not only use of its services but provide new techniques in training that will enable Stakeholder Users to perform required functions. The Contractor must collaborate with Provider Management services to assure Providers receive the training and technical assistance required to use the Financial Services components. Examples include:

- Regular provider and staff training;

- Technical assistance for payment related issues;

- Targeted provider outreach;

- Bulletins and educational materials to be available to provider communities,

The Contractor must provide to the State and implement a Training Plan that includes at a minimum:

1. Outlines the proposed classes and curriculum for each in-person and online class;

2. Provides a content outline to guide development of online (e.g., self-led tutorials, learning management systems [LMS], distance eLearning, instructor led WebEx) training and classroom materials;

3. Identifies attendees and instructors;

4. Provides a training schedule and sign-up capability;

5. Provides role-based User training and support;

6. Describes the process for accessing Contractor SMEs for training assistance; and

7. Provides a mechanism for tracking completion of training and assistance.

## 11.2    Training Materials

The Contractor must provide content and materials in agreed upon formats (e.g., on-line, printed) with State approval for each training tailored to the FS configuration and contents.

## 11.3    Business User Manual

The Contractor must provide and make available online a Business User Manual to guide Stakeholder staff with the use of all FS. The Contractor must provide online help (e.g., Screen Tip, hyperlinks to other documents, keyword search, chat, tool tips, definitions page, user guide, policy guidance, hover over help) and documentation that supports Stakeholder-specific business use of the FS tools and provides guidance to end Users in correct execution of User-performed application maintenance and report configuration activities.

The Business User Manual must be delivered no less than thirty (30) days prior to User Acceptance Testing (UAT).

# 12. Support and Maintenance

The Contractor is required to provide all the support necessary to operate and maintain its business services over the contract life, including creating and maintaining required documentation. The Contractor shall deliver an approach that:

- Ensures that its services (including all FS components) are available twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year, for 99.999% of the time except for agreed-upon maintenance windows;

- Provides appropriate, tier level support as defined in the contract, via a help desk function available during all State business hours for Users and for other MMISR contractors to address questions or issues involving FS and interaction across the MMISR Solution; and

- Complies with service levels (e.g., response times, resolution times, performance levels, issue resolution and prevention) agreed upon with the State and plans for expanded service capacity as required (see APPENDIX K – HHS 2020 Performance Measures).

## 12.1    Operational Stabilization Plan

The Contractor must provide to the State a detailed task plan, including a readiness checklist and resource assignments, to support moving FS into production.

The go-live task plan must be delivered 30 days before UAT and be updated after UAT is complete, based on lessons learned from UAT.

## 12.2   FS in Operational Use

The Contractor must provide all functioning services configured to meet the State's functional requirements, loaded with data per the Conversion Plan and updated regularly from source systems per the SI Interface Management Plan.

The Contractor must coordinate with the SI Contractor to ensure all FS components adhere to MMISR technical standards and integrate with the other modules within the MMISR Solution. Changes to the FS solution may not be made without the approval of the State and sufficient testing to ensure that the modifications operate correctly without negatively affecting the other MMISR components. The FS Contractor must coordinate with the State, SI Contractor and other BPOs throughout the operation and maintenance of its solution.

## 12.3   Financial Services Support

The Contractor must provide the State with ongoing FS support to include troubleshooting and problem resolution. The Contractor must adhere to the SLAs defined in APPENDIX K-HHS 2020 Performance Measures.

## 12.4   Performance Analysis and Reporting

The Contractor must conduct performance monitoring utilizing tools and reporting that comply with SI and EPMO tools. Performance metrics include, but are not limited to, the SLAs defined in APPENDIX K -HHS 2020 Performance Measures.

## 12.5   Financial Services Quality Management Plan

The Contractor must submit a Quality Management Plan (QMP) for the business services that will integrate with the SI Master Quality Management (QM) and Quality Assurance Plan (QAP).

The Contractor's State-approved QMP must be a guide to an active, independent QM program throughout the contract life. The QMP must include, but is not limited to, the following:

1. Reporting progress to the State regarding project corrective action plans (CAPs) on all deficiencies identified by the QM staff;

2. Conducting work groups to support and proactively engage in Continuous Process Improvement (e.g., streamlining costs, reducing risks, streamlining processes, increasing efficiency) and to measure and report on effectiveness of new approaches or processes; and

3. Regular reporting on QM activities, including but not limited to, work performed, detailed analyses of QM findings, statistics related to the findings and CAPs and statuses.

## 12.6   Optimized the FS Platform

The Contractor must suggest and implement State-approved improvements to achieve optimal performance. The Contractor must complete system optimization and document improvements made to tune the system for optimal performance within State and SI Contractor agreed upon timelines. In addition, the Contractor must ensure that the hardware and software components of its solution remain under vendor support and, at no additional cost, must upgrade to a supported release prior to any hardware or software version falling out of vendor support.

# 13. Business Continuity, Disaster Recovery and Backup

The FS and the MMISR Solution as a whole are mission critical systems for the State. For that reason, continuity of operations is essential. The FS proposed services must maintain availability 24 hours a day, 7 days a week, 365 days a year for 99.999% of the time except for agreed upon maintenance windows.

The Contractor must achieve a Recovery Point Objective (RPO) of five (5) minutes. This is applicable to the FS module only however Contractor is responsible for integration with the SI Platform. All database components of the FS module must be restored within sixty (60) minutes of declaration of disaster.

## 13.1 Business Continuity

The Contractor must develop, document, coordinate and implement a comprehensive Business Continuity Plan that complies with State and Federal standards, integrates with the SI Contractor's consolidated Business Continuity and Recovery plan and process and commits the Contractor to the following:

1. Identifies essential organizational missions and business functions and associated contingency requirements;
2. Provides recovery objectives, restoration priorities, and metrics;
3. Addresses contingency roles, responsibilities, assigned individuals with contact information;
4. Addresses maintaining essential organizational missions and business functions despite an information system disruption, compromise, or failure;
5. Addresses eventual, full information system restoration without deterioration of the security safeguards originally planned and implemented.

## 13.2 Disaster Recovery and Backup

In accordance with the requirements found in APPENDIX H, the Contractor must develop, document, coordinate and implement a comprehensive Disaster Recovery Plan

that includes a secondary DR site. This Plan must address all CMS, DoIT, HSD and other applicable State requirements. The Contractor must update this Plan quarterly, at a minimum, with any required changes to its architecture, application inventory, procedures and processes and the DR Plan must be tested at least annually with documented results.

The Contractor must perform and manage all system backup activities in accordance with the State's policies and requirements, including regular testing of restore procedures and performing capacity management related to backup files. The Contractor also must plan, lead and document an end-to-end disaster recovery exercise at least annually and participate in the Enterprise end-to-end disaster recovery exercise that includes failover of all components with the results provided to the State within thirty (30) days.

The Contractor must develop, document, coordinate and implement a comprehensive Disaster Recovery Plan that both integrates with the SI Contractor's consolidated Disaster Recovery plan and process and commits the Contractor to the following:

1. Performance and storage of incremental and full system backups in accordance with State backup and retention policies;
2. Development, documentation, coordination and implementation of a comprehensive Disaster Recovery Plan that includes a secondary DR site. This Plan must address all CMS, DoIT, HSD and other applicable State requirements;
3. Performance and management of all system backup activities in accordance with the State's policies and requirements, including regular testing of restore procedures and performing capacity management related to backup files;
4. Planning and leading an end-to-end disaster recovery exercise for all FS components at least annually and participate in the Enterprise end-to-end disaster recovery exercise that includes failover of all components;
5. Compliance with State and Federal document retention requirements;
6. Maintenance of a secure and fully replicated recovery version of its Solution at the State's non-production data center;
7. Disaster avoidance, critical partner communications, execution of appropriate business continuity and disaster recovery activities upon discovery of a failure;
8. Timely recovery after a failure, with the ability to successfully roll back to a previous state based upon State-defined timelines;
9. Use of all necessary means to recover or generate lost system data (at Contractor's expense) as soon as possible, but no later than one (1) calendar day from the date the Contractor learns of a loss;
10. Catastrophic failure recovery, disaster recovery, backup (with off-site storage) and rapid failover redeployment, including all stored data;
11. Meeting Recovery Point Objectives (RPO), as defined by the State, to ensure that no data within the RPO window will be lost;

12. Meeting Recovery Time Objectives (RTO), as defined by the State, to ensure that its Solution is available within that timeframe; and
13. The BCP must comply with CMS requirements and the SLAs defined in APPENDIX K - HHS 2020 Performance Measures.

## 14. Financial Services Transition Planning and Management

A smooth and successful transition requires true collaboration and effective communication amongst the State, Stakeholders and the Contractor.

Upon request, or at least one hundred and twenty (120) days before the contract ends, the Contractor must develop and submit a FS Transition Plan that includes, at a minimum:

1. Proposed approach to transition;
2. Transition tasks and activities;
3. Personnel and level of effort in hours;
4. Transition schedule, including tasks and activities, start and end dates of each, dependencies, milestones and resources;
5. List of all FS documentation and schedules for updating documentation before transition; and
6. Any requirements for State or other MMISR Contractor participation.

The FS Transition Plan must take into consideration HSD-provided and other applicable State requirements. After the State, has agreed to the Contractor's FS Transition Plan, the Contractor must implement the plan to transition the FS module to the State or to another Contractor, as required.

## 15. Certification

Contractor shall collaborate with HSD and the MMISR Independent Verification and Validation (IV&V) Contractor through the CMS MMIS certification process including but not limited to the following:

- Ensure that the FS module meets CMS certification requirements;
- Comply with applicable CMS MMIS MECT checklist System Review Criteria for the FS module per Addendum 18 in the procurement library;
- Provide the necessary FS artifacts and evidence for CMS Operational and Final Milestone reviews as defined in the State's Certification Plan;
- Work with HSD and the MMISR IV&V Contractor to review the FS artifacts and evidence and update the documentation if needed; and
- As part of weekly and monthly status report, provide update on FS Certification activities.

Contractor shall refer to CMS Certification guidelines, updated August 2018, at https://www.medicaid.gov/medicaid/data-and-systems/mect/index.html.

Contractor is responsible for the following Certification Activities during all Milestone Reviews:

- Coordinate preparation for FS Certification activities and artifacts;
- Respond to questions from the State, IV&V or CMS for FS components;
- Resolve issues that prevent the State from receiving certification based upon components of the FS Module; and
- Perform required certification activities as necessary for the FS Components.

# APPENDIX H - OFFEROR AND CONTRACTOR REQUIREMENTS

The Contractor ("Contractor") for this MMISR module and services procurement must ensure that its Services meets all applicable State and Federal requirements and standards, including but not limited to those listed in this APPENDIX and those in APPENDIX G. The requirements contained herein will extend through the life of the Project and the FS Contract issued pursuant to this RFP. The RFP is intended to provide clarity of the State's vision for the Project. Offerors must consider the entire RFP when providing responses to the requirements listed herein. As this procurement is for BPO services the Offeror must review the list of SLAs in Appendix K - HHS 2020 Performance Measures found in the Procurement Library and indicate ability to comply with this preliminary list of Services Level Agreements (SLAs) and Liquidated Damages (LDs).

Offerors must respond to the requirements in a requirement/response format and **must** present its cross-referenced response to the requirements in the order in which they are presented below. Offerors also must provide, for each applicable requirement, Product Type (SaaS, PaaS, COTS, OS, ECS, NCS), if it is currently Deployed (Yes - MMIS, Yes - NoDDI, No) and Security Tested within the last 12 months, more than 12 months or not security tested (12, 12+, No). Offerors **also must** respond to the questions that follow the numbered requirements.

Offerors will note that instead of the typical historical MMIS requirements that specify the manner and process by which things are to be done, the requirements contained herein have been written to focus on desired outcomes; i.e., instead of a "how" focus, the focus is on "what." The State is not dictating Offeror's Services; it is interested in securing a Contractor for the Financial Services (FS) component service who brings leading edge service capability that responds to the State's goals and desired outcomes and which offers change improvement coupled with low risk. Offerors should understand that a request for "description of how its Services…." is in effect a performance requirement and an expectation of the Offeror's Services. CMS shares our desire to have a FS Contractor and module which fosters best-in-breed services for the state MMIS, with the selected Contractor responsible for successful integration of the chosen services and infrastructure into a seamless service. The State seeks a Contractor that will enable the State and CMS to achieve that goal through improved performance, adaptability, use of open APIs, more comprehensive services and leveraged experience from similar projects elsewhere.

Prior to preparing proposals in response to this procurement, Offerors are expected to review the SI, DS, CCSC and QA module RFPs as well as the related questions and answers (Q&A's) and addendums for the respective RFPs which may be found in the Procurement Library.

Requirements can be found on the following pages.

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*Table 4 FS Financial Processing Requirements*

| Category | ID | Requirement |
|---|---|---|
| Financial Processing (Payment Processing) | 1.001 | Offeror shall describe how its proposed services process multiple programs within the system. All transactions must be assigned time-span appropriate financial coding and such coding and time-spans maintained so that:<br>• Updates are done as defined by the State (e.g., fiscal year), coding spans are maintained, and processes to update coding are user-friendly;<br>• Service payments can be linked to the correct funding source and report line definition;<br>• Funding codes are aligned with the Enterprise accounting systems funding code sets and chart of accounts;<br>• Payment data is cross walked and validated using Enterprise defined business rules (e.g., Category of Service [COS] matching, NM State Government chart of accounts, program code, reason code, account code assignment, budget category, Federal COS defined in CMS Financial Reports);<br>• FMAP and FFP rates are used to calculate, apply, record and maintain, for each transaction, as appropriate to include the Federal Categories of Service;<br>• The categories of eligibility and categories of service that are used are approved by the State and facilitate accurate CMS-64 reporting;<br>• Payment funds and fund types are captured;<br>• Program funding sources, financial and enrollment caps are identified and notification occurs based upon State configurable rules as thresholds are approached;<br>• State and Federal Budget categories are accessed, identified and tracked at the detail level;<br>• Public and private providers are identified and distinguished for reporting purposes; and<br>• Children's Medical Services, non-Medicaid services, Home and Community Based Services (HCBS) Waivers, School-based services, incarceration facilities and other State designated programs identified separately from other transactions. |

| Category | ID | Requirement |
|---|---|---|
| Financial Processing (Payment Processing) | 1.002 | Offeror shall describe how its proposed services allocate costs for non-Medicaid transactions. |
| Financial Processing (Payment Processing) | 1.003 | Offeror shall describe how its proposed services allow authorized users or systems to apply multiple payment types or other financial transaction dispositions and reasons manually or automatically using configurable business rules including but not limited to:<br>• Requires or does not contribute to 1099/W2 calculations or adjustments;<br>• Holds, voids, adjustments;<br>• Timing, date spans, recurring;<br>• Other types as necessary to process or report financial transactions;<br>• Disposition to the correct AR records of manually or electronically receipted payments based on user-defined parameters;<br>• Recovery payment adjustments received from third parties that do not affect the provider's 1099/W2;<br>• AR detail with drill-down and links to related accounts, receipts and claims or other supporting documentation; and<br>• Mass AR transactions declaring accounts uncollectable, both individually and in mass, with the proper authority based on a user defined AR threshold. |
| Financial Processing (Payment Processing) | 1.004 | Offeror shall describe how its proposed services coordinate benefits to adjust co-payment amounts for services that are reimbursed (e.g., carriers, Medicaid, Medicare) as mandated by State and Federal requirements. |
| Financial Processing (Payment Processing) | 1.005 | Offeror shall describe how its proposed services flag accumulators and related dollar amounts (e.g., co-pays, Out of Pocket [OOP], procedure/service limits). |
| Financial Processing (Payment Processing) | 1.006 | Offeror shall describe how its proposed services recalculate balances when an adjustment (e.g., Per Member Per Month [PMPM] reconciliation errors [e.g., retroactive member enrollment, disenrollment, termination], claim, invoice) is |

| Category | ID | Requirement |
|---|---|---|
| | | completed. |
| Financial Processing (Payment Processing) | 1.007 | Offeror shall describe how its proposed services monitor, identify, record, maintain and release a claim or payment issuance limit, delay or hold, according to Enterprise configurable business rules including, but not limited to:<br>• A specified future release date is reached;<br>• Vendor, member or provider type;<br>• Billing or rendering status;<br>• To satisfy an outstanding debt to the Enterprise or legal third party (e.g., Medicare, IRS, State taxation authorities);<br>• Minimum payment amount limits and time period since last payment;<br>• As directed by an authorized Enterprise user;<br>• Other user-configurable parameters (e.g., timeframe); and<br>• Offset. |
| Financial Processing (Payment Processing) | 1.0008 | Offeror shall describe how its proposed services manually or automatically generate and process advance disbursements and payments (e.g., gross payables in advance of claims disbursements and payments, timed gross adjustment recoveries spread over time, adjustment recoveries as percentages or fixed amounts). |
| Financial Processing (Payment Processing) | 1.0009 | Offeror shall describe how its proposed services maintain a payment hold on payees by reason (e.g., determined to be out of cost report compliance, change of ownership, voluntary closure, are subject to liens and court orders, are out of compliance with Enterprise program policies and procedures). |
| Financial Processing (Payment Processing) | 1.010 | Offeror shall describe how its proposed services accurately and timely generate automatic or manual disbursements and payments for provider, vendor member, insurance carrier or other non-provider populations based on approved documentation (e.g., adjudicated claim, invoice, accounting transaction request) in accordance with program, State and Federal policies and guidelines (e.g., primary care case managers [PCCM], Tribal Health Centers, Federally Qualified Health Center [FQHC], beneficiaries, retroactive fee-for-service [FFS] Disbursements and Payments to MCOs, foster |

| Category | ID | Requirement |
|---|---|---|
| | | care and home help, counties, school based services, public health clinics or any other contractual relationships, Prospective Payments not based on claims, capitation, lump sum delivery, DSH, incentive Disbursements and Payments). |
| Financial Processing (Payment Processing) | 1.011 | Offeror shall describe how its proposed services processes payment exceptions and special cases (e.g., User-definable financial thresholds for contracts and budgets, application of Medicaid Upper Payment Limits to payments, suppression of payment generation for Enterprise-controlled facilities and school-based Providers while identifying expenditures for budget reconciliation, "wrapping" or supplementing monthly clinic payments made to Medicaid clinic Providers such as Rural Health Clinic [RHC] and Federally Qualified Health Centers [FQHC], suppress printing or transmitting zero balance payments while producing a remittance advice) as directed by the State. |
| Financial Processing (Payment Processing) | 1.012 | Offeror shall describe how its proposed services create and send an Automated Clearing House (ACH) file to the State's bank in order support Electronic Funds Transfer (EFT) and a payment file to the State for printing of paper warrants (checks) for those entities that are not set up for EFT. |
| Financial Processing (Payment Processing) | 1.013 | Offeror shall describe how its proposed services issue payments based upon provider ownership information and assure that payments, including appropriate tax information for the provider that billed the service, are made to the appropriate provider location. |
| Financial Processing (Payment Processing) | 1.014 | Offeror shall describe how its proposed services enter, use and record all applicable dates (e.g., receipt, effective, posted) for distribution of all collections (e.g., maintains a history of claim recovery payments in excess of expenditures and allows distribution to the appropriate parties, including providers, Members, or insurers) and recompute if appropriate. |
| Financial Processing (Payment | 1.015 | Offeror shall describe how its proposed services support dynamic financial cycle controls based on Enterprise configurable business rules or by authorized User intervention |

| Category | ID | Requirement |
|---|---|---|
| Processing) | | to include, but not limited to:<br>• Immediate processing of financial activities;<br>• Prioritization of transactions by submitter and transaction type;<br>• Delaying, suspending or changing processing order of transactions;<br>• Changing take back schedules;<br>• Adjusting the timing of any payment cycle (e.g., daily, weekly, monthly) or disposition as directed by the Enterprise;<br>• Generate expedited payments outside of the normal payment cycle as needed; and<br>• Configuring the date and other specific values for accounting segments. |
| Financial Processing (Payment Processing) | 1.016 | Offeror shall describe how its proposed services identify, track, maintain, verify, adjust, test and report W2 and 1099 information for Providers, vendors and other payees as applicable to maintain compliance with appropriate W2 and 1099 regulations. |
| Financial Processing (Payment Processing) | 1.017 | Offeror shall describe how its proposed services withhold the Federal share for payments that are made with State approval but which exceed CMS timeliness requirements. |
| Financial Processing (Financial Transactions) | 1.0018 | Offeror shall describe how its proposed services initiate and approve receipt adjustments (both automatic and by authorized users) and multiple adjustments to a single receipt (e.g., claim id, case number, receipt date, payment source, amount). |
| Financial Processing (Financial Transactions) | 1.019 | Offeror shall describe how its proposed services provide the ability to link specific re-adjudicated claims to specified balances and to determine net balance for the re-adjudicated claims. |
| Financial Processing (Financial Transactions) | 1.020 | Offeror shall describe how its proposed services identify using unique Enterprise identifier (ID) (claims ID, case number, SSN, Transaction Identification Number (TIN), other approved IDs), initiate, record, and maintain all recoupment and collection activities (e.g., lump sum, case, participant |

| Category | ID | Requirement |
|---|---|---|
| | | level) allowing for the collection of individual receivables to be suspended but still reported. |
| Financial Processing (Financial Transactions) | 1.021 | Offeror shall describe how its proposed services record and maintain the recoupment recovery method (e.g., dollar amount, percentage). |
| Financial Processing (Financial Transactions) | 1.022 | Offeror shall describe how its proposed services manage accounts payable and receivable transactions including but not limited to:<br><br>• Automatically, or by authorized user, create accounts payable and receivable for any type of payee (multiple for the same payee as appropriate), that are based on a system or authorized user selection of claims or other transactions, to collect vendor or provider cost share for a service, when net transaction of payments and financial transactions results in a negative amount and establish a user-created AR account and associate a user defined reason to that account;<br><br>• Allow creation of AR that can be adjusted to reflect a percentage, scheduled amount to be paid or other criteria;<br><br>• Track and provide user defined aging criteria for AP and AR, identify open aging ARs based upon Enterprise configurable rules and refer such ARs for follow up for compliance with State and Federal regulations;<br><br>• Establish, monitor and maintain receivable balances for each payee and provide information to the Enterprise through reports, electronic transactions and as defined by the State.<br><br>• Allow easy online access to outstanding account summary information;<br><br>• Reduce the amount of open AR by applying claim or other payment amounts to the debt and automatically create AR when recoupment is realized;<br><br>• Void processes are performed, and the debt cannot be |

| Category | ID | Requirement |
|---|---|---|
| | | satisfied by the current payment amount;

• Provide the capability to allow the transfer of AR when providers go through change of ownership or other legal restructuring;

• Create hierarchy(s) for resolution of ARs based on Enterprise defined rules;

• Allow the development of a schedule for each adjustment event;

• Allow scheduled payments from a payee based on percentages, set payment amounts or other criteria relating to the total amount owed;

• Allow for claim-specific AP/AR at both header and detail levels;

• Allow for netting of payments, based upon Enterprise configurable rules, against credit balances or account receivable amounts due in the payment cycle in determining the payment due and for future claims to hit against any AR uncollectable accounts; and

• Ensuring that the status and date on the claim aligns with the status and date of a payment. |
| Financial Processing (Financial Transactions) | 1.023 | Offeror shall describe how its proposed services maintain an online AR that can update, process and report financial data by transactions types including at a minimum:
• Account details as applicable (e.g., Member ID, drug rebate manufacturer code, Provider ID, vendor ID, insurance company [carrier] ID, account balance, payment netting or withholding methodologies, reason indicators, type of collection, authorizing entity or party, claim  ID);
• Due date for recoupment;

• Program and authorizing agency to be charged;
• Entities (e.g., individual, provider, organization, corporation) responsible for an AR account;
• Detailed comments; and |

| Category | ID | Requirement |
|---|---|---|
| | | • Other Enterprise program data. |
| Financial Processing (Financial Transactions) | 1.024 | Offeror shall describe how its proposed services provide access to AP/AR detail with links to related information (e.g., accounts, receipts, invoices, claims). |
| Financial Processing (Financial Transactions) | 1.025 | Offeror shall describe how its proposed services conduct AR activities according to Enterprise rules. |
| Financial Processing (Financial Transactions) | 1.026 | Offeror shall describe how its proposed services process, with proper authorization and documentation, financial transactions, including advances, cost settlements, gross level payouts to providers; including but not limited to: <br>• Calculation of disproportionate share and related payments, per business rules; <br>• Update of cumulative totals by applying all payments and recoupment, including those resulting from cost settlements and manual warrants; and <br>• Capture non claim specific recoupments including but not limited to FQHC settlements, PI recoveries and appeal recoveries, as specified by State and Federal rules and policies. |
| Financial Processing (Financial Transactions) | 1.027 | Offeror shall describe how its proposed services identify, generate, process and disburse refunds on a schedule specified by Enterprise or configurable business rules. |
| Financial Processing (Financial Transactions) | 1.028 | Offeror shall describe how its proposed services process payments from Providers for refunds and updates records (e.g., history, original claim). |
| Financial Processing (Financial Transactions) | 1.029 | Offeror shall describe how its proposed services allow authorized Users to perform the following "for claim", "Provider or Vendor-specific" or "Member-specific" and "non-specific" financial transactions and communicate such activities with the Enterprise, including but not limited to: |

| Category | ID | Requirement |
|----------|-----|-------------|
| | | • Submit gross or single transaction adjustments;<br>• Perform mass and individual financial adjustments;<br>• Accept returned financial transactions;<br>• Void payments issued by voiding or cancelling outstanding checks and/or EFTs and adjusting associated claims according to Enterprise direction, crediting fund source accounts and creating accounts receivable or credit balances where appropriate;<br>• Reissue payments as appropriate and update records with new warrant or other payment type information;<br>• Issue manual or automated payments;<br>• Accept and receipt payments received;<br>• Transfer, void, split payments received between multiple financial codes, claims and accounts receivables;<br>• Suspend or hold a payment or group of payments based on user defined criteria (e.g., fraud or willful misrepresentation);<br>• Automatically reverse all related financial transactions, as appropriate, upon entry of any voided entry;<br>• Perform mass and individual recoupments and withholds based on various selection (e.g., provider, member, lien, cost settlement) and methodology criteria (e.g., percentage, flat rate, payback plan) until outstanding balance is satisfied;<br>• Process replacements for lost or stolen warrants and update records with new warrant information;<br>• Process provider refunds;<br>• Accept returned payments and void previous related transactions;<br>• Automatically notify vendors, providers, members, or Enterprise users of the change to include appropriate claim or other appropriate detail;<br><br>• Designates portions of claim amounts collected to reimburse CMS and the State with any remainder paid to the recipient;<br>• Suppress notification of vendors, providers, members, or Enterprise users if authorized and is allowed by program rules; and<br>• Perform any necessary next appropriate actions. |
| Financial | 1.030 | Offeror shall describe how its proposed services verify, |

| Category | ID | Requirement |
|---|---|---|
| Processing (Financial Transactions) | | validate and resolve errors around all financial activities entered into or processed by the FS system including but not limited to:<br>• Payment data entered using Enterprise defined business rule logic (e.g., COS matching, Program Code, Reason Code, Account Code Assignment, FMAP/FFP assignment);<br>• Adjustments and mass adjustments;<br>• Resolutions of payment errors;<br>• Transactions requests (e.g., accounts receivable, accounts payable adjustments prior to processing a transaction); and<br>• EFT and warrants and other payment types are issued only to the correct payee account. |
| Financial Processing (Financial Transactions) | 1.031 | Offeror shall describe how its proposed services automatically assign or accept unique control numbers and identifying criteria (e.g., batch number) to monitor, track and maintain control over financial transactions (e.g., claims, invoices, PMPM capitation, non-claim, incentive payments) as defined by the State. |
| Financial Processing (Financial Transactions) | 1.032 | Offeror shall describe how its proposed services provide a preview of the impact of a 'proposed' transaction(s)/modification(s) for acceptance or re-do. |
| Financial Processing (Billing & Collections) | 1.033 | Offeror shall describe how its proposed services review financial information (e.g., outstanding accounts receivables, outstanding payables) for payees for whom bankruptcy notices are received either directly or as referred by the State. |
| Financial Processing (Billing & Collections) | 1.034 | Offeror shall describe how its proposed services check on the status of bankruptcy cases in accordance with the State defined review schedule and take appropriate follow-up action as the status changes. |
| Financial Processing (Billing & Collections) | 1.035 | Offeror shall describe how its proposed services automate the "Claw Back" process and Medicare accounts payable process. |
| Financial Processing (Billing | 1.036 | Offeror shall describe how its proposed services identify, define, generate, process, calculate, apply and maintain history |

| Category | ID | Requirement |
|---|---|---|
| & Collections) | | on garnishments and liens using configurable business rules including but not limited to:<br>• Define third party garnishment criteria as specified by the Enterprise;<br>• Produce claim and provider specific information for generating warrants to third parties with garnishments on a payee's payment(s);<br>• Process garnishments and liens within three (3) business days of receipt or in accordance with court documents, whichever is earlier; and<br>• Apply automated or user defined payment calculation rules. |
| Financial Processing (Billing & Collections) | 1.037 | Offeror shall describe how its proposed services track, identify, maintain and manage recovery cases, AR/AP and overpayment recoupments using configurable business rules. |
| Financial Processing (Billing & Collections) | 1.038 | Offeror shall describe how its proposed services identify and collect outstanding receivables directly from providers when netting procedures are not possible, or appropriate, using configurable business rules. |
| Financial Processing (Billing & Collections) | 1.039 | Offeror shall describe how its proposed services manage the payment offset process to collect receivables, such as recovering from provider future payments (e.g. claims, prospective payments, supplemental payment reconciliation) when not disputed. |
| Financial Processing (Billing & Collections) | 1.040 | Offeror shall describe how its proposed services provide multiple receivable categories (e.g., TPL, audit, overpayments, fraud, escrow, cost report reconciliation balance, supplemental payment reconciliation balance) to be identified, collected and reported by category. |
| Financial Processing (Billing & Collections) | 1.041 | Offeror shall describe how its proposed services support multiple types of payment receipts (e.g., check, cash, money order, electronic check, ACH, debit card, automatic draft withdrawal from designated bank accounts, via telephone, mail, web portal) and provides administrative expense accounts for costs associated with alternate payment types based on configurable business rules. |

| Category | ID | Requirement |
|---|---|---|
| Financial Processing (Billing & Collections) | 1.042 | Offeror shall describe how its proposed services provide a configurable process allowing authorized users to modify collection calculations and be flexible to allow new State and Federal rules. |
| Financial Processing (Billing & Collections) | 1.043 | Offeror shall describe how its proposed services apply money received for claim specific and non-claim specific AR balances based upon State configurable rules (e.g., to a Provider's outstanding, non-claims specific ARs first, regardless of the age of the ARs). |
| Financial Processing (Billing & Collections) | 1.044 | Offeror shall describe how its proposed services automate post payment recovery processes based on Federal and State defined criteria. |
| Financial Processing (Billing & Collections) | 1.045 | Offeror shall describe how its proposed services recognize and track collections and disbursements obtained from private collection agencies. |
| Financial Processing (Billing & Collections) | 1.046 | Offeror shall describe how its proposed services perform mass recoupments based on user-defined selection criteria with automated Provider notification. |
| Financial Processing (Billing & Collections) | 1.047 | Offeror shall describe how its proposed services identify and refer accounts to the Enterprise that are uncollectable or have not been satisfied per agreed upon payment plans or other mechanisms established to satisfy account receivable. |
| Financial Processing (Billing & Collections) | 1.048 | Offeror shall describe how its proposed services identify providers with no activity, Out of Business Provider/aged receivables to identify uncollectable and potentially uncollectable receivables to reclaim Federal share. Offeror shall generate appropriate backup documentation and responses, for the State's use, in reclaiming FFP (on the CMS-64) in those instances in which previously returned FFP on uncollectible accounts receivable become eligible for repayment to the State. |
| Financial Processing (Billing | 1.049 | Offeror shall describe how its proposed services have the ability to identify, record, maintain payment with related types and update source codes (e.g., SSA, Lump Sum) and/or |

| Category | ID | Requirement |
|---|---|---|
| and Collections) | | method of collection(s) with a status (e.g., suspense, unidentified). |
| Financial Processing (Billing and Collections) | 1.050 | Offeror shall describe how its proposed services identify, configure, calculate, assess, pay, record, maintain, adjust, void and otherwise manage fees (e.g., interest, penalties, surcharges, pass on costs) based on Enterprise and user-configurable rules to allow for, but not limited to the following:<br>• Assessing or pay unique fee rates or values at configurable timing and reoccurrence on various account types and transactions at the detail level (e.g., AR, AP, obligations);<br>• Claim submission penalties (e.g., paper, electronic, exceeding volume caps, clean claim);<br>• Pass on fees for services (e.g., court costs, process server, collection fees, genetic testing); and<br>• Assessments, payments, adjustments, reversals, holds and the ability to refrain from fee assessments or payments based on trigger events (e.g., adjusting a claim originally paid to include interest, claims submission penalties, AP paid in full) or authorized User intervention. |
| Financial Processing (Billing and Collections) | 1.051 | Offeror shall describe how its proposed services calculate interest and other money owed separately by account and applies receivables to various accounts with the flexibility to waive interest as directed by the State. |
| Financial Processing (Billing and Collections) | 1.052 | Offeror shall describe how its proposed services apply full and partial payments (both automatic and by authorized users) to satisfy fee collection before satisfaction of debt according to State rules or as directed by the State. |
| Financial Processing (Billing & Collections) | 1.053 | Offeror shall describe how its proposed services provide a mechanism for searching, sorting, and categorizing collections. |
| Financial Processing (Billing & Collections) | 1.054 | Offeror shall describe how its proposed services integrate with the IP Notification Engine to generate (automatic and manual) initial and follow-up notices/bills/invoices (in a user-defined format including paper, email or web posting, based on user- |

| Category | ID | Requirement |
|---|---|---|
| | | defined criteria) for accounts receivable. |
| Financial Processing (Billing & Collections) | 1.055 | Offeror shall describe how its proposed services generate, adjust and maintain AR invoices using configurable business rules to include, but not limited to:<br>• Generating updated invoices when the underlying AR or sub-account is updated or changed;<br>• Maintaining historical records of invoice lines and disposition (disputed, accepted, paid, rejected); and<br>• Querying of any AR invoice or invoice line item including linkages back to any claims usage detail. |
| Financial Processing (Billing & Collections) | 1.056 | Offeror shall describe how its proposed services generate, record, deliver (electronic and/or paper format), and maintain billing statements based on a configurable timeframe while recognizing that billing statements must contain payment identifier(s) that are compliant with payment processing requirements (e.g., Lockbox). |
| Financial Processing (Billing & Collections) | 1.057 | Offeror shall describe how its proposed services provide configurable (automatic and manual) billing statement processing (e.g., Employers, Third Party) that allows for billing statements suppression (paper or electronic). |
| Financial Processing (Billing & Collections) | 1.058 | Offeror shall describe how its proposed services generate Electronic Billing in the X12 5010 837 format as needed. |
| Financial Processing (Billing & Collections) | 1.059 | Offeror shall describe how its proposed services process electronic payments (e.g., from providers, third parties, members) securely (e.g., National Automated Clearing House Association [NACHA] rules for electronic data interchange [EDI]) and monitor from receipt to accounting/application of each payment. |
| Financial Processing (Billing & Collections) | 1.060 | Offeror shall describe how its proposed services include a repository to maintain check receipts with Enterprise access that tracks and reports existing cases, AR/AP, overpayments, Enterprise originated invoices (e.g., check numbers, payer, payee, date, amount, memo), with seamless interfacing to contracts, Revenue codes, SHARE, case management, |

| Category | ID | Requirement |
|---|---|---|
| | | provider, recipient, manufacturer, labeler, drug rebate invoices, credit balance reporting. |
| Financial Processing (Billing & Collections) | 1.061 | Offeror shall describe how its proposed services log cash and checks securely, monitoring cash and checks from receipt to accounting/application of that receipt. |
| Financial Processing (Billing & Collections) | 1.062 | Offeror shall describe how its proposed services associate payment receipt data to the documentation and/or associated data of the billing instrument (e.g., collection, bill, invoice). |
| Financial Processing (Accounting Detail & Interfaces) | 1.063 | Offeror shall describe how its proposed services integrate with other Enterprise agencies and entities to establish business rules and reusable services for automating the cost settlement process, assisting the State to establish and maintain cost settlement procedures, establish a basis for cost settlement or compliance reviews, calculate the final annual cost settlement and validate cost settlement data. |
| Financial Processing (Accounting Detail & Interfaces) | 1.064 | Offeror shall describe how the proposed services accommodate collating financial information across multiple agencies and multiple systems (e.g., SHARE, BMS, QA) to facilitate two-way sharing of financial data including, but not limited to: <br> • Capture all financial transactions as defined by the Enterprise; <br> • Integrating, reconciling and tracking account code balances, payables and receivables, warrants, EFTs, Federal and State financial reports and other financial transactions between financial systems and identifying and correcting balancing issues; <br> • Providing the Enterprise with complete Federal and State financial reporting data where some data resides in other systems (e.g., CMS-64 data resides in both SHARE and FS); <br> • Linking and tracking FS transaction detail (e.g., claims, invoices, adjustments) to items generated in or for other systems (e.g., SHARE will print and manage information about all warrants, FS will send a file of warrants to be recorded, printed and distributed); <br> • Accommodate multi-agency recoupment and recovery |

| Category | ID | Requirement |
|---|---|---|
| | | services in FS and other Enterprise systems;<br>• Processing appropriate transactions (e.g., payments, adjustments, administrative adjustments, distributions, recoveries, stale-dated warrants or payments) from other Enterprise systems;<br>• Providing financial data (e.g., claims, accounts receivable, payments, dispositions, distributions, recoveries) to other Enterprise systems for their internal use and with their required data fields and format; and<br>• Update claims and provider files with information about returned, stopped payment or cancelled checks forwarded from DFA. |
| Financial Processing (Accounting Detail & Interfaces) | 1.065 | Offeror shall describe how its proposed services integrate and collaborate with the Enterprise to provide and receive data capture forms to support any business process or function (e.g., accounting transaction request forms, HIPAA transaction sets). |
| Financial Processing (Accounting Detail & Interfaces) | 1.066 | Offeror shall describe how its proposed services provide fund transfers including but not limited to:<br>• Estimate aggregate payment cycle amounts on various schedules mandated by the State;<br>• Collected fund deposits and expenditure refunds; and<br>• Identification of funds due to/from Enterprise entities from other Enterprise programs or external programs. |
| Financial Processing (Accounting Detail & Interfaces) | 1.067 | Offeror shall describe how its proposed services collaborate with the State and its designees to develop financial management procedures that implement the State approved rules and processes for:<br>• Financial transactions, payments and refunds processed by the FS;<br>• Segregating all transactions involving expenses by State and Federal fiscal years;<br>• Recording financial transactions appropriately and in accordance with Generally Accepted Accounting Principles (GAAP) and Government Accounting Standards Board (GASB) in the accounting records managed by FS;<br>• Coordinating activities with State financial units and all |

| Category | ID | Requirement |
|---|---|---|
| | | vendors responsible for handling finances on behalf of the State;<br>• Ensure correct disposition of financial transactions;<br>• Maintain cash management techniques to include managing zero-balance bank accounts;<br>• Disburse and distribute funds timely and appropriately;<br>• Provide documentation to Enterprise Users, Providers, Vendors, Members as appropriate;<br><br>• Maintain enough information in transactions to allow for cash, accrual and modified accrual basis; and<br>• Integrate quality improvement for financial processes through collaboration with Enterprise stakeholders. |
| Financial Processing (Accounting Detail & Interfaces) | 1.068 | Offeror shall describe how its proposed services manage, reconcile and balance various types of accounts and financial activities at periodic intervals and generate all appropriate adjustments to support data reconciliation of various accounting systems while ensuring retroactive changes do not change periodic closing totals but retains them while reflecting revised totals. Reconciliations include, but are not limited to:<br>• Monthly bills/invoices from vendors (e.g., Process Servers, GT Vendors, value-based payments);<br>• Budget and expenditures to grant authorizations and Federal draws using State and Federal Budget categories;<br>• Payment accounts by funding source;<br>• Received and transferred funds;<br>• Weekly check write or warrant write amounts;<br>• Liens and garnishments;<br>• Cash and check receipts against repositories; and<br>• Financial reports to transactions and transaction sources (e.g., CMS 64). |
| Financial Processing (Accounting Detail & Interfaces) | 1.069 | Offeror shall describe how its proposed services have the ability to display, search and filter unidentified payments in suspense, and record and maintain research history. |
| Financial Processing | 1.070 | Offeror shall describe how its proposed services accommodate audits and on-site inspections by the State of New Mexico, the |

| Category | ID | Requirement |
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| (Audits) | | State Auditor, CMS, the U.S. Comptroller General, the U.S. General Accounting Office, or their authorized representatives. |
| Financial Processing (Audits) | 1.071 | Offeror shall describe how its proposed services provide support for hearings, legal cases, audit, inquiries, and other studies as required, including testifying, attending meetings or other scheduled events, responding to subpoenas as directed by the Procuring Agency, and providing other documentation as required. |
| Financial Processing (Audits) | 1.072 | Offeror shall describe how its proposed services provide, through an independent contractor, an in-depth electronic data processing (EDP) audit of internal controls in accordance with the Auditing Standards Board's "Statements on Standards for Attestation Engagements No. 16" (SSAE 16), a formal written report of which shall be provided to the State no later than August 15 following each State Fiscal Year or portion thereof that the contractor provides operational services. |

*Table 5 Claims Processing Requirements*

| Category | ID | Requirement Text |
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| Claims (Ingesting via web portal) | 2.001 | Offeror shall describe how its proposed services perform balancing procedures (e.g., controls, tracks, and reconciles captured claims and validates that all claims received are processed identify claims input for control and balancing [hardcopy and electronic media]) to guarantee control within the claims processing cycles. |
| Claims (Ingesting via web portal) | 2.002 | Offeror shall describe how its proposed services accept portal (web portal [provider, clearinghouse], SFTP web portal) and/or web-based individual and batch electronic claim submissions (e.g. direct SFTP) and adjustments in Health Insurance Portability and Accountability Act (HIPAA) standard formats and assigns a unique Transaction Control Number (TCN) rejecting only |

| Category | ID | Requirement Text |
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| | | individual bad claims and accepting all others. |
| Claims (Ingesting via web portal) | 2.003 | Offeror shall describe how its proposed services accept web-based individual and batch timesheet submissions, payment requests, and mileage reimbursements. |
| Claims (Ingesting via web portal) | 2.004 | Offeror shall describe how its proposed services send HIPAA compliant standard electronic transactions (e.g., ASC X12N 820, 835, 837, 997, 999) per the standards required by 45 CFR Part 162. |
| Claims (Ingesting via web portal) | 2.005 | Offeror shall describe how its proposed services ingest via electronic media control, paper claims and claims entered via web portal |
| Claims (Ingesting via web portal) | 2.006 | Offeror shall describe how its proposed services implement and document balance (input/output) control procedures and batch control procedures (e.g., automatic number assignment, error handling, check-digit validation) to ensure that claims are not lost or misrouted and that security measures (e.g., HIPAA, HITRUST, Addendum 14 - HHS 2020 Security Privacy and Standards and Addendum 21 – HHS 2020 Security and Standards in the procurement library) are in place to prevent unauthorized action or access to information. |
| Claims (Adjudicating FFS Claims edits) | 2.007 | Offeror shall describe how its proposed services edit FFS claims submitted via paper or web portal and rejects back to the submitter any that are missing critical data that would be needed to process the claim. |
| Claims (Adjudicating FFS Claims edits) | 2.008 | Offeror shall describe how its proposed services return a claim or attachment to a provider, with the return reason, when a claim cannot be successfully submitted for processing. |

| Category | ID | Requirement Text |
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| Claims (Adjudicating FFS Claims edits) | 2.009 | Offeror shall describe how its proposed services edit all electronic FFS claims and rejects back to the submitter any that are missing critical data (SNIP Level 2) that would be needed to process the claim. |
| Claims (Adjudicating FFS Claims edits) | 2.010 | Offeror shall describe how its proposed services process and adjudicate dental claims using configurable business rules to enforce State policies (e.g., bundle vs. unbundle, duplicates, invalid tooth number, age vs. procedure, category of eligibility vs. procedure, mutually exclusive, incidental, emergent visits). |
| Claims (Adjudicating FFS Claims edits) | 2.011 | Offeror shall describe how its proposed services apply edits to claims and sends the processed claims to the Enterprise. |
| Claims (Adjudicating FFS Claims edits) | 2.012 | Offeror shall describe how its proposed services use health records and appropriate registry information to adjudicate claims, based on Enterprise program, State, and Federal policies. |
| Claims (Adjudicating FFS Claims edits) | 2.013 | Offeror shall describe how its proposed services provide the ability for services to be paid or denied when related to a third-party payer (e.g., Medicare, casualty, Insurance Carrier, hearing plan, vision plan, worker's compensation, VA benefits). |
| Claims (Adjudicating FFS Claims edits) | 2.014 | Offeror shall describe how its proposed services suspend claims that are designated for prepayment review for given reasons (e.g., procedure/service code, diagnosis code, modifiers, Provider, Member, FADS findings, previous fraud identification, other State-defined criteria, number of visits and services delivered are logically consistent with the Member's characteristics and circumstances, such as type of illness, age, sex, service location, payment does not exceed any reimbursement rates or limits in the State plan, at State direction, third party liability within the requirements of § 433.137). |

| Category | ID | Requirement Text |
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| Claims (Adjudicating FFS Claims edits) | 2.015 | Offeror shall describe how its proposed services implement claim exceptions and special processing rules upon instruction from the State. |
| Claims (Adjudicating FFS Claims edits) | 2.016 | Offeror shall describe how its proposed services adjudicate claims per the State's instruction manuals (e.g., provider billing, claim resolution) and in conformity with medical, dental or institutional care practices as instructed by the State. |
| Claims (Adjudicating FFS Claims edits) | 2.017 | Offeror shall describe how its proposed services adjudicate and performs mathematical calculations across claims (e.g., bundling/unbundling of professional services, global charges, multiple surgical procedures, laboratory, radiology, content of service, laboratory panel, other as specified by the Enterprise) and that those mathematical calculations agree with the results of that manipulation. |
| Claims (Adjudicating FFS Claims edits) | 2.018 | Offeror shall describe how its proposed services adjudicate claims using data from a variety of sources. |
| Claims (Adjudicating FFS Claims edits) | 2.019 | Offeror shall describe how its proposed services verify that all coded data items consist of valid codes (e.g., National Drug Code [NDC] for J code drugs administered in office, anesthesia codes). |
| Claims (Adjudicating FFS Claims edits) | 2.020 | Offeror shall describe how its proposed services edit claims for consistency and payment limitations using the Medicare correct coding initiative or similar editing criteria, based upon State policies. |
| Claims (Adjudicating FFS Claims edits) | 2.021 | Offeror shall describe how its proposed services process dental claims and PA using Current Dental Terminology (CDT) procedure codes and prices based on State-defined criteria. |
| Claims (Adjudicating FFS Claims edits) | 2.022 | Offeror shall describe how its proposed services adjudicate claims using configurable indicators for enhanced payments (e.g., dental, home health, rural, |

| Category | ID | Requirement Text |
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| | | Indian Health Service [IHS], Tribal 638s). |
| Claims (Adjudicating FFS Claims edits) | 2.023 | Offeror shall describe how its proposed services use configurable business rules (e.g., disability review, IHS, Tribal 638s, dollar threshold, service type, Provider, Member, lock-in, PA required, Member date of death on claim, TPL on claim, diagnosis and procedure which indicate an emergency that occur within one day of a similar claim from the same provider, billed amount is within reasonable and acceptable limits or if it differs from the allowable fee schedule amount by more than a certain percentage, third-party discrepancies, limitations including once-in-a-lifetime procedures and other frequency, periodicity, dollar limitations) to suspend, post the exception/error/audit and route claims for review and disposition. |
| Claims (Adjudicating FFS Claims edits) | 2.024 | Offeror shall describe how its proposed services perform automated cross-checks and relationship edits on all claims. |
| Claims (Adjudicating FFS Claims edits) | 2.025 | Offeror shall describe how its proposed services provide the capability and flexibility to: a) Pend to a specific location for correction and notify appropriate User(s) of the disposition and exception of edits (e.g., bill/claim type, submission media, Provider type, individual Provider number, revenue code, procedure code, diagnosis codes, Member specific); b) Deny and flag with explanatory message(s) on Provider RA, c) Authorize payment and report to a User (e.g. RAC, PI, OIG, TPL) with explanatory messages. |
| Claims (Adjudicating FFS Claims edits) | 2.026 | Offeror shall describe how its proposed services perform automated adjudication using historic claims, suspended claims, in-process claims, and same cycle claims. |

| Category | ID | Requirement Text |
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| Claims (Adjudicating FFS Claims edits) | 2.027 | Offeror shall describe how its proposed services suspend, deny, or reduces payment per Federal and State regulations and laws. |
| Claims (Adjudicating FFS Claims edits) | 2.028 | Offeror shall describe how its proposed services deny payments for Provider Preventable Conditions (e.g., Stage III and IV pressure ulcers, air embolism) per Federal and State regulations and laws. |
| Claims (Adjudicating FFS Claims edits) | 2.029 | Offeror shall describe how its proposed services provide the ability to edit claims and only deny claims with "uncovered" diagnosis when it is the primary diagnosis but allow payment if the "uncovered" diagnosis is a secondary or tertiary diagnosis. |
| Claims (Adjudicating FFS Claims edits) | 2.030 | Offeror shall describe how its proposed services flag, re-price, suspend, or deny claims when a particular claim does not have required related claim(s) (e.g., anesthesia claim with no facility or professional claim, surgical assistant claim with no surgeon's claim). |
| Claims (Adjudicating FFS Claims edits) | 2.031 | Offeror shall describe how its proposed services use data in any claim field to apply an edit. |
| Claims (Adjudicating FFS Claims edits) | 2.032 | Offeror shall describe how its proposed services adjudicate inpatient hospital claims through a grouper for Diagnostic Related Grouping (DRG) assignment and edits for covered/non-covered DRGs. |
| Claims (Adjudicating FFS Claims edits) | 2.033 | Offeror shall describe how its proposed services adjudicate facility claims through an Outpatient Code Editor (OCE). |
| Claims (Adjudicating FFS Claims edits) | 2.034 | Offeror shall describe its proposed services incorporates historical records of Member eligibility for claims adjudication and how retroactive changes in member eligibility trigger automated adjustment processing (e.g., retroactive Date of Death [DOD] triggers adjustment of any Date of Service paid post the DOD, retro Date of Birth [DOB] triggers adjustment of any DOS prior to DOB, retro Medicare triggers adjustment of claims paid |

| Category | ID | Requirement Text |
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| | | without Medicare EOB). |
| Claims (Adjudicating FFS Claims edits) | 2.035 | Offeror shall describe how its proposed Solution adjudicates claims with EPSDT services and flags the claim for reporting. |
| Claims (Adjudicating FFS Claims edits) | 2.036 | Offeror shall describe how its proposed services identify behavioral health claims or vouchers and adjudicate based upon configurable rules. |
| Claims (Adjudicating FFS Claims edits) | 2.037 | Offeror shall describe how its proposed services edit and validate each data element of the claim record for required presence, format, consistency, reasonableness, and allowable values, within a timeframe determined by the State. |
| Claims (Adjudicating FFS Claims edits) | 2.038 | Offeror shall describe how its proposed services continually calculate the available service authorization units or total dollar coverage amounts as each applicable claim line item is adjudicated. |
| Claims (Adjudicating FFS Claims edits) | 2.039 | Offeror shall describe how its proposed services edit for duplicates within and across claim lines (e.g., dates of service of an institutional claim do not overlap with the dates of service of an institutional claim from the same or a different institution, dates of service for a practitioner claim do not overlap with the dates of service for another claim from the same practitioner for a single Member unless the additional services are appropriate for the same date of service) in accordance with State program policy using configurable business rules. |
| Claims (Adjudicating FFS Claims edits) | 2.040 | Offeror shall describe how its proposed services coordinate benefits for overlapping programs (Medicare, Medicaid, Waivers) and multi-state claims to prevent duplicate or over payments. |

| Category | ID | Requirement Text |
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| Claims (Adjudicating FFS Claims edits) | 2.041 | Offeror shall describe how its proposed services deny claims for fee-for-service (FFS) Providers for gatekeeper (e.g., MCO, Accountable Care Organization [ACO], PCCM, PIHP, PAHP) Member services included in the MCO benefit package and generates payment for the exceptions stated within the State Plan. |
| Claims (Adjudicating FFS Claims edits) | 2.042 | Offeror shall describe how its proposed services edit and verify across all claims, that the services on one or more claims do not exceed defined limits associated with the services or procedures of one or more plans (e.g., member benefit plan, budgets, Enterprise rules, voucher limits, post-partum care provided sixty days after delivery, re-admits, rental vs. purchase, cannot provide more than 24 hours' worth of services in one day, lifetime limits, service authorization, plan of care, treatment plan). |
| Claims (Adjudicating FFS Claims edits) | 2.043 | Offeror shall describe how its proposed services maintain real time service limit history for accurate adjudication and inquiry. |
| Claims (Adjudicating FFS Claims edits) | 2.044 | Offeror shall describe how its proposed services adjudicate current claim against associated claims in history to limit payments to a dollar threshold. |
| Claims (Adjudicating FFS Claims edits) | 2.045 | Offeror shall describe how its proposed services deny payment authorizations for non-facility providers for claims when individuals are inpatients (e.g., hospital, nursing facility, Intermediate Care Facility for the Intellectually Disabled [ICF/IID]) with exceptions (e.g., State has an approved personal care retainer, respite services provided in an ICF/IID building but not covered under the ICF/IID benefit). Offeror's proposed services must identify when a non-inpatient claim comes in first and automatically adjust the non-inpatient claim to deny and pay the incoming inpatient/residential claim. |
| Claims (Adjudicating | 2.046 | Offeror shall describe how its proposed services use |

| Category | ID | Requirement Text |
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| FFS Claims edits) | | designated Provider numbers on the Member file indicating Lock-in restrictions and restrict payment authorizations of claims from non-designated Providers with exceptions (e.g., emergency, referral. consultation criteria are met). |
| Claims (Adjudicating FFS Claims edits) | 2.047 | Offeror shall describe how its proposed services issue payment authorizations for FFS Provider claims for services rendered in pre-enrollment periods or other periods of transition (e.g., presumptive eligibility) based upon configurable rules. |
| Claims (Adjudicating FFS Claims edits) | 2.048 | Offeror shall describe how its proposed services use real-time eligibility and other information from the State Medicaid eligibility determination system (ASPEN) or other State eligibility program when adjudicating claims. |
| Claims (Adjudicating FFS Claims edits) | 2.049 | Offeror shall describe how its proposed services ensure services that are bundled in the Member's LTC payment rate are not billed separately by individual practitioners or other Providers. |
| Claims (Adjudicating FFS Claims edits) | 2.050 | Offeror shall describe how its proposed services edits newborn claims based upon eligibility. |
| Claims (Adjudicating FFS Claims edits) | 2.051 | Offeror shall describe how its proposed services apply configurable business rules to determine claim value based on date-specific Member data (e.g., benefit package, age, income level, gender, spending cap, date of death, voucher eligibility, eligibility category at the time of service, waiver or other program, EPSDT eligibility, Member specific exceptions). |
| Claims (Adjudicating FFS Claims edits) | 2.052 | Offeror shall describe how its proposed services use referral and/or authorization information to adjudicate claims across multiple providers during overlapping dates of service, based on State and Federal policies. |

| Category | ID | Requirement Text |
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| Claims (Adjudicating FFS Claims edits) | 2.053 | Offeror shall describe how its proposed services use and capture the related PA (including override or force indicator) data during the claims adjudication process to reflect usage of services at the claim line level (decrement) (e.g., authorized unit, visit, dollar amounts used; authorized unit remaining, visit remaining, dollar amounts remaining) and adjust accumulators (de-decrement) (e.g., reversed claims, adjusted claims and others as identified by Enterprise during design). |
| Claims (Adjudicating FFS Claims edits) | 2.054 | Offeror shall describe how its proposed services automatically override otherwise applicable service authorization rules, based on information submitted on claims (e.g., diagnosis code, DRG). |
| Claims (Adjudicating FFS Claims edits) | 2.055 | Offeror shall describe its proposed services track conditions of interest to the State (e.g., referred but not treated, disease management) to claims submitted for the Member until all conditions have been treated. |
| Claims (Adjudicating FFS Claims edits) | 2.056 | Offeror shall describe how its proposed services edit for an authorization (e.g., PA, service authorization, POC, issued voucher), as required) during claims adjudication and deny claims for services that require authorization when an active authorization does not exist. |
| Claims (Adjudicating FFS Claims edits) | 2.057 | Offeror shall describe how its proposed services edit for an authorization (e.g., PA, service authorization, POC), during claims adjudication and reduce service value to only those that are authorized, for example an authorization exists for five (5) services and seven (7) are billed, claims pay for only those authorized and denies the two (2) in excess of the authorization. |
| Claims (Adjudicating FFS Claims edits) | 2.058 | Offeror shall describe how its proposed services, using configurable rules, process for payment claims for emergency services for payment without an authorization (e.g., PA, service authorization, POC). |

| Category | ID | Requirement Text |
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| Claims (Adjudicating FFS Claims edits) | 2.059 | Offeror shall describe how its proposed services process claims to the same Provider for multiple types of claims (e.g., fee-for-service, MCO carveout, capitation, waiver services) concurrently and deny when the Provider is not authorized to receive payment for the type of service. |
| Claims (Adjudicating FFS Claims edits) | 2.060 | Offeror shall describe how its proposed services validate and use National Provider Identifier (NPI) and State-assigned non-NPI information to accurately adjudicate claims. |
| Claims (Adjudicating FFS Claims edits) | 2.061 | Offeror shall describe how its proposed services edit and deny claims from Providers (lab, radiology, specialty physician) if service is not referred and authorized by a gatekeeper (e.g., Health Home, ACO, PCCM) when required by State or Federal policy. |
| Claims (Adjudicating FFS Claims edits) | 2.062 | Offeror shall describe how its proposed services edit provider date specific eligibility information for claim processing (e.g., NPI when appropriate, State assigned non-NPI, provider classification, MCO, individual or group enrollment, referral conflict, licenses, trainings, certifications, accreditations, prospective payment review, taxonomy, or other Enterprise-granted special permissions or characteristics, Clinical Laboratory Improvement Amendments (CLIA) certifications, LTC facility certification, Federal disbarment, Provider agreement, lock-in, sanction, professional licensing departments or other regulatory agencies of authority, group membership effective dates; enrollment status, trading partner number (TPN) for providers or clearing houses, service restriction indicator; billing categories of service, identification numbers; profit/nonprofit status, and other user-specified Provider status codes and indicators) and authorize payment when met or deny when not met. |
| Claims (Adjudicating | 2.063 | Offeror shall describe how its proposed services confirm the appropriateness of any override code used |

| Category | ID | Requirement Text |
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| FFS Claims edits) | | on a claim. |
| Claims (Adjudicating FFS Claims edits) | 2.064 | Offeror shall describe how its proposed services identify Providers who are eligible to use Electronic Funds Transfer (EFT) and Electronic Claims Submission. |
| Claims (Adjudicating FFS Claims edits) | 2.065 | Offeror shall describe how its proposed services identify and use during claim adjudication, multiple providers associated with the claim (e.g., rendering, supervising, billing, attending, prescribing) in accordance with the HIPAA Implementation guides and State policies and procedures. |
| Claims (Adjudicating FFS Claims edits) | 2.066 | Offeror shall describe how its proposed services validate that all providers on a claim (e.g., servicing, prescribing, referring) are enrolled and authorized with Medicaid. |
| Claims (Adjudicating FFS Claims edits) | 2.067 | Offeror shall describe how its proposed services process claims, regardless of the source, using Enterprise-approved reference data (e.g., Provider, PA, TPL, Member Eligibility, procedure, pricing). |
| Claims (Adjudicating FFS Claims edits) | 2.068 | Offeror shall describe how its proposed services adjudicate claims based upon timely filing deadlines as defined by the State (e.g., rules for date of service, date of adjudication, waiver of timely filing requirements, third-party carrier timely filing requirements, claims are no later than twelve [12] months from the date of service). |
| Claims (Adjudicating FFS Claims edits) | 2.069 | Offeror shall describe how its proposed services edit claims to confirm that the date of service is within the provider's and member's eligibility periods (allowable time frame) for payment authorization. |
| Claims (Adjudicating FFS Claims edits) | 2.070 | Offeror shall describe how its proposed services accept Medicare crossover claims (for Medicare coinsurance and deductible) or Medicare Explanation of Benefits (EOB) claims attachments and adjudicate a Medicare |

| Category | ID | Requirement Text |
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| | | crossover claim. |
| Claims (Adjudicating FFS Claims edits) | 2.071 | Offeror shall describe how its proposed services meet claim adjudication standards for "clean" (error-free) claims set by the State and the Federal policies. |
| Claims (Adjudicating FFS Claims edits) | 2.072 | Offeror shall describe how its proposed services process error code overrides and provide a view of all errors and overrides associated with the claim at both the header and detail line item level. |
| Claims (Adjudicating FFS Claims edits) | 2.073 | Offeror shall describe how its proposed services adjudicate claims at the line level (e.g., service dates, diagnosis, procedure code) allowing providers to submit services for different programs on the same claim form. |
| Claims (Adjudicating FFS Claims edits) | 2.074 | Offeror shall describe how its proposed services perform preliminary adjudication of claims (e.g., pre-payment review, PA) against system data (e.g., adjudicated claims history) based upon configurable rules. |
| Claims (Adjudicating FFS Claims edits) | 2.075 | Offeror shall describe how its proposed services accommodate outpatient prospective payment system (OPPS). |
| Claims (Adjudicating FFS Claims edits) | 2.076 | Offeror shall describe how its proposed services aggregate an inpatient length of stay across multiple claims and audit readmissions when a single admission spans multiple claims. |
| Claims (Adjudicating FFS Claims edits) | 2.077 | Offeror shall describe how its proposed services adjudicate claims for eVisits (e.g., telemedicine, video consultation) based upon State and Federal policy. |
| Claims (Adjudicating FFS Claims edits) | 2.078 | Offeror shall describe how its proposed services adjudicate single or multiple line items through multiple edits, audits and pricing algorithms allowing for some |

| Category | ID | Requirement Text |
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| | | lines to be paid while others are denied or suspended. |
| Claims (Adjudicating FFS Claims edits) | 2.079 | Offeror shall describe how its proposed services ensure that edits are applied in accordance with the State's policies (e.g., hierarchy, claim type differentiation). |
| Claims (Adjudicating FFS Claims edits) | 2.080 | Offeror shall describe how its proposed services prioritize claim adjudication based upon claim characteristics as identified by the State. |
| Claims (Adjudicating FFS Claims edits) | 2.081 | Offeror shall describe how its proposed services adjudicate claims and hierarchically assign status of claims (e.g., paid, suspend, deny) based on configurable rules. |
| Claims (Adjudicating FFS Claims edits) | 2.082 | Offeror shall describe how its proposed services adjudicate claims through a hierarchy of benefit plans that contains all possible benefit plan combinations allowable by the State and claims should adjudicate through the benefit plans as listed in order on the individual benefit plan hierarchy threads and assign the related account code (funding source). |
| Claims (Adjudicating FFS Claims edits) | 2.083 | Offeror shall describe how its proposed services automatically deduct variable Member liability (e.g., LTC patient liability, responsibility, participation, cost share, co-insurance, co-payment, Room and Board, out of pocket maximum, enrollment fees) amounts from claims reported by the provider or referenced and calculated from the Master Member data and authorize payment for the remainder of the claim in accordance with configurable business rules to comply with program policy. |
| Claims (Adjudicating FFS Claims edits) | 2.084 | Offeror shall describe how its proposed services adjudicate claims exceptions that would otherwise be denied, based on State policies. |

| Category | ID | Requirement Text |
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| Claims (Adjudicating FFS Claims edits) | 2.085 | Offeror shall describe how its proposed services provide authorized Users the ability to manually intervene in claims adjudication (e.g., research and correction of possible errors, manual override or force of edits, manual claims edit exceptions, manual pricing). |
| Claims (Adjudicating FFS Claims edits) | 2.086 | Offeror shall describe how its proposed services capture and maintain all Medicare Parts (e.g., A, B, C) claims payment information as specified by the State. |
| Claims (Adjudicating FFS Claims edits) | 2.087 | Offeror shall describe how its proposed services adjudicate claims based on national standard adjustment reason codes and remark codes from third parties where Medicaid is not the primary payer. |
| Claims (Adjudicating FFS Claims edits) | 2.088 | Offeror shall describe how its proposed services process and track Medicare crossover claims by various criteria (e.g., Member, program type) allowing for coinsurance, deductible, and other patient responsibility amounts while maintaining and using an accurate cross-reference between Medicare and Medicaid Provider Numbers to ensure accurate payment. |
| Claims (Adjudicating FFS Claims edits) | 2.089 | Offeror shall describe how its proposed services accept and adjudicate, at the header or line level, all Medicare crossover claims (paid or denied) for co-insurance and deductible charges from Providers regardless of the source (e.g., hardcopy, electronic media). |
| Claims (Adjudicating FFS Claims edits) | 2.090 | Offeror shall describe how its proposed services adjust, adjudicate, and/or price Medicaid/Medicare dual eligible claims in accordance with CMS guidelines, including claims for Members who are in Managed Medicare Part C. |
| Claims (Adjudicating FFS Claims edits) | 2.091 | Offeror shall describe how its proposed services use real-time Medicare eligibility information to identify Medicare crossover claims. |
| Claims (Adjudicating | 2.092 | Offeror shall describe how proposed services use configurable rules to authorize the payment of interest |

| Category | ID | Requirement Text |
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| FFS Claims edits) | | or tax on clean claims. |
| Claims (Adjudicating FFS Claims edits) | 2.093 | Offeror shall describe how its proposed services accurately adjudicate, based upon configurable rules, all suspended claims, except those suspended for medical review, within twenty (20) days of receipt by the Contractor's Solution. |
| Claims (Adjudicating FFS Claims edits) | 2.094 | Offeror shall describe how its proposed services post all claim-relevant RA codes to the claim at the service-line level for all paid, suspended or denied claims or invoices. |
| Claims (Adjudicating FFS Claims edits) | 2.095 | Offeror shall describe how its proposed services suspend claims and post valid error/exception codes if reference data conflicts (e.g., category of eligibility and rate cells, taxonomy and place of service, procedure or service code and attachments). |
| Claims (Adjudicating FFS Claims edits) | 2.096 | Offeror shall describe how its proposed services perform all edit processing cycles within agreed upon timeframes (not greater than twenty [20] days) and reports any claims exceeding the timeframe. |
| Claims (Adjudicating FFS Claims edits) | 2.097 | Offeror shall describe how its proposed services coordinate claims adjudication activities with the State or its State specified designees to comply with State and Federal timelines (e.g., pay within ninety [90] days of the date of receipt ninety-nine [99] percent of all clean claims). |
| Claims (Adjudicating FFS Claims edits) | 2.098 | Offeror shall describe how its proposed services maintain, integrate and coordinate claims adjudication with multiple financial cycle timetables (see Accounting and Fiscal Agent [Financial Cycle] 1.043). |
| Claims (Adjudicating FFS Claims edits) | 2.099 | Offeror shall describe how its proposed services provide claims adjudication software, compliant with all State and Federal privacy and security regulations (e.g., HIPAA x12 5010, International Classification of Diseases (ICD), UB04 editor with updates, NPI |

| Category | ID | Requirement Text |
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| | | compliant), without financial impact to the State. |
| Claims (Adjudicating FFS Claims edits) | 2.100 | Offeror shall describe how its proposed services integrate into the claim adjudication process, third-party claims editing and auditing software or services (e.g., DRG bundling software, OPPS bundling software). |
| Claims (Adjudicating FFS Claims edits) | 2.101 | Offeror shall describe how its proposed services adjudicate claims, claim adjustments, claims voids accurately from multiple sources and formats (e.g., Web Portal, EDI, Paper, Electronic batch; Individual electronic; Paper claims converted to electronic; Direct Data Entry (DDE), Fax, Enterprise generated claims, 837D, ADA dental paper billing form) with field validity edits and pre-editing for:<br>• Provider number<br>• Member ID number<br>• Procedure codes<br>• Diagnosis codes<br>• Dates of Service. |
| Claims (Adjudicating FFS Claims edits) | 2.102 | Offeror shall describe how its proposed services automatically identify line-level claim workflow dispositions (e.g., Provider for additional information, Fiscal Agent for correction) based on highest severity edit status or force code for that line and independently process each line to claim completion. |
| Claims (Adjudicating FFS Claims edits) | 2.103 | Offeror shall describe how its proposed services automatically retain adjudicated claims in a "hold for payment authorization" status until adjusted, voided or authorized for payment. |
| Claims (Adjudicating FFS Claims edits) | 2.104 | Offeror shall describe how its proposed services automatically assign, track and monitor all claim line statuses (e.g., processed, re-processed, suspended, audit, special processing, paid, denied, void, pre-payment or post-payment review, pay-and-report only) and the related edits or audits based upon State defined criteria. |

| Category | ID | Requirement Text |
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| Claims (Adjudicating FFS Claims edits) | 2.105 | Offeror shall describe how its proposed services identify items subject to taxation (e.g. sales tax, gross receipts tax), associate an appropriate (e.g., date, location) tax rate to the item and automatically calculate line-level tax amounts and aggregate at the header level by tax type. |
| Claims (Adjudicating FFS Claims edits) | 2.106 | Offeror shall describe how its proposed services adjudicate claims using configurable business rules that allow for a claims payment authorization that would have been rejected due to TPL coverage when override codes indicate that benefits are not available. |
| Claims (Adjudicating FFS Claims edits) | 2.107 | Offeror shall describe how its proposed services edit claims based on multiple third-party payers at both the claim header and detail line item level and uses National Association of Insurance Commissioners (NAIC) primacy rules. |
| Claims (Adjudicating FFS Claims edits) | 2.108 | Offeror shall describe how its proposed services automatically assign or accept unique control numbers to monitor, track, and maintain control over claims, adjustments, voids, attachments, supporting documentation, capitations and other financial transactions. |
| Claims (Adjudicating FFS Claims edits) | 2.109 | Offeror shall describe how its proposed services ensure the payment of all claims within 12 months of the date of receipt except for the following circumstances: (i) Retroactive adjustments paid to providers who are reimbursed under a retrospective payment system, as defined in § 447.272 of this part. (ii) If a claim for payment under Medicare has been filed in a timely manner, the agency may pay a Medicaid claim relating to the same services within 6 months after the agency or the provider receives notice of the disposition of the Medicare claim. (iii) Claims from providers under investigation for fraud or abuse. (iv) The agency may make payments at any time in |

| Category | ID | Requirement Text |
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| | | accordance with a court order, to carry out hearing decisions or agency corrective actions taken to resolve a dispute, or to extend the benefits of a hearing decision, corrective action, or court order to others in the same situation as those directly affected by it.<br>The date of receipt is the date the agency receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment." |
| Claims (Adjudicating FFS Claims edits) | 2.110 | Offeror shall describe how its proposed services apply edits related to IME's responsibility for nursing facility payments for a Medicare member (days 21-100) as defined by the State. |
| Claims (Adjudicating FFS Claims edits) | 2.111 | Offeror shall describe how its proposed services apply edits specific to incarcerate individuals (e.g., The STMII charges for inpatient hospital stays of 24 hours or more are applied only to incarcerated individuals whose benefits have been suspended) and identify for recovery those individuals incarcerated in a County correctional facility to bill the county for the State portion of the payment. For individuals incarcerated in a State correctional facility, we don't bill Corrections for recovery. For other Justice-involved individuals, claims are paid through the MCO until the individual has been incarcerated for 30 or more days. |
| Claims (Adjudicating FFS Claims edits) | 2.112 | Offeror shall describe how its proposed services post all edits on the claim at the time of processing. |
| Claims (Adjudicating FFS Claims edits) | 2.113 | Offeror shall describe how its proposed services use State defined criteria (hierarchy) for determining the correct account code assignment (funding source). |
| Claims (Maintain edits and audits) | 2.114 | Offeror shall describe how its proposed services create rules at a group level with the ability for the underlying subgroups to inherit the rules as needed. |

| Category | ID | Requirement Text |
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| Claims (Maintain edits and audits) | 2.115 | Offeror shall describe how its proposed services provide a BRE that allows the Enterprise to configure (e.g., add, change, date specific, modified date, start date, end date, effective date, hierarchy, disposition, status, approval routing, override options) approved rules with minimal User intervention. |
| Claims (Maintain edits and audits) | 2.116 | Offeror shall describe how its proposed services provide a platform (e.g., BRE) with the ability to pilot business rules in Contractor's environment prior to implementing in production or other environments (training, "what if", UAT). The platform BRE must provide the flexibility to add and change indicators and parameters easily and to allow for Enterprise configurable adjudication rules. The platform must have the capability to set specific date parameters based on what your testing and have the data loaded that supports those parameters. |
| Claims (Maintain edits and audits) | 2.117 | Offeror shall describe how its proposed services provide a platform (e.g., BRE) with the ability to pilot business rules in Contractor's test environment prior to implementing in production or other environments (training, "what if", UAT). The platform BRE must be kept up to date, provide the flexibility to add and change indicators and parameters easily and to allow for Enterprise configurable adjudication rules. |
| Claims (Maintain edits and audits) | 2.118 | Offeror shall describe how its proposed services provide unlimited program specific configurable business rules (e.g., edits, statuses, disposition, suppress payment at State direction). |
| Claims (Maintain edits and audits) | 2.119 | Offeror shall describe how its proposed services execute an approval process for any changes to the claims business rules platform while acknowledging that only the State has the authority to activate or deactivate business rules. |
| Claims (Maintain edits and audits) | 2.120 | Offeror shall describe how its proposed services provide a platform that uses rules-based, table driven, modular |

| Category | ID | Requirement Text |
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| | | and reusable components. |
| Claims (Maintain edits and audits) | 2.121 | Offeror shall describe how its proposed services provide for business rules to be configured by a trained Enterprise Business Analyst (BA) or Contractor BA and not hard coded in the Solution. |
| Claims (Maintain edits and audits) | 2.122 | Offeror shall describe how its proposed services implement processes improvements that identify, analyze, and correct errors that have resulted in improper claims processing (e.g., if final edit dispositions are incorrect, incorrect loaded rate), trace to the source, reprocess as needed, and reports to the Enterprise. |
| Claims (Maintain edits and audits) | 2.123 | Offeror shall describe how its proposed services maintain, as part of the master set of claim edits, a cross reference to the policy or billing requirement justification for each specific edit, edit disposition and configurable processing actions to comply with State and Federal requirements. |
| Claims (Maintain edits and audits) | 2.124 | Offeror shall describe how its proposed services maintain real-time claim edit disposition information, based on configurable rules (e.g., claim type, claim submission format [e.g., paper, fax, OCR, portal, electronic, system generated claim], provider classification, program), with the ability to add or modify edit dispositions at a very granular level at the direction of the State. |
| Claims (Maintain edits and audits) | 2.125 | Offeror shall describe how its proposed services provide authorized Users the ability to define and redefine claim edits (e.g., by program, benefit package, other Enterprise defined criteria) when appropriate. |
| Claims (Maintain edits and audits) | 2.126 | Offeror shall describe how its proposed services obtain and use all information (e.g., standard code sets, groups of code sets, place of service, category of service, taxonomy match, provider type, program policy, |

| Category | ID | Requirement Text |
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| | | program benefit plans, units of service, PA requirements, restrictions, TPL coverage, lock-in, Member eligibility, Provider eligibility, gender, age, PI findings, reference files, historic claims, registry data, modifiers, valid dates, service conflicts, required attachments, required documentation, limits, check-digit validation, referring NPI, waiver eligibility) to establish and enforce edits that are based upon date spans (retroactive, future, current, active, inactive) during claim adjudication to comply with State and Federal requirements. |
| Claims (Maintain edits and audits) | 2.127 | Offeror shall describe how its proposed services ensure code set to code set are appropriate (e.g., CMS NCCI edits, diagnosis codes to procedure codes, revenue codes with valid and approved Current Procedural Terminology [CPT]/ Healthcare Common Procedure Coding System [HCPCS] codes). |
| Claims (Maintain edits and audits) | 2.128 | Offeror shall describe how its proposed services use standard code sets (e.g., International Classification of Diseases [and Related Health Problems], 10th Revision, Clinical Modification, and Procedure Coding System (ICD-10-CM-PCS), ICD9, DSM, CPT, HCPCS, ADA, DRG, NCPDP, DC:0-5) in standard format to comply with State and Federal policies. |
| Claims (Maintain edits and audits) | 2.129 | Offeror shall describe how its proposed services maintain an unlimited number of error code occurrences per claim line and readjudicate automatically when changes occur on the claim. |
| Claims (Maintain edits and audits) | 2.130 | Offeror shall describe how its proposed services prevent future re-occurring errors identified during manual claims adjudication interventions. |
| Claims (Maintain edits and audits) | 2.131 | Offeror shall describe how its proposed services conduct testing for any modifications (e.g., pricing, edits, audits, policy changes) to confirm accuracy of those changes prior to implementation into production. |

| Category | ID | Requirement Text |
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| Claims (Maintain edits and audits) | 2.132 | Offeror shall describe how its proposed services provide assistance to the Enterprise in defining claim edits to enforce all cost avoidance and TPL rules specified in State or Federal regulations. |
| Claims (Maintain edits and audits) | 2.133 | Offeror shall describe how its proposed services provide and maintain, for each error code, a resolution code, an override, force or deny indicator, and the date that the error was resolved, forced, or denied. |
| Claims (Maintain edits and audits) | 2.134 | Offeror shall describe how its proposed services provide and maintain, for standard and State specific codes (e.g., HCPCS, Diagnosis, CPT, DPT, DSM, DC:0-5) multiple indicators (e.g., PA required, taxonomy associated, accident diagnosis, pay and chase, attachment(s) required [e.g., chart notes, operative report, EOB]) for claims processing. |
| Claims (Maintain edits and audits) | 2.135 | Offeror shall describe how its proposed services assign a federal report code on all transactions processed through an adjudication cycle based on the State provided business rules. The federal report code must cross walk to the correct report, report page, report line and report column. |
| Claims (Ingesting MCO encounter 835) | 2.136 | Offeror shall describe how its proposed services match and link incoming encounters, or adjusted encounters with original provider submission for pricing and encounter edits. |
| Claims (Ingesting MCO encounter 835) | 2.137 | Offeror shall describe how its proposed services receive, process, and store claim/encounter (e.g., PIHP, FFS, PAHP, Waiver) data, based upon State and Federal retention policies, to monitor services furnished to enrollees (e. g., special health needs, EPSDT, Waiver care). |
| Claims (Ingesting MCO encounter 835) | 2.138 | Offeror shall describe how its proposed services match capitation summary data and fee-for- service (FFS) claims data to verify that the MCO payments do not |

| Category | ID | Requirement Text |
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| | | exceed FFS upper limits. |
| Claims (Ingesting MCO encounter 835) | 2.139 | Offeror shall describe how its proposed services calculate the "Encounter Cost Value," or the cost of services reported on the encounter claim had they been paid on a fee-for-service basis. |
| Claims (Ingesting MCO encounter 835) | 2.140 | Offeror shall describe how its proposed service ingest encounter 835's from the MCOs and update the original encounter with the MCO's disposition status MCO Paid Amount, COB applied, interest and fees identified, MCO Paid date and price any that the MCO reflects as paid. |
| Claims (Sending MCO encounters to the ESB) | 2.141 | Offeror shall describe how its proposed services identify claims for which no 835 record has been submitted within the time period specified by the State and send these to the ESB for submission to the DS with a status of 'pending'. |
| Claims (Invoices and non-traditional claims) | 2.142 | Offeror shall describe how its proposed services track and authorizes payments to Members and other non-providers based upon approved business rules. |
| Claims (Invoices and non-traditional claims) | 2.143 | Offeror shall describe how its proposed services receive waiver program authorizations or plan of care (POC) and process claims within limits (e.g., units, dollars) established in the authorization or POC based on State or Federal policies. |
| Claims (Invoices and non-traditional claims) | 2.144 | Offeror shall describe how its proposed services automatically generate recurring claims based upon State authorized parameters. |
| Claims (Invoices and non-traditional claims) | 2.145 | Offeror shall describe how its proposed services adjudicate incentive transactions (e.g., EHR, DSH, uncompensated care) based upon State or Federal policies. |

| Category | ID | Requirement Text |
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| Claims (Invoices and non-traditional claims) | 2.146 | Offeror shall describe how its proposed services process non-standard claims (e.g., vouchers, invoices, non-member specific payment). |
| Claims (Invoices and non-traditional claims) | 2.147 | Offeror shall describe how its proposed services automatically create claims based upon configurable criteria and timelines when a traditional claim is not submitted (e.g., Capitation, State Residential Facilities, Voucher, Case Management, Health Department payments, value-based purchase invoices, non-member specific invoices). |
| Claims (Invoices and non-traditional claims) | 2.148 | Offeror shall describe how its proposed services convert electronic visit verification (EVV) and non-claim specific invoices or vouchers to a standard format (e.g., 837) and routes to the appropriate next step (e.g., FS claims for adjudication, IP for dissemination to MCOs, approval workflow). |
| Claims (Invoices and non-traditional claims) | 2.149 | Offeror shall describe how its proposed services produce claim and provider specific information to allow the authorization of payment(s) to payees other than medical service providers. |
| Claims (Invoices and non-traditional claims) | 2.150 | Offeror shall describe how its proposed services automatically adjudicate for medical, non-medical, and non-standard services (e.g., Custody Medical, Nursing Home supplemental claims, program vouchers). |
| Claims (Invoices and non-traditional claims) | 2.151 | Offeror shall describe how its proposed services adjudicate Enterprise program non-traditional claims (e.g., Personal Care Adult, Children Foster Care placements, Personal Care allowance, equine therapy, synar services, voucher). |
| Claims (Invoices and non-traditional claims) | 2.152 | Offeror shall describe how its proposed services incorporate Enterprise-defined data beyond existing RA format to include unique State defined criteria (e.g. FICA, FUTA, SUTA, GRT, specific messages ). |

| Category | ID | Requirement Text |
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| Claims (Invoices and non-traditional claims) | 2.153 | Offeror shall describe how its proposed services accommodate a Member being defined as the "Employer" and the service provider being defined as the "Employee' for specific services to accommodate payroll transactions. |
| Claims (Invoices and non-traditional claims) | 2.154 | Offeror shall describe how its proposed services accommodate other claim related inputs to the MMIS, including but not limited to:<br>• Sterilization, abortion, and hysterectomy consent forms<br>• Manual or automated medical expenditure transactions which have been processed outside of the MMIS (e.g. spend-down)<br>• treatment notes<br>• treatment surveys<br>• Non claim-specific financial transactions such as fraud and abuse settlements, insurance recoveries, and cash receipts<br>• Electronic cost reports<br>• Disproportionate share reports<br>• Drug rebate<br>• Any other inputs required for services under the State's approved plan. |
| Claims (Invoices and non-traditional claims) | 2.155 | Offeror shall describe how its proposed services provide for non-Member specific payments. |
| Claims (Invoices and non-traditional claims) | 2.156 | Offeror shall describe how its proposed services provide for payments to non-medical providers and other entities. |
| Claims (Capitated Per Member Per Month processing) | 2.157 | Offeror shall describe how its proposed services allow authorized Users to perform capitation corrections prior to payment authorization. |
| Claims (Capitated Per Member Per Month processing) | 2.158 | Offeror shall describe how its proposed services accurately and timely adjudicate claims for services carved out of a gatekeeper (e.g., Health Home, MCO, ACO, PCCM) benefit package (e.g., family planning, |

| Category | ID | Requirement Text |
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| | | women health specialist, emergency medical condition, bundled payments). |
| Claims (Capitated Per Member Per Month processing) | 2.159 | Offeror shall describe how its proposed services generate appropriate capitation adjustment claims (e.g., prorate, retroactive, additional payment amount, recoupment) automatically for changes to configurable criteria. |
| Claims (Capitated Per Member Per Month processing) | 2.160 | Offeror shall describe how its proposed services use a protected Member's residential zip code for calculation of capitation while protecting the privacy of these Members. |
| Claims (Capitated Per Member Per Month processing) | 2.161 | Offeror shall describe how its proposed services generate add-on capitation claims based on the receipt of claim data. |
| Claims (Capitated Per Member Per Month processing) | 2.162 | Offeror shall describe how its proposed services automatically generate Per Member Per Month (PMPM) capitation (health plan) payment authorizations based on a number of criteria, algorithms and cohorts (e.g., State-Only capitation, FQHC, RHC, Member's program category of eligibility, benefit package, gender, age, date of death, geography, disease management program algorithms, provider/member relationship, plan, rate table, retroactive eligibility, full risk, partial risk, specialty or ancillary service, premium payment, time span). |
| Claims (Capitated Per Member Per Month processing) | 2.163 | Offeror shall describe how its proposed services maintain and provide, to the Enterprise, the individual capitation transactions, including adjustments, for each member and links to the original capitation transaction(s) if adjusted. |
| Claims (Capitated Per Member Per Month processing) | 2.164 | Offeror shall describe how its proposed services aggregates cohort totals if sending summary premium. |

| Category | ID | Requirement Text |
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| Claims (Capitated Per Member Per Month processing) | 2.165 | Offeror shall describe how its proposed services edit capitation claims prior to adjudication to prevent duplicate capitation payment requests or capitations generated for clients who have lost eligibility or duplication of capitation and fee-for-service payment requests for services covered under the managed care program and pay claims per capita, from encounter data or fee-for-service as defined by State criteria. |
| Claims (Capitated Per Member Per Month processing) | 2.166 | Offeror shall describe how its proposed services track immunizations provided by FFS providers to EPSDT Members enrolled in an MCO/Primary Care Provider [PCP] and generate an adjustment to the capitation based on State defined criteria. |
| Claims (Capitated Per Member Per Month processing) | 2.167 | Offeror shall describe how its proposed services generate, send and adjust administrative fee payments and capitation payments based on configurable rules including but not limited to:<br>• Processing MCO capitation payments based upon each individual MCO enrollee with the appropriate rate cell for each Member;<br>• Processing partial monthly payments;<br>• Calculating supplemental or direct payments at the individual transaction level;<br><br>• Calculate in the amount for directed payments when the MCO has demonstrated the entire payment amount was passed thorough to the provider;<br>• Suppressing payments, and capitation, in whole and in part (e.g., at the Member level, gross level, netted against adjustments);<br>• Adjusting, retroactively or otherwise, rates and payments based on reconciliation (e.g., errors, enrollment corrections, member changes, rate corrections, enrollment periods, rate categories, cohort changes, Medicaid Eligibility Grouping (MEG) changes, contracted rate changes, transfer between MCOs); and<br>• Limiting the length of time to retroactively adjust a |

| Category | ID | Requirement Text |
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| | | capitation rate or payment. |
| Claims (Adjustments) | 2.168 | Offeror shall describe how its proposed services perform history only adjustments based upon Enterprise configurable rules (e.g., changes in funding sources, various accounting actions that do not impact provider payment amounts or 1099/W2 reporting, addition of history limits) and prevents generation of remittance advice (RA) to provider. |
| Claims (Adjustments) | 2.169 | The Offeror shall describe how its proposed services manage supporting documentation that triggers claim and payment adjustments or voids. |
| Claims (Adjustments) | 2.170 | Offeror shall describe how its proposed services process claims voids or cancellations when all or a portion of any claim is incorrect. |
| Claims (Adjustments) | 2.171 | Offeror shall describe how its proposed services automatically re-adjudicate paid claims when appropriate, based on configurable business rules defined by the Enterprise. |

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| Claims (Adjustments) | 2.172 | Offeror shall describe how its proposed services execute retroactive adjustment processing within one (1) business day of receipt of the request from the Enterprise or its designee and notifies the Enterprise when the SLA is not met. |
| Claims (Adjustments) | 2.173 | Offeror shall describe how its proposed services identify claims to reflect recovery amounts (e.g., adjustments, TPL, claw back, Recovery Audit Contractor [RAC]) from Enterprise Contractors and external entities who have retained a contingency fee, while properly reflecting the total amount of recovery with the contingency fee for that adjustment allocated as an administrative fee. |
| Claims (Adjustments) | 2.174 | Offeror shall describe how its proposed services ensure claims are not denied without valid reasons and that each claim denial will clearly provide a specific denial explanation in addition to standard adjustment and reason codes. |
| Claims (Adjustments) | 2.175 | Offeror shall describe how its proposed services receive, process and release requests for mass adjustments, providing audit trails of the processing, assigning statuses and validates the successful completion of all mass adjustments. |

| Category | ID | Requirement Text |
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| Claims (Adjustments) | 2.176 | Offeror shall describe how its proposed services provide configurable claims adjustment functionality that provides the ability for updates in accordance with changes to program policy that includes but is not limited to:<br> - Performing full or partial claim adjustments;<br> - Prevents removing a claim line during adjustment;<br> - Preventing claims identified for subrogation from being adjusted by providers;<br> - Processing multiple adjustment requests in the order that they are received;<br> - Identifying the type of adjustment performed;<br> - Utilizing industry standards and systems that have the flexibility to change the criteria for identification of claims and application of the adjustments;<br> - Preventing the rebilling of claims adjusted or recouped by a third-party Contractor or paid by another program or entity;<br>- Provide for zero (0) payment claim lines;<br>and<br> - Processing gross adjustments. |
| Claims (Adjustments) | 2.177 | Offeror shall describe how its proposed services adjust claims using a configurable formula that applies a portion of the total recovery amount for a group of claims to each individual claim within that specified group, as approved by the State. |
| Claims (Adjustments) | 2.178 | Offeror shall describe how its proposed services identify and correct any mispayments and system deficiencies that result in mispayment or potential mispayment of claims. |
| Claims (Adjustments) | 2.179 | Offeror shall describe how its proposed services assign a unique tracking number to all claims adjustments and maintains traceability links through all previous submissions, including the original claim and all subsequent adjustments (e.g., adjusted, voided, duplicate) resubmitted for payment. |

| Category | ID | Requirement Text |
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| Claims (Adjustments) | 2.180 | Offeror shall describe how its proposed services allow real-time submission, retrieval, processing, adjustment and tracking of any claim (e.g., archived, institutional, professional, non-medical) through all edits, audits and pricing logic to comply with State and Federal policies (e.g., updates all code sets [e.g., procedure, diagnosis] if required prior to each payment cycle). |
| Claims (Adjustments) | 2.181 | Offeror shall describe how its proposed services restrict (with the ability to override) claim readjudication for a closed Provider and alerts the user and generates an audit report. |
| Claims (Adjustments) | 2.182 | Offeror shall describe how its proposed services provide the ability to automatically or manually include or exclude paid and denied claims, capitation payments, and zero pays, in mass adjustment adjudications. |
| Claims (Adjustments) | 2.183 | Offeror shall describe how its proposed services readjudicate claims that have not been finalized for payment. |
| Claims (Adjustments) | 2.184 | Offeror shall describe how its proposed services prevent adjustment or resubmission of claims based upon configurable criteria (e.g., previously recouped, adjusted, identified for recovery, PI provider alert). |
| Claims (Adjustments) | 2.185 | Offeror shall describe how its proposed services automatically identify claims based upon changes that effect adjudication (e.g., Member eligibility, Provider eligibility, rate table change, fee schedule change, policy changes, account code changes, duplicate, upper and lower limit bundled/unbundled, global charges, Enterprise rules) and automatically create an adjustment to the claims, within the same payment cycle of the identified change. |

| Category | ID | Requirement Text |
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| Claims (Adjustments) | 2.186 | Offeror shall describe how its proposed services process manual and automatic voids or adjustment requests (e.g., to correct SHARE account code assignment, audit adjustments to the CMS 64, gross adjustments, claim specific recoveries, recoupments, settlements, liens, non-claim specific returns, based on national standard adjustment reason codes and remark codes from third parties where Medicaid is not the primary payer). |
| Claims (Adjustments) | 2.187 | Offeror shall describe how its proposed services automatically and manually perform mass adjustments of claims, capitation, and zero pay transactions, based on multiple criteria/parameters (e.g., date spans, Provider types, specialties, FMAP changes, rate change, annual adjustments, court settlements, location, procedure, account codes, Member eligibility, denial codes, Provider ID, categories of service, program, shift from FMAP to ten [10]% funding for referrals). |
| Claims (Adjustments) | 2.188 | Offeror shall describe how its proposed services provide continuous process improvement (CPI) of claims editing to reduce number of mass adjustments and processing time. |
| Claims (Adjustments) | 2.189 | Offeror shall describe how its proposed services apply configurable rules for gross adjustment amounts applied to the detailed line or header level of a claim. |
| Claims (Adjustments) | 2.190 | Offeror shall describe how its proposed services accommodate "history only adjustments" for individual payments (e.g., Medicare Parts A, B and C, being applied to the Member's history, account code assignment reclassification) and forward financial data to accounting for reconciliation including creating a summary of history file transfers. |
| Claims (Adjustments) | 2.191 | Offeror shall describe how its proposed services suspend claims and capitations (e.g., initial, adjusted, voided) and alert Users to review the outcome prior to final adjudication. |

| Category | ID | Requirement Text |
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| Claims (Adjustments) | 2.192 | Offeror shall describe how its proposed services achieve improvements to claims adjudication and mass adjustment accuracy rate of ninety-eight percent (98%) or higher. |
| Claims (Adjustments) | 2.193 | Offeror shall describe how its proposed services improve timeliness of the mass adjustment processes such that processing time does not exceed twenty-four (24) clock hours. |
| Claims (Adjustments) | 2.194 | Offeror shall describe how its proposed services maximize automation and minimize Enterprise manual review of mass adjustments. |
| Claims (Adjustments) | 2.195 | Offeror shall describe how its proposed services perform the following activities when retroactive rate changes are made:<br>a) Identify the affected claims and based upon rules, adjust to pay at the corrected rate;<br>b) Review claims to ensure that they process appropriately (setting up appropriate accounts payable and/or receivable transactions for accounting);<br>c) If Providers are inactive, the Contractor will work with the State to determine how any applicable money will be recovered or paid;<br>d) For affected claims beyond State defined timelines, at the State's discretion, no adjustments may be made. |
| Claims (Adjustments) | 2.196 | Offeror shall describe how its proposed services perform mass claim and encounter adjustment claims and encounters, based upon State defined criteria or as directed and associate adjusted/voided claims to the request and reason for the action |
| Claims (Pricing) | 2.197 | Offeror shall describe how its proposed services accurately adjudicate and price all submitted modifiers, procedure codes and diagnosis codes based upon configurable business rules. |

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| Claims (Pricing) | 2.198 | Offeror shall describe how its proposed services use a related authorization (e.g., PA, service authorization, POC, issued voucher) price for claim adjudication. |
| Claims (Pricing) | 2.199 | Offeror shall describe how its proposed services price hospice services as a function of the nursing home rate (e.g., percentage, blended bundling, carve-out) to calculate payment to the hospice provider. |
| Claims (Pricing) | 2.200 | Offeror shall describe how its proposed services determine the amount to be paid to the Provider. |
| Claims (Pricing) | 2.201 | Offeror shall describe how its proposed services calculate the original Medicare Usual and Customary Charge amount and apply different reimbursement methodologies to various claim types (e.g., mental health, physician, facility, anesthesia, waiver programs) based upon State and Federal rules. |
| Claims (Pricing) | 2.202 | Offeror shall describe how its proposed services price and adjudicates claims under special circumstances (e.g., reimbursements to other entities for Medicaid and non-Medicaid services, out-of-State providers, reduce or increase the amount allowed by a specified amount or percentage as defined by IME) in accordance with program policies. |
| Claims (Pricing) | 2.203 | Offeror shall describe how its proposed services uses date-effective rates including retroactive rates. |
| Claims (Pricing) | 2.204 | Offeror shall describe how its proposed services allow manual claims pricing (e.g., State or Federal Policy requires, when automatic pricing fails) with a valid override code, and routes for approval as required. |
| Claims (Pricing) | 2.205 | Offeror shall describe how its proposed services capture, adjudicate and price claims/encounters based upon multiple payment methods or rates for the same services (e.g., claim type, Provider type, Provider specialty, place of service, Member characteristics, |

| Category | ID | Requirement Text |
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| | | geography, pricing modifiers, category of service). |
| Claims (Pricing) | 2.206 | Offeror shall describe how its proposed services use data elements and algorithms to compute claim reimbursement for claims that are consistent with 42 CFR 447. |
| Claims (Pricing) | 2.207 | Offeror shall describe how its proposed services differentiate between zero (0) and null dollar amounts on claims where no money is paid. |
| Claims (Pricing) | 2.208 | Offeror shall describe how its proposed services apply a rate based on the performing Provider instead of the billing Provider location as configured in the business rules. |
| Claims (Pricing) | 2.209 | Offeror shall describe how its proposed services price claims/encounters using fractions of quantities where applicable. |
| Claims (Pricing) | 2.210 | Offeror shall describe how its proposed services create claims payment authorization requests for non-service obligations (e.g., lump sum incentive payments, Pay for Performance (P4P), value-based payments, recovery funds, advance payments). |
| Claims (Pricing) | 2.211 | Offeror shall describe how its proposed services automatically or manually reduce payment amount to a provider, in whole, part, using various methodologies (percentage, flat amount, cut-back, net against EOB) based on State and Federal policies and record the reduction and methodology reason code on the claim at the service detail level. |
| Claims (Pricing) | 2.212 | Offeror shall describe how its proposed services automatically adjudicate and "cuts back" a claim line when only a portion of the units are payable. |

| Category | ID | Requirement Text |
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| Claims (Pricing) | 2.213 | Offeror shall describe how its proposed services price a claim/encounter based on the presence of other procedure(s) in history (e.g., global pricing, technical and professional components, multiple modifiers). |
| Claims (Pricing) | 2.214 | Offeror shall describe how its proposed services correctly price all claims/encounters at the detail service line and header levels based upon configurable rules. |
| Claims (Pricing) | 2.215 | Offeror shall describe how its proposed services assign a Ratio of Costs to Charges (RCC) amount on a provider specific basis. |
| Claims (Pricing) | 2.216 | Offeror shall describe how its proposed services calculate variable payment amounts using date spans (e.g., fee schedules, per diems, DRG rates, Pay for Performance [P4P] value add, FMAP, value based payments [VBP], capitation rates, case management fees, per diems, case mix, percentage-of-charge rates, rates based on level of care, preferred Provider global rates, DME, supplies, Provider specific, Primary Care Physician Payment Incentive [PCPPI], Member specific, fixed and/or variable rates, rate add-ons). |
| Claims (Pricing) | 2.217 | Offeror shall describe how its proposed services deduct other paid amounts, (e.g., TPL, Medicare) based upon program policy rules, when pricing claims such that Provider contractual write-off amount (e.g., Medicaid, commercial, other) is not considered for reimbursement to ensure that Medicaid is the payer of last resort. |
| Claims (Pricing) | 2.218 | Offeror shall describe how its proposed services establish and apply configurable reimbursement methodologies across all claim types (e.g., crossover, waivers, anesthesia, other claim types) as required and defined by the Enterprise to meet State and Federal regulations. |

| Category | ID | Requirement Text |
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| Claims (Account Codes Assignment) | 2.219 | Offeror shall describe how its proposed services structure claims to be adjudicated at the service line level and provide the data necessary for the category of service to be defined at the service-line and financial transaction level so that CMS 64 reporting is methodical. |
| Claims (Account Codes Assignment) | 2.220 | Offeror shall describe how its proposed services automatically or manually assign a funding source (account code) to a specific claim line item for claims that are processed as an exception. |
| Claims (Account Codes Assignment) | 2.221 | Offeror shall describe how its proposed services establish payment requests that retain a claim line item tagged with State funds, Federal funds, or a combination of both on a case-by-case basis. |
| Claims (Account Codes Assignment) | 2.222 | Offeror shall describe how its proposed services retroactively re-assign account codes to a payment request adjustment to reflect a change in Member eligibility or other factors that may change payment such as Setting of care (SOC), Level of Care (LOC), Institutions for Mental Diseases (IMD) designation. |
| Claims (Attachments) | 2.223 | Offeror shall describe how its proposed services maximize the automated association of electronic and non-electronic claims, claim attachments, claim notes, and supporting information (e.g., date-stamps, hardcopy claim form(s), uniquely assigned control numbers), in a standard format in accordance with State and Federal policies through a variety of sources (e.g., scanned, email, paper, fax, HIPAA transaction, Optical Character Recognition [OCR]) and performs quality control procedures to verify that the electronic image is legible and meets quality standards. |
| Claims (Attachments) | 2.224 | Offeror shall describe how its proposed services capture or obtain, stores, retrieves, forwards electronic and non-electronic claim attachments, claim notes, and supporting information, when the automatic process is |

| Category | ID | Requirement Text |
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|  |  | unable to capture or receive the document or all information submitted on the document. |
| Claims (Attachments) | 2.225 | Offeror shall describe how its proposed services provide and display, for sender and receiver, an attachment indicator field on all electronic media claims to differentiate claims where attachments have been submitted separately. |
| Claims (Attachments) | 2.226 | Offeror shall describe how its proposed services integrate with the SI content management processes and allow automatic quality and validation procedures to ensure accuracy of the information from paper claims attachments. |
| Claims (Attachments) | 2.227 | Offeror shall describe how its proposed services, edit a claim for the submission of required documents or attachments and supporting documentation based upon Enterprise configurable rules (e.g., program, clinical data, procedure, diagnosis, surgical reports, consent forms, incapacity evaluations, Provider communications, adjustment/void forms, updated turnaround documents) and maintain for audit purposes. |
| Claims (Attachments) | 2.228 | Offeror shall describe how its proposed services link (e.g. one to many, many to one, many to many) electronic claims attachments and images to appropriate transaction(s). |
| Claims (Attachments) | 2.229 | Offeror shall describe how its proposed services request claim attachments and supporting information based on configurable business rules (e.g., program, clinical data, procedure, diagnosis). |
| Claims (Data Integration) | 2.230 | Offeror shall describe how its proposed services provide prompt response to inquiries regarding the status of any claim through a variety of appropriate technologies (electronic, paper, portal, fax, phone) and tracks and monitors responses to the inquiries. Processes electronic claim status request and response transactions (ASC |

| Category | ID | Requirement Text |
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| | | X12N 276/277) required by 45 CFR Part 162. |
| Claims (Data Integration) | 2.231 | Offeror shall describe how its proposed services manage the collection of claims and adjustment information data (e.g., reporting, cost settlement, status, payment amounts, edit disposition, submission data, claim receipt date, information that is associated with the initial entry process such as batch or sequence numbers, captures Provider at the detail service line level, captures NDC and quantity amount information for physician administered drugs) and provide to the Enterprise in a standard format. |
| Claims (Data Integration) | 2.232 | Offeror shall describe how its proposed services update claims history and financial files with SHARE data (e.g., warrant or EFT number, payment date, amount paid). |
| Claims (Data Integration) | 2.233 | Offeror shall describe how its proposed services produce and provide claim and provider specific information for the accounting and fiscal processes. |
| Claims (Data Integration) | 2.234 | Offeror shall describe how its proposed services provide alternative and cost-effective distribution of remittance advice or 835 transactions that save the cost of mailing while continuing to meet the providers' needs. |
| Claims (Data Integration) | 2.235 | Offeror shall describe how its proposed services capture NDC and quantity amount information for physician administered drugs (e.g., revenue description field on all UB04 Medicare Crossover claims, "J" codes administered in the physician office on a CMS1500 form, HIPAA 837). |

| Category | ID | Requirement Text |
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| Claims (Data Integration) | 2.236 | Offeror shall describe how its proposed services provide User configurable RA templates (e.g., adjustment/void in a separate section, deductions) to the State to specify the organization, level of detail, and order of appearance on the RA. |
| Claims (Approving Claims and related transactions processing) | 2.237 | Offeror shall describe how its proposed services authorize claims for payment or deny claims based on adjustment reason and remark codes related to TPL. |
| Claims (Approving Claims and related transactions processing) | 2.238 | Offeror shall describe how its proposed services receive, edit and generate payment authorizations based on other submitted claims, voids and adjustments (e.g., EVV timesheets, TPL, recovery voids, recovery adjustments, PBM claims, QA claim adjustments or voids). |
| Claims (Claims and related transactions processing) | 2.239 | Offeror shall describe how its proposed services coordinate benefits during claims adjudication for Members with other coverage; to include, but not limited to, the following actions:<br>• Screen claims to determine if claims are for Members with TPL coverage (current and retroactive) and determine if service is covered by the third party and if date of service is within coverage period;<br>• Capture and update TPL coverage and match information to Member file for claim adjudication and refers to Enterprise TPL updates;<br>• Deny claims if the third-party payment information is not provided and message the provider to bill other party<br>• Deny claims for products or services that are covered by a third party and authorize payment when the service is not covered by the third-party;<br>• Edit claims, based on TPL information, and cost avoid or initiate "pay and chase" based on procedure code and/or eligibility data (e.g., age, pregnancy, institutionalized status) as specified in business rules<br>• Accept and update data on Member or third party payments (e.g., source, employer, copay, co-insurance, |

| Category | ID | Requirement Text |
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| | | deductible, Cost-avoidance, Trauma Editing, Post-payment Recovery actions) and deduct amounts from claim payment during adjudication at the line or header level based upon Enterprise configurable business rules; • Capture and provide TPL and/or cost avoidance data for reporting as required by Federal and State rules and regulations. |

*Table 6 Self-Directed Home and Community Based Services (SDHCBS) Requirements*

| Category | ID | Requirement Text |
|---|---|---|
| SDHCBS (Service & Support Plans and Authorized Budgets) | 3.001 | The Offeror shall describe how its proposed services provide web-based capability for SSP entry, updating, and inquiry. |
| SDHCBS (Service & Support Plans and Authorized Budgets) | 3.002 | The Offeror shall describe how its proposed services generate automated email notifications to the appropriate agency or broker for pending SSP entries, changes, approvals, and rejections. |
| SDHCBS (Service & Support Plans and Authorized Budgets) | 3.003 | The Offeror shall describe how its proposed services generate automated email notifications to the appropriate agency or broker for SSPs with insufficient funds for payroll. |
| SDHCBS (Service & Support Plans and Authorized Budgets) | 3.004 | The Offeror shall describe how its proposed services generate email notifications to the appropriate agency or broker of upcoming SSP expirations. |
| SDHCBS (Service & Support Plans and Authorized Budgets) | 3.005 | The Offeror shall describe how its proposed services provide queuing and workflow capabilities for handling SSPs. |
| SDHCBS (Service & Support Plans and Authorized Budgets) | 3.006 | The Offeror shall describe how its proposed services provide a mechanism to modify existing SSPs and pend, review, approve, and reject service-level SSP changes. |
| SDHCBS (Service & Support Plans and Authorized Budgets) | 3.007 | The Offeror shall describe how its proposed services validate participant eligibility on a daily basis based on updated client data. |

| Category | ID | Requirement Text |
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| SDHCBS (Service & Support Plans and Authorized Budgets) | 3.008 | The Offeror shall describe how its proposed services store key SSP dates, including but not limited to the date of expiration. |
| SDHCBS (Service & Support Plans and Authorized Budgets) | 3.009 | The Offeror shall describe how its proposed services track payroll expenditures against the SSP and display this data online. |
| SDHCBS (Service & Support Plans and Authorized Budgets) | 3.0010 | The Offeror shall describe how its proposed services provide the ability to produce the SSP as a report. |
| SDHCBS (Employer, Employee and Vendor Enrollment) | 3.011 | The Offeror shall describe how its proposed services create and distribute Employer Information Packets and Employee Information Packets with fields pre-populated from the Offeror's SDHCBS solution. |
| SDHCBS (Employer, Employee and Vendor Enrollment) | 3.012 | The Offeror shall describe how its proposed services provide telephone support to participants and employees for completion of information packets. |
| SDHCBS (Employer, Employee and Vendor Enrollment) | 3.013 | The Offeror shall describe how its proposed services support the receipt and review completed Employer Information Packets and Employee Information Packets. |
| SDHCBS (Employer, Employee and Vendor Enrollment) | 3.014 | The Offeror shall describe how its proposed services receive, process and store federal and state forms as required, including but not limited to the New Mexico Department of Labor Form ES-802, USCIS Form I-9, and IRS Forms SS-8, W-3, and W-9. |
| SDHCBS (Employer, Employee and Vendor Enrollment) | 3.015 | The Offeror shall describe how its proposed services enter employer and employee data from information packets into the SDHCBS solution. |
| SDHCBS (Employer, Employee and Vendor Enrollment) | 3.016 | The Offeror shall describe how its proposed services obtain license information and associated expiration dates and update this information in the SDHCBS solution. |
| SDHCBS (Employer, Employee and Vendor Enrollment) | 3.017 | The Offeror shall describe how its proposed services perform background and criminal record checks and fingerprinting, store hardcopy documents, and update indicators in the SDHCBS solution. |
| SDHCBS (Timesheet & Invoice Processing and Payment) | 3.018 | The Offeror shall describe how its proposed services receive timesheets and payment requests and enter them into the SDHCBS solution. |

| Category | ID | Requirement Text |
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| SDHCBS (Timesheet & Invoice Processing and Payment) | 3.019 | The Offeror shall describe how its proposed services use information from the EVV to create timesheets for support workers employed directly by participants. |
| SDHCBS (Timesheet & Invoice Processing and Payment) | 3.020 | The Offeror shall describe how its proposed services place telephone calls to timesheet and payment request submitters to resolve errors encountered during the data entry process, determine corrections, and enter corrections into the SDHCBS solution. |
| SDHCBS (Timesheet & Invoice Processing and Payment) | 3.021 | The Offeror shall describe how its proposed services set up positive and negative adjustments for retroactive timesheet changes. |
| SDHCBS (Timesheet & Invoice Processing and Payment) | 3.022 | The Offeror shall describe how its proposed services initiate retroactive payments, recoveries, and deductions from ongoing payments to offset previous overpayments. |
| SDHCBS (Timesheet & Invoice Processing and Payment) | 3.023 | The Offeror shall describe how its proposed services compute gross and net wages to employees, including deductions for retroactive recoveries and New Mexico gross receipt taxes. |
| SDHCBS (Timesheet & Invoice Processing and Payment) | 3.024 | The Offeror shall describe how its proposed services issue checks or direct deposits to employees at least biweekly and to vendors at least weekly. |
| SDHCBS (Timesheet & Invoice Processing and Payment) | 3.025 | The Offeror shall describe how its proposed services issue checks for retroactive underpayments. |
| SDHCBS (Timesheet & Invoice Processing and Payment) | 3.026 | The Offeror shall describe how its proposed services issue payments via prepaid debit card and block cash transactions and transactions from specified merchant category codes. |
| SDHCBS (Timesheet & Invoice Processing and Payment) | 3.027 | The Offer shall describe how its proposed services audit debit card use to verify that only approved goods and services have been purchased. |
| SDHCBS (Timesheet & Invoice Processing and Payment) | 3.028 | The Offeror shall describe how its proposed services track payroll expenditures against SSP. |

| Category | ID | Requirement Text |
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| SDHCBS (Timesheet & Invoice Processing and Payment) | 3.029 | The Offeror shall describe how its proposed services provide the data to update the vendor's solution with payroll and payment information. |
| SDHCBS (Timesheet & Invoice Processing and Payment) | 3.030 | The Offeror shall describe how its proposed services print and mail participant and vendor payroll/payment reports. |
| SDHCBS (Timesheet & Invoice Processing and Payment) | 3.031 | The Offeror shall describe how its proposed services produce all Internal Revenue Service (IRS) and New Mexico payroll, income tax, and worker's compensation forms, reports, and data. |
| SDHCBS (Timesheet & Invoice Processing and Payment) | 3.032 | The Offeror shall describe how its proposed services produce and distribute W-2 and 1099 forms to employees and vendors. |
| SDHCBS (Timesheet & Invoice Processing and Payment) | 3.033 | The Offeror shall describe how its proposed services provide routine workers compensation administration as part of payroll processing. |
| SDHCBS (Timesheet & Invoice Processing and Payment) | 3.034 | The Offeror shall describe how its proposed services perform an annual reconciliation and reimbursement process to properly account for Federal Insurance Contributions Act (FICA), State Unemployment Tax Act (SUTA) and Federal Unemployment Tax ACT (FUTA) dollars for employees/employers who did not generate sufficient wages within the tax year. |
| SDHCBS (Customer Support, Training and Reporting) | 3.035 | The Offeror shall describe how its proposed services incorporate a Mi Via Call Center to assist participants and employees with issues pertaining to the contractor's FMA responsibilities. |
| SDHCBS (Customer Support, Training and Reporting) | 3.036 | The Offeror shall describe how its proposed services provide call center representatives in English and Spanish Monday through Friday from 7:30 AM to 5:30 PM Mountain Time, except for State holidays. |
| SDHCBS (Customer Support, Training and Reporting) | 3.037 | The Offeror shall describe how its proposed services provide initial and ongoing training in a variety of formats and media to users of its SDHCBS solution, including State and MCO staff, home health agencies and support brokers, and participants and their |

| Category | ID | Requirement Text |
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| | | representatives. |
| SDHCBS (Customer Support, Training and Reporting) | 3.038 | The Offeror shall describe how its proposed services allow State and MCO Staff to run and generate various reports via a user-friendly interface, including but not limited to queries on participants, employees, EORs, vendors, and utilization of specific services. |

*Table 7 Pharmacy Benefit Management Requirements*

| Category | ID | Requirement Text |
|---|---|---|
| PBM | 4.001 | Offeror shall describe how its proposed services perform batch control and reporting. The uniquely TCN assignment, upon entering the system, shall be coordinated with the Enterprise standards for length and nonduplication for claims. |
| PBM | 4.002 | Offeror shall describe how its proposed services create and modify Pharmacy Benefit Plans within the Pharmacy Benefits Management service (PBM) such that the services, services limitations, prior authorizations, Provider rates, and Member cost sharing amounts within a Pharmacy Benefit Plan are easily configurable through a rule-driven design. |
| PBM | 4.003 | Offeror shall describe how its proposed services identify and limit services within a Pharmacy Benefit Plan for a specific Member, based on utilization criteria established by the State. |
| PBM | 4.004 | Offeror shall describe how its proposed services add, update, or delete Pharmacy Benefit Plan elements (e.g., TPL information, pricing, prior authorizations). |

| Category | ID | Requirement Text |
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| PBM | 4.005 | Offeror shall describe how its proposed services allow authorized Users to set and override Pharmacy Benefit Limits (e.g., Over-the-counter [OTC], Quantity limits). |
| PBM | 4.006 | Offeror shall describe how its proposed services provide the flexibility to support Pharmacy Benefit Plan geographical service areas (e.g., county, city, zip code, mileage, census tract, longitude and latitude, various combinations). |
| PBM | 4.007 | Offeror shall describe how its proposed services would calculate and set Medicaid co-pays by Pharmacy Benefit Plan and Member eligibility if so directed by HSD. |
| PBM | 4.008 | Offeror shall describe how its proposed services capture benefits used in a managed care plan and then apply those services to the benefit limits when a Member returns to FFS. |
| PBM | 4.009 | Offeror shall describe how its proposed services assign Members to Providers within a new Pharmacy Benefit Plan as a part of the Member Over-Utilization Program (COUP) program so that Members can only receive benefits from specific pharmacies, prescribers or combinations of the two. |
| PBM | 4.010 | Offeror shall describe how its proposed services allow manual enrollment/disenrollment in a Pharmacy Benefit Plan when data is not passed through the system. |
| PBM | 4.011 | Offeror shall describe how its proposed services support accurate and timely enrollment in, or disenrollment from, (e.g., automatic, choice-based) a Pharmacy Benefit Plan. |
| PBM | 4.012 | Offeror shall describe how its proposed services generate an error report when a Member is incorrectly enrolled or disenrolled in a Pharmacy Benefit Plan. |
| PBM | 4.013 | Offeror shall describe how its proposed services maintain current and historical records of Pharmacy benefit assignment(s) for Members. |
| PBM | 4.014 | Offeror shall describe how its proposed services perform Member prescription copay reset processing annually. |

| Category | ID | Requirement Text |
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| PBM | 4.015 | Offeror shall describe how its proposed services develop, establish, maintain and approve Specialty Pharmacy Benefit Plans in coordination with the State and other applicable stakeholders. |
| PBM | 4.016 | Offeror shall describe how its proposed services validate that a new drug is a covered outpatient drug before adding such a drug to the pharmacy benefit plan. |
| PBM | 4.017 | Offeror shall describe how its proposed services rules engine provides flexibility and capacity to support edits regarding high dose, standard billing units, and statistical outliers for drugs, including the ability to configure claims/encounter edits, pre-adjudication business rules, alerts and notification triggers. |
| PBM | 4.018 | Offeror shall describe how its proposed services allows authorized Users to create PBM rules for business functions with the ability to configure rules to be date specific (e.g., date added, date modified, start date, end date, effective date). |
| PBM | 4.019 | Offeror shall describe how its proposed services provide a built-in multi-level rule review and approval process with the State that will validate logic errors, conflicts, redundancy and incompleteness across business rules to identify any conflicts as they are being configured, tested, and implemented. |
| PBM | 4.020 | Offeror shall describe how its proposed services produce and maintain documentation regarding all business rules (e.g., exception handling rules, rule usage, exception usage, when the rules fail to work as designed), and provide recommendations to resolve rule failure. |
| PBM | 4.021 | Offeror shall describe how its proposed services allow real-time access and the flexibility to add and change business rules, indicators and parameters easily. |
| PBM | 4.022 | Offeror shall describe how its proposed services responds to changes in the business by using business rules management, business process management, and business activity |

| Category | ID | Requirement Text |
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| | | monitoring tools. |
| PBM | 4.023 | Offeror shall describe how its proposed services provide reporting for all contact channels with Members and Providers that includes total number of contacts received, contact received by channel, length of calls, hold time, abandoned calls, the nature of the inquiries, and the timeliness of inquiry responses for all PBM contact center and help desk activities. |
| PBM | 4.024 | Offeror shall describe how its proposed services maintain and staff a Provider communications/relations function. This Provider communications/relations function shall include, but is not limited to, the following: providing and receiving communication from toll-free lines; email communication; webinar communication; toll-free fax communication; an automated IVR message informing the Provider of their hold and wait times; providing NM-specific staff during the contractor's business hours. Maintaining adequate numbers of telephone lines, technology, and personnel so that all performance standards are met. |
| PBM | 4.025 | Offeror shall describe how its proposed services provide a centralized contact/call center and help desk database or reporting capability that creates, edits, sorts, and filters tickets or electronic records of all contacts made to the PBM contact/call center and help desk that can be accessed and utilized by authorized State Staff for Provider and Member tracking and management. |
| PBM | 4.026 | Offeror shall describe how its proposed services provide contact/call center, help desk, web knowledge base and other support services to users, including PBM, and pharmacy Point of Sales (POS). |
| PBM | 4.027 | Offeror shall describe how its proposed services provide qualified staff as the primary point of contact for drug manufacturers and their representatives on behalf of the State. |

| Category | ID | Requirement Text |
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| PBM | 4.028 | Offeror shall describe how its proposed services provide, maintain and completely staff a Pharmacy Support Help Desk available twenty-four (24) hours per day, seven (7) days per week, to include a state of the art call center telephony system, an appropriate number of telephone lines/trunks, and 24-hour pharmacist backup. |
| PBM | 4.029 | Offeror shall describe how its proposed services monitor and report the Pharmacy Support Help Desk's performance and call blockage rate. |
| PBM | 4.030 | Offer shall describe how its proposed services provides bi-directional integration capabilities between the PBM contact/call center/help desk and the CCSC's services (CRM, chat, phone, and data) for all relevant contact types and channels |
| PBM | 4.031 | Offeror shall describe how its proposed services ensure all Pharmacy Support Help Desk Staff Members are trained in billing procedures and current New Mexico Medicaid policy. The Contractor shall provide for periodic training of telephone representatives. |
| PBM | 4.032 | Offeror shall describe how its proposed services respond, track, and resolve all Provider inquiries made concerning recipient eligibility, Provider status, claim status, billing procedures, and remittance vouchers upon initial request, if possible. If immediate responses are not possible, written responses to inquiries will be made within five (5) workdays of the date of the inquiry. The State will approve all form letters in writing before they are put into production use. |
| PBM | 4.033 | Offeror shall describe how its proposed services maintain a log of Pharmacy Support Help Desk activity that will include, at a minimum and when applicable, the name and phone number of the pharmacy, prescriber's name and identification number, Member's name and identification number, name of drug, therapeutic class, type of call, action taken, and outcome. The contractor shall make an electronic version of the log available to the State upon request. The |

| Category | ID | Requirement Text |
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|  |  | contractor shall provide summary reports as directed by the State. The format of the log and of the summary reports will be subject to the State's approval. |
| PBM | 4.034 | Offeror shall describe how its proposed services provide and maintain user-controlled and user-configurable parameters for alerts, notifications messages, emails, PBM letters, and other PBM generated notices. |
| PBM | 4.035 | Offeror shall describe how its proposed services integrate with the Customer Communication Managements (CCM) so that authorized Users can incorporate information on Members and Providers, from the PBM, to be merged into template letters and forms to communicate with Members, Providers, and others. |
| PBM | 4.036 | Offeror shall describe how its proposed services utilize user-defined templates to generate correspondence (notices) to drug manufacturers relating to disputed rebates (e.g., initial acknowledgement, resolution of disputed amounts, details on adjustments to accounts receivable). |
| PBM | 4.037 | Offeror shall describe how its proposed services create and maintain a directory of all contact information for use in generation of correspondence. |
| PBM | 4.038 | Offeror shall describe how its proposed services capture, store, and transmit, to the Enterprise, all data elements submitted on drug related claims from PBM. |
| PBM | 4.039 | Offeror shall describe how its proposed services capture, store and maintain data necessary to: correctly adjudicate pharmacy claims; perform online pharmacy claim correction; maintain and perform edits (e.g., date of service, provider eligibility, member eligibility, duplicate, conflict/compatible, complies with State Plan, field validation, referral, prior authorization)  and audits; allow claims adjustments; allow online access to pharmacy claims history; correctly price all pharmacy claims/encounters at the detail service line and header level; allow online access to suspended pharmacy claims; provide and allow online access to pharmacy claims |

| Category | ID | Requirement Text |
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| | | adjudication and status reporting; and maintain pharmacy claims history. |
| PBM | 4.040 | Offeror shall describe how its proposed services provide ongoing analysis and a clinical review of new name brand and generic drugs for clinical safety and efficacy. |
| PBM | 4.041 | Offeror shall describe how its proposed services provide ongoing analysis and a clinical review of existing drugs for new indications or changes to indications, and for new product forms and strengths. |
| PBM | 4.042 | Offeror shall describe how its proposed services provides a field for authorization or identification when the Provider enters the required override codes for actions taken in response to the drug interaction alerts/warnings and the outcomes of those actions (e.g., physician contacted, incorrect ICD-9-CM/ICD-10-CM, patient quit taking the medication). The system must maintain these acknowledgement codes in history, as well as report them in compliance with HIPAA specifications. |
| PBM | 4.043 | Offeror shall describe how its proposed services support interaction criteria in the system using clinically significant drug criteria so that only appropriate alerts/denials are transmitted back to the Provider. |
| PBM | 4.044 | Offeror shall describe how its proposed services ensure that, for each alert/denial, the system must inform the Provider of the following: <br> a) Alert conflict type (e.g., drug allergy alert), <br> b) Alert severity level (e.g., minor, major), <br> c) Available data related to the alert (e.g., other drug or condition in conflict), including references, <br> d) Other alerts as identified by the State. |
| PBM | 4.045 | Offeror shall describe how its proposed services provide configurable Pro-DUR edits based on State and CMS standards. |

| Category | ID | Requirement Text |
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| PBM | 4.046 | Offeror shall describe how its proposed services ensure Pro-DUR edits are applied to claims and any edits that post are reported back to the submitting pharmacy. |
| PBM | 4.047 | Offeror shall describe how its proposed services receive and maintain DUR data with associated DUR processing algorithms to allow Pro-DUR processing with the capability of receiving data and algorithm updates on at least a monthly basis or more frequently as specified by the State. |
| PBM | 4.048 | Offeror shall describe how its proposed services identify, based upon State configurable criteria, patients receiving active prescriptions concurrently and refer them for clinical review. |
| PBM | 4.049 | Offeror shall describe how its proposed services incorporate diagnosis codes from medical claims history in the Pro-DUR editing process. |
| PBM | 4.050 | Offeror shall describe how its proposed services analyze POS and DUR processing and make recommendations supported by data on any criteria or DUR areas to improve the prescription drug benefit and increase cost-effectiveness. |
| PBM | 4.051 | Offeror shall describe how its proposed services identify clinically significant alerts (e.g., drug allergy, interaction) and edits for POS that the State has determined should receive on automatic denial. |
| PBM | 4.052 | Offeror shall describe how its proposed services provide DUR outputs as requested by the State. |
| PBM | 4.053 | Offeror shall describe how its proposed services track and set up alerts for any new drugs for DUR consideration. |
| PBM | 4.054 | Offeror shall describe how its service provide Pro-DUR capability twenty-four (24) hours per day, seven (7) days a week (24x7), with response times as agreed to by the State. Exception may be allowed for downtime required for regular maintenance if pre-approved by the State. |

| Category | ID | Requirement Text |
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| PBM | 4.055 | Offeror describe how its services identify any Member restricted to a specific pharmacy ("lock-in") and/or Provider and alert the dispensing pharmacy as necessary. |
| PBM | 4.056 | Offeror shall describe how its proposed services provide real-time Pro-DUR alerts for pharmacy claims submitted through the POS system. |
| PBM | 4.057 | Offeror shall describe how its proposed services provide a method for Providers to override Pro-DUR edits or audits to allow payment of the pharmacy claim, as approved by the State. |
| PBM | 4.058 | Offeror shall describe how its proposed services establishes and maintains edits for Pro-DUR alerts requiring service authorization, including but not limited to early refills, level I drug-to-drug interactions, drugs restricted to a thirty-four (34) day supply limit. |
| PBM | 4.059 | Offeror shall describe how its proposed services perform all necessary clinical data analysis (e.g., supports DUR examination pattern analysis using predetermined standards of physician prescribing practices, drug use by individual patients and, where appropriate, dispensing practices of pharmacies) to develop recommendations for specific DUR intervention initiatives and the associated objectives, protocols, guidelines and operational procedures. |
| PBM | 4.060 | Offeror shall describe how its proposed services annually perform a number of DUR interventions as determined by the State and in accordance with a schedule provided by the State. |
| PBM | 4.061 | Offeror shall describe how its proposed services integrate with the web portal through the Enterprise IP to allow authorized users to access DUR information. |
| PBM | 4.062 | Offeror shall describe how its proposed services provide training to State staff, Contractor staff, and to Providers on application of Pro-DUR principles. |

| Category | ID | Requirement Text |
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| PBM | 4.063 | Offeror shall describe how its proposed services establish and maintain a connection with the New Mexico Prescription Drug Monitoring Program (PDMP) system. |
| PBM | 4.064 | Offeror shall describe how its proposed services access the (PDMP) system for the purpose of identifying, analyzing, and monitoring controlled substance utilization for specified New Mexico Medicaid Members. |
| PBM | 4.065 | Offeror shall describe how its proposed services use predetermined standards to monitor the following:<br>(1) Therapeutic appropriateness, that is, drug prescribing and dispensing that is in conformity with the predetermined standards.<br>(2) Overutilization and underutilization, as defined in § 456.702.<br>(3) Appropriate use of generic products, that is, use of such products in conformity with State product selection laws.<br>(4) Therapeutic duplication as described in § 456.705(b)(1).<br>(5) Drug-disease contraindication as described in § 456.705(b)(2).<br>(6) Drug-drug interaction as described in § 456.705(b)(3).<br>(7) Incorrect drug dosage as described in § 456.705(b)(4).<br>(8) Incorrect duration of drug treatment as described in § 456.705(b)(5).<br>(9) Clinical abuse or misuse as described in § 456.705(b)(7). |
| PBM | 4.066 | Offeror shall describe how its proposed services set post-processing edit(s) or flag rejected claims and indicate the reason for which the claim was rejected. |
| PBM | 4.067 | Offeror shall describe how its proposed services reject or deny pharmacy claims with certain diagnoses codes, for specific situations (e.g., services, Members, pharmacies, prescribers). |
| PBM | 4.068 | Offeror shall describe how its proposed services validate that a submitted Member's diagnosis code(s) supports the service being billed. |

| Category | ID | Requirement Text |
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| PBM | 4.069 | Offeror shall describe how its proposed services verify that one or more claims do not exceed State defined service limits established in a Pharmacy Benefit Plan prior to payment. |
| PBM | 4.070 | Offeror shall describe how its proposed services pursue edits on all benefits and services, and benefit utilization service claims for TPL coverage prior to payment (cost avoid) based on the Pharmacy Benefit Plan to ensure Medicaid is the payer of last resort. |
| PBM | 4.071 | Offeror shall describe how its proposed services perform clinical claims edits using nationally accepted medical review criteria. |
| PBM | 4.072 | Offeror shall describe how its proposed services respond to Providers, based on State-defined criteria, when claims with automated NCPDP edits and/or supplemental customized edits fail. |
| PBM | 4.073 | Offeror shall describe how its proposed services post edits and deny claims billing separately for a drug for the same Member using different drug identifiers such as HCPCS or NDC number. |
| PBM | 4.074 | Offeror shall describe how its proposed services post edits and deny claims from the same Provider who is billing more than once for the same drug, Member, and/or the same claim. |
| PBM | 4.075 | Offeror shall describe how its proposed services post edits and deny claims from different Providers who are billing separately for a drug for the same Member. |
| PBM | 4.076 | Offeror shall describe how its proposed services deny claims by comparing the Pharmacy claim against Member history and benefit rules and per State and Federal policy, (e.g., over or under utilization of a drug, used in lower or higher than effective doses, a refill pattern that indicates noncompliance, drug-use duration outside of therapy recommendations, prescribed overlap of two drugs within the same therapeutic class, drug that would be contraindicated for any reason (e.g., such as allergy, age, gender) therapeutic |

| Category | ID | Requirement Text |
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| | | appropriateness, appropriate use of generic products, therapeutic duplicate disease. |
| PBM | 4.077 | Offeror shall describe how its proposed services edit the active drug claim against up to twelve (12) month of utilization history. |
| PBM | 4.078 | Offeror shall describe how its proposed services limit pharmacy claims payments to NDCs manufactured by manufacturers (labelers) with a current CMS drug rebate agreement. |
| PBM | 4.079 | Offeror shall describe how its proposed services maintain systems edits to recognize and deny pharmacy claims for an inappropriate number of units based on clinically appropriate dosing guidelines with allowed Provider overrides. |
| PBM | 4.080 | Offeror shall describe how its proposed services perform all necessary validity, logic, consistency, and coverage editing based on Enterprise policy for all pharmacy claims submitted. |
| PBM | 4.081 | Offeror shall describe how its proposed services maintain edits to support "emergency supply" limitations for pharmaceuticals, as determined by the State. |
| PBM | 4.082 | Offeror shall describe how its proposed services allow claim editing and disposition based on specific characteristics of the Provider (e.g., claims for drugs prescribed by a psychiatrist versus non-psychiatrist Provider type) or therapeutic class of the prescribed drug(s). |
| PBM | 4.083 | Offeror shall describe how its proposed services integrate on-line real-time edits and audits on pharmacy claims to support State and Federal policy-compliant pro-DUR edits that are tied to NCPDP pro-DUR codes as determined and directed |

| Category | ID | Requirement Text |
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| | | by the State and the DUR Board. |
| PBM | 4.084 | Offeror shall describe how its proposed services assist in development of claim edits and audits for coded drug claims (e.g., HCPCS, drug procedure codes), as specified by the State. |
| PBM | 4.085 | Offeror shall describe how its proposed services splits cash receipts between multiple Providers, carriers, drug and rebate manufacturers. |
| PBM | 4.086 | Offeror shall describe how its proposed services create financial transactions for PBM generated claims through the Enterprise and Supporting Services for payment. |
| PBM | 4.087 | Offeror shall describe how its proposed services integrate with the IP to obtain and retain Member real-time enrollment and eligibility information that was current for the dates of service at the time of processing the claim. |
| PBM | 4.088 | Offeror shall describe how its proposed services integrate with Enterprise content management services to view, store and search all imaged and electronic attachments associated with each claim. |
| PBM | 4.089 | Offeror shall describe how its proposed services integrate with the IP to provide claim information that can be used for proving fraud and abuse cases in a legal setting. The Contractor shall provide original claim information submitted by the Provider and generate a replica of the appropriate claim format, on a claim-by-claim basis. |
| PBM | 4.090 | Offeror shall describe how its proposed services coordinate PBM and supporting systems-related integrations between the Enterprise and other Contractors required to manage and execute a process using the PBM. |

| Category | ID | Requirement Text |
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| PBM | 4.091 | Offeror shall describe how its proposed services receive, maintain and update Member eligibility data, managed care enrollment data, Medicare data, Provider eligibility, other insurance resources, Member benefit limitations, and other data necessary for the PBM to correctly process pharmacy claims. |
| PBM | 4.092 | Offeror shall describe how its proposed services provide files to Contractors for data exchanges with other entities (e.g., insurance carriers, governmental agencies, providers) for use in utilization review. |
| PBM | 4.093 | Offeror shall describe how its proposed services receive Provider data from the Enterprise to support claims adjudication. |
| PBM | 4.094 | Offeror shall describe how its proposed services accept NCPDP 1.1 batch (non-real time) format for electronic pharmaceutical drug encounter records. |
| PBM | 4.095 | Offeror shall describe how its proposed services interface with: <br> a) Provider services <br> b) Enterprise files (e.g., claims, Beneficiary, Provider, procedure, drug, diagnosis. |
| PBM | 4.096 | Offeror shall describe how its proposed services integrate with the Enterprise IP for posting and reporting of rebate receipts in FS cash log. |
| PBM | 4.097 | Offeror shall describe how its proposed services set different reimbursement methodologies or pricing methodologies for pharmacy claims using such information as dispensing fees, Provider type, CMS national coding standards, HIPAA/NCPDP standards, urban/rural locations or other information identified by the State. |
| PBM | 4.098 | Offeror shall describe how its proposed services receive pricing information from various sources, (e.g., third party vendors, contactors, CMS, the Enterprise), and input into the |

| Category | ID | Requirement Text |
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| | | PBM. |
| PBM | 4.099 | Offeror shall describe how its proposed services provide a configurable system to allow for updates and changes to rates and various pricing methodologies. |
| PBM | 4.100 | Offeror shall describe how its proposed services create date-sensitive modifications to the reimbursement rates as directed by the State. |
| PBM | 4.101 | Offeror shall describe how its proposed services price claims/encounters based on reimbursement methodology criteria, dispensing fee criteria and date specifications set by the State. |
| PBM | 4.102 | Offeror shall describe how its proposed services price and process DME supply claims/encounters. |
| PBM | 4.103 | Offeror shall describe how its proposed services maintain current and historical coverage status and pricing information on pharmaceuticals (e.g., legend drugs, OTC items, injection codes). |
| PBM | 4.104 | Offeror shall describe how its proposed services flag, for review, individual drugs and compounds which indicate a need for manual pricing intervention. |
| PBM | 4.105 | Offeror shall describe how its proposed services maintain pricing for all procedure coded outpatient covered drugs utilizing a method approved by the State that is in compliance with State and Federal guidelines. |
| PBM | 4.106 | Offeror shall describe how its proposed services allow authorized PBM users to view detailed pricing (e.g., dispensing fee, prescription amount) methodology per prescription and calculations used to process each line on the claim. |

| Category | ID | Requirement Text |
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| PBM | 4.107 | Offeror shall describe how its proposed service process weekly updates from First Data Bank or a similar State-approved from drug pricing service to receive and update reference file data. The Pricing Service Contractor will provide the subcontracted drug pricing service at no additional cost to the State. Maintain and update all pricing levels as defined by the State, including estimated acquisition costs, state allowed maximum costs, federal upper limits, baseline pricing, WAC (wholesale actual cost), federal supply schedule pricing, and any other pricing levels which the State can supply directly or through electronic interface. |
| PBM | 4.108 | Offeror shall describe how its proposed services edit prescription claims based on presence of prior authorization (PA). |
| PBM | 4.109 | Offeror shall describe how its proposed services automatically adjudicate claims for drugs requiring prior authorization for which criteria has been met. |
| PBM | 4.110 | Offeror shall describe how its proposed services supports electronic signature functionality and accepts digital signatures from Providers on prior authorization request and prescribing Physicians. |
| PBM | 4.111 | Offeror shall describe how its proposed services auto-assign a unique, non-duplicated PA number for tracking throughout the life of the PA. This PA number shall be used in claim processing to validate the services and shall be recorded on the claim record. |
| PBM | 4.112 | Offeror shall describe how its proposed services accept, store and edit PAs, including the ability to automatically and manually edit PAs. |
| PBM | 4.113 | Offeror shall describe how its proposed services identify and reject duplicate PAs. |
| PBM | 4.114 | Offeror shall describe how its proposed services link |

| Category | ID | Requirement Text |
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| | | multiple PAs to a Member record and display them. |
| PBM | 4.115 | Offeror shall describe how its proposed services produce and maintain notices to Members and Providers regarding PAs. |
| PBM | 4.116 | Offeror shall describe how its proposed services update notification letters regarding PA determinations when business rules are updated (e.g., changing denial reasons). |
| PBM | 4.117 | Offeror shall describe how its proposed services coordinate and standardize processing and tracking of PA data for the purpose of utilization review. |
| PBM | 4.118 | Offeror shall describe how its proposed services identify, search, and report on PAs with potentially conflicting or duplicative data. |
| PBM | 4.119 | Offeror shall describe how its proposed services exempt designated Members from PA requirements, according to State policy. |
| PBM | 4.120 | Offeror shall describe how its proposed services allow users to search and view PAs by selected criteria such as Provider, Member, PA type and drug information. |
| PBM | 4.121 | Offeror shall describe how its proposed services maintain a history of PA attachments such as: a) Surgical/anesthesia report b) Medical record c) X-rays/images d) Orthodontic study models e) LTC PA f) Certain prescription drugs as required g) Other items required by State or Federal rule. |
| PBM | 4.122 | Offeror shall describe how its proposed services maintain online inquiry access and update capability for authorized Users to the PA data set (e.g., in-process or pending requests, approvals, denials, referred to the State or a consultant, PAs for which all services have been used, PA closed), with access by various criteria (e.g., Member ID, Provider ID, ordering Provider ID, PA number, program, service type, procedure, drug code). |

| Category | ID | Requirement Text |
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| PBM | 4.123 | Offeror shall describe how its proposed services adjudicate and edit claims for drugs that require prior authorization. |
| PBM | 4.124 | Offeror shall describe how its proposed services provide the ability to assign PBM caseload "weights" to cases, PI requests, or PA requests based upon difficulty or other criteria such as complexity and priority. |
| PBM | 4.125 | Offeror shall describe how its proposed services alert authorized PBM user and/or Providers when a Member is approaching prior authorization benefit/service maximum. |
| PBM | 4.126 | Offeror shall describe how its proposed services include prior authorization support (e.g., capability to search the claims history to determine if previous steps in therapy have occurred) prior to approving or denying the drug claim. |
| PBM | 4.127 | Offeror shall describe how its proposed services enforce the State's prior authorization policies by performing the following activities: Receiving prior authorization requests from Providers, processing such requests in accordance with State policy, and entering approved authorizations into the PBM. Interfacing with the MMIS prior authorization information as determined by the State's Third-Party Assessor (TPA) contractor, Children's Medical Services, and other agencies providing authorizations for service, and enforcing prior authorization criteria as a requirement for payment as defined by the State, performing both electronic interface and manual updates.  Continually analyzing the prior authorization data interfaces and process to improve the accuracy of the information in the PBM.  Entering authorization information as necessary from paper copies, reports, logs or other documents as determined by the State as necessary to process claims timely and accurately including allowing for directing of authorization information into the PBM by Contractor staff. |
| PBM | 4.128 | Offeror shall describe how its proposed services flag or re-price claims/encounters when requested by the State. |

| Category | ID | Requirement Text |
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| PBM | 4.129 | Offeror shall describe how its proposed services suppress claims processing (e.g., entirely, specific edits, pricing) based on criteria (e.g., behavioral health, pay and chase, management override) defined by the State and refer for follow up. |
| PBM | 4.130 | Offeror shall describe how its proposed services identify 340B claim lines, conforming to the NCPDP Standard Transactions Format. |
| PBM | 4.131 | Offeror shall describe how its proposed services prevent Providers, pharmacies, and prescribers from submitting claims or verifications successfully unless the Provider is actively enrolled. |
| PBM | 4.132 | Offeror shall describe how its proposed services maintain identifiers for designating Providers who can submit paper claims or electronic claims. |
| PBM | 4.133 | Offeror shall describe how its proposed services maintain Provider data to support claims processing and prior authorizations. |
| PBM | 4.134 | Offeror shall describe how its proposed services accept National Provider Identifier (NPI) numbers from prescribers on all claims and provide the ability to capture other ID numbers, (e.g., Drug Enforcement Agency [DEA], National Association of Boards of Pharmacy [NABP], Enterprise ID), where appropriate. |
| PBM | 4.135 | Offeror shall describe how its proposed services allow adjustment and/or void of claims (e.g., payment amounts, mass adjustments) based on data received from the Enterprise and/or user-defined selection criteria and provide adjustment and void information to the Enterprise. |
| PBM | 4.136 | Offeror shall describe how its proposed services accept and process approved national standard paper claim forms or electronic claims transactions and send appropriate associated standard responses. |

| Category | ID | Requirement Text |
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| PBM | 4.137 | Offeror shall describe how its proposed services link original claims to subsequent adjustments for a consistent audit trail including overrides. |
| PBM | 4.138 | Offeror shall describe how its proposed services perform claim corrections, making paid, denied, or rejected claims available for review and analysis and when deemed appropriate, allow for reversal or resubmission for applying corrections. |
| PBM | 4.139 | Offeror shall describe how its proposed services provide an NCPDP/HIPAA-compliant transmission response, (e.g., acceptance, rejection) to the submitting Provider on the success/failure of the submission of claims and/or files. |
| PBM | 4.140 | Offeror shall describe how its proposed services process claims against defined services, policy and payment parameters within the Pharmacy Benefit Plan for each Benefit Plan. |
| PBM | 4.141 | Offeror shall describe how its proposed services perform adjudication, including validating data items which can be obtained by mathematical manipulation of other data items, agree with the results of that manipulation and utilizes data elements and algorithms to compute claim reimbursement for claims that is consistent with 42 CFR 447, for individual claims and batch claims. |
| PBM | 4.142 | Offeror shall describe how its proposed services process, verify, and adjudicate mass adjustments for all paid and denied claims and zero pays. |
| PBM | 4.143 | Offeror shall describe how its proposed services exclude claims from mass adjustments (as defined by State rules) that have zero impact to a payment. |
| PBM | 4.144 | Offeror shall describe how its proposed services adjust, process and/or price Medicaid/Medicare dual eligible claims in accordance with Medicare guidelines. |

| Category | ID | Requirement Text |
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| PBM | 4.145 | Offeror shall describe how its proposed services adjudicate claims based on national standard adjustment reason codes and remark codes from third parties where Medicaid is not the primary payer. |
| PBM | 4.146 | Offeror shall describe how its proposed services use co-insurance, co-pay and deductibles from third parties at the detail level for detail-oriented claims. |
| PBM | 4.147 | Offeror shall describe how its proposed services limit payment for drugs to those described within the Pharmacy Benefit Plan and shall deny claims exceeding dollar or utilization limits established in the Pharmacy Benefits Plan. |
| PBM | 4.148 | Offeror shall describe how its proposed services allow Providers to report Member payments on their claims such as copays, co-insurance and deductibles. |
| PBM | 4.149 | Offeror shall describe how its proposed services utilize quality and validation procedures to ensure accuracy of the information from paper claims and attachments, entered the PBM while validating data entry before it is adjudicated. |
| PBM | 4.150 | Offeror shall describe how its proposed services apply, track and document recovered or recoverable monies to the appropriate claims at the detail level. |
| PBM | 4.151 | Offeror shall describe how its proposed services adjudicate claims based on Provider type and specialty data per State and Federal policy (e.g., only allowing mental health medications to be prescribed by a psychiatrist). |
| PBM | 4.152 | Offeror shall describe how its proposed services contain current reference files of all data required to provide validation and pricing verification during claims processing for all approved claims and reimbursement methodologies. |
| PBM | 4.153 | Offeror shall describe how its proposed services identify claims currently and previously subject to audit or recovery down to the line detail level. |

| Category | ID | Requirement Text |
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| PBM | 4.154 | Offeror shall describe how its proposed services identify, analyze, and correct errors that have resulted in improper claims processing (e.g., final edit dispositions are incorrect, incorrect rate), trace to the error source, reprocess as needed, and report to the State. |
| PBM | 4.155 | Offeror shall describe how its proposed services return real-time, to the pharmacy Provider, the status of the claim and any errors or alerts associated with the processing, (e.g., edit failures, ProDUR alerts, Member or coverage restrictions, prior authorization missing, required coordination of benefits, refill too soon, requires generic substitution, deny experimental drugs, requires unit dose {or not}, package size not approved, drug efficacy study implementation [DESI] are not covered) as defined by the State. |
| PBM | 4.156 | Offeror shall describe how its proposed services provide a method of extracting claims and other documentation for NDC line items that are in dispute. |
| PBM | 4.157 | Offeror shall describe how its proposed services automatically recoup claim details and generate a report if the billing Provider does not respond within the State specified timeframe to request for invoices or billing documents. |
| PBM | 4.158 | Offeror shall describe how its proposed services provide the capability to override Provider recoupments in accordance with State-defined criteria. |
| PBM | 4.159 | Offeror shall describe how its proposed services initiate adjustments if the billing Provider identifies an error in the claim data billed. |
| PBM | 4.160 | Offeror shall describe how its proposed services report to the State all pharmacy adjustments and recoupments made as a result of dispute research. |

| Category | ID | Requirement Text |
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| PBM | 4.161 | Offeror shall describe how its proposed services provide an automated mechanism to subject each disputed prescription to a series of queries that compare the billed amount, quantity paid, and system-calculated allowed amount (e.g., the maximum amount the State would pay for the prescription, data items which can be obtained by mathematical manipulation of other data items, agree with the results of that manipulation and utilizes data elements and algorithms to compute claim reimbursement for claims that is consistent with 42 CFR 447) in order to identify the universe of claims for disputed NDCs. |
| PBM | 4.162 | Offeror shall describe how its proposed services implement and maintain the capability to apply Drug Rebate Recoveries to encounters/claims through history only adjustments for the Claims Administration/Drug Rebate activities. |
| PBM | 4.163 | Offeror shall describe how its proposed services track, by manufacturer, pharmacy claims for drug rebate reporting. |
| PBM | 4.164 | Offeror shall describe how its proposed services provide the capability to track, report, and process prior period adjustments. |
| PBM | 4.165 | Offeror shall describe how its proposed services adjudicate ninety-nine percent (99%) of pharmacy claims submitted via POS technology in real-time. |

| Category | ID | Requirement Text |
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| PBM | 4.166 | Offeror shall describe how its proposed services provide a POS Solution, which includes at a minimum the following capabilities:<br>a) Transmission and online real-time processing of pharmacy claims with immediate response to the Provider,<br>b) Real-time access to Member and Provider eligibility information and IDs,<br>c) Prior approval processing,<br>d) TPL processing and response,<br>e) Notification of co-payment requirements,<br>f) Reversal of claims,<br>g) Compounded prescriptions processing including processing of drug rebates related to compounded prescriptions,<br>h) Accept and process qualifier from the pharmacy or help desk to permit overrides for emergencies, life-threatening illnesses, and other situations defined by the Enterprise. |
| PBM | 4.167 | Offeror shall describe how its proposed services price pharmacy claims according to Enterprise-defined reimbursement methodologies at the lesser of the Enterprise's recognized pharmacy reimbursement methods (e.g., WAC + dispensing fee; Federal MAC [CMS Federal Upper Limit + Dispensing Fee]; Usual and Customary Charges to General Public; Enterprise MAC [Enterprise MAC + Dispensing Fee]). |
| PBM | 4.168 | Offeror shall describe how its proposed services adjudicate electronic adjustments to paid claims submitted through the Pharmacy POS Solution. |
| PBM | 4.169 | Offeror shall describe how its proposed services verify the pharmacy Provider and Member was eligible on the same date that the service was provided. |
| PBM | 4.170 | Offeror shall describe how its proposed services allow for multiple reversals and partial fills on drug claims. |

| Category | ID | Requirement Text |
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| PBM | 4.171 | Offeror shall describe how its proposed services automatically identify and validate the dispensing pharmacist against a database of sanctioned pharmacists. |
| PBM | 4.172 | Offeror shall describe how its proposed services capture, calculate, and store the duration of time between the initial prescription and subsequent refills. |
| PBM | 4.173 | Offeror shall describe how its proposed services generate pharmacy claims to bill for reimbursement purposes. |
| PBM | 4.174 | Offeror shall describe how its proposed services provide an alert to designated staff when a pharmacy claim is paid for specific NDCs (e.g., smoking cessation). |
| PBM | 4.175 | Offeror shall describe how its proposed services perform online real-time capture, processing and adjudication of pharmacy claims, including applying copayment amounts, submitted by Providers via POS devices, a switch, or through the Internet (e.g., ASC X12N NCPDP and subsequent-version claims required by 45 CFR Part 162). |
| PBM | 4.176 | Offeror shall describe how its proposed services ensure the processing and adjudication of claims for medical supplies (e.g., diabetic test strips, blood glucose monitors, other medical supplies) in accordance with a process approved by the State. |
| PBM | 4.177 | Offeror shall describe how its proposed services suspend POS claims per State policy. |
| PBM | 4.178 | Offeror shall describe how its proposed services suspend compounded pharmaceutical claims when the submitted "usual and customary" charge exceeds a State defined threshold. |
| PBM | 4.179 | Offeror shall describe how its proposed services perform pharmacist review and either approve or deny all compound claims that suspend for review. |

| Category | ID | Requirement Text |
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| PBM | 4.180 | Offeror shall describe how its proposed services adhere to all applicable State and Federal requirements pertaining to State and Federal rebate programs in processing claims. |
| PBM | 4.181 | Offeror shall describe how its proposed services use NCPDP standards and the Pharmacy Universal Claim Form or a similar Form approved by the State, including online submission of multiple ingredient compound prescriptions, ability to receive and verify all NCPDP data fields, voids, rebilling, partial fill transactions, and the most detailed levels of reject code specificity. |
| PBM | 4.182 | Offeror shall describe how its proposed services process other input documents including, but not limited to, claims for Medicare coinsurance and deductible (crossover claims), in both paper and electronic formats, authorizations for service in paper and electronic formats, and claim adjustments in paper and electronic formats. |
| PBM | 4.183 | Offeror shall describe how its proposed services accept return responses for eligibility verification and claim history requests in real-time. |
| PBM | 4.184 | Offeror shall describe how its proposed services work with pharmacies to minimize or eliminate missing or invalid prescriber identifying information. |
| PBM | 4.185 | Offeror shall describe how its proposed services maintain Member records and provide response to Provider inquiries on Member claims, services, or benefits, as appropriate. |
| PBM | 4.186 | Offeror shall describe how its proposed services accommodate CMS quarterly updated drug data information in electronic formats defined by CMS. |
| PBM | 4.187 | Offeror shall describe how its proposed services report any encounters that would have been adjudicated differently if they had been processed as fee for service claims. |
| PBM | 4.188 | Offeror shall describe how its proposed services provide the capability to display multiple POS explanation of benefits |

| Category | ID | Requirement Text |
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| | | messages. |
| PBM | 4.189 | Offeror shall describe how its proposed services create explanation of benefit codes to use when denying a compound claim. |
| PBM | 4.190 | Offeror shall describe how its proposed services identify and notify the State of all errors and discrepancies found in the PBM that pertain to the State. |
| PBM | 4.191 | Offeror shall describe how its proposed services assist State staff and Contractors with research, resolution, and response to Member and Provider issues related to the PBM. |
| PBM | 4.192 | Offeror shall describe how its proposed services access, plan, develop, implement, and evaluate locally-based Provider and Member education initiatives including pharmacy program-specific training and communications to pharmacy Providers, medical Providers and Members. |
| PBM | 4.193 | Offeror shall describe how its proposed services allow authorized Users to define plans, benefits, and pricing in the PBM. |
| PBM | 4.194 | Offeror shall describe how its proposed services facilitate the State's E-Prescribing. |
| PBM | 4.195 | Offeror shall describe how its proposed services provide a Member eligibility file to third party E-Prescribing vendors on a real-time basis. |
| PBM | 4.196 | Offeror shall describe how its proposed services provide a POS Solution with the ability to identify Medicare dual-eligible and to edit pharmacy claims pursuant to the State's policies. |
| PBM | 4.197 | Offeror shall describe how its proposed services provide a mechanism where an NDC code can be entered via the POS and a response will designate if a pharmaceutical is covered or non-covered, and if prior authorization is required. |

| Category | ID | Requirement Text |
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| PBM | 4.198 | Offeror shall describe how its proposed services provide electronic prescribing (E-Prescribing) functionality that captures and tracks electronic prescriptions. |
| PBM | 4.199 | Offeror shall describe how its proposed services accept and adjudicate all POS transactions. |
| PBM | 4.200 | Offeror shall describe how its proposed services pay for compound drugs through the POS; including those with multiple NDC codes. |
| PBM | 4.201 | Offeror shall describe how its proposed services support limitations on prescriptions for specified date/time ranges as defined by the State (e.g., number of prescriptions, day supply or quantity, duplicate therapy, total dollar amount) for review. |
| PBM | 4.202 | Offeror shall describe how its proposed services verify that a dispensing Provider is enrolled and eligible, including authentication and certification for access to the POS Solution. |
| PBM | 4.203 | Offeror shall describe how its proposed services verify that a prescribing Provider is a valid prescriber. |
| PBM | 4.204 | Offeror shall describe how its proposed services provide the ability for a pharmacy to override an alert. |
| PBM | 4.205 | Offeror shall describe how its proposed services provide POS functionality that will be available to Providers for claims submission. |
| PBM | 4.206 | Offeror shall describe how its proposed services perform the claim reconsideration process electronically so that claims and attachments are submitted electronically and connected in the PBM. |
| PBM | 4.207 | Offeror shall describe how its proposed services provide the capability to accept decimal amounts in the unit field in compliance with NCPDP standard claims format (version 5 and higher). |

| Category | ID | Requirement Text |
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| PBM | 4.208 | Offeror shall describe how its proposed services process claim adjustments within five (5) business days of receiving audit findings from the Enterprise and coordinate as necessary with the State or others. |
| PBM | 4.209 | Offeror shall describe how its proposed services perform quality control procedures to screen and capture electronic images from hardcopy claim forms and attachments, adjustment/reconsiderations and updated documents, then date-stamp, Julian date, and assign unique control numbers. |
| PBM | 4.210 | Offeror shall describe how its proposed services provide ongoing quality management initiatives subject to State approval. |
| PBM | 4.211 | Offeror shall describe how its proposed services establish, implement and maintain a quality assessment and performance improvement plan aimed at enhancing the delivery of services to Stakeholders. |
| PBM | 4.212 | Offeror shall describe how its proposed services measure and evaluate Provider activities to be defined by the State (e.g., quality measures, utilization, adherence) and provide recommendations based upon the measurements. |
| PBM | 4.213 | Offeror shall describe how its proposed services provide reference services to manage current and historical PBM reference data so that updates do not overlay, and historical information is maintained and made accessible. |

| Category | ID | Requirement Text |
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| PBM | 4.214 | Offeror shall describe how its proposed services maintain a drug data set of the eleven- (11) digit National Drug Code (NDC), which can accommodate weekly updates from an updating service; the Drug data set must include legend, over-the-counter (OTC) drugs, durable medical equipment (DME), supplies, and all injectable drugs and contain, at a minimum the following elements: a) Therapeutic class indicator b) Schedule code c) DESI code d) Prior authorization indicator e) Strength f) Unit type indicator g) Minimum and maximum indicator h) Indicator (and other information, as necessary) for drug rebate i) State-specified restrictions on conditions to be met for a claim to be paid (e.g., minimum/maximum days' supply, quantities including fractional units, and others) j) Description of the drug code k) Information on drug usage and contraindication parameters for use in DUR editing and reporting l) Allow all other data identified by the State. |
| PBM | 4.215 | Offeror shall describe how its proposed services maintain a Drug data set which can accommodate updates from a contracted drug data and pricing service (e.g., First Data Bank, Medi-Span), the CMS Drug Rebate file, and future Enterprise rebate program updates, updates from Enterprise staff as needed and identify conflicts. |
| PBM) | 4.216 | Offeror shall describe how its proposed services establish and maintain a procedure code data set that ensures the acceptance by the claims processing system of all HCPCS modifiers. |
| PBM | 4.217 | Offeror shall describe how its proposed services update codes J, Q, and I, within thirty (30) calendar days of when CMS posts the quarterly pricing updates to the CMS website. |
| PBM | 4.218 | Offeror shall describe how its proposed services update anesthesia RVUs in accordance with State, and Federal specifications. |

| Category | ID | Requirement Text |
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| PBM | 4.219 | Offeror shall describe how its proposed services establish, provide and maintain a drug file (e.g., First Data Bank, Medi-Span) such that it correctly reflects and supports pharmacy claims processing functionality. |
| PBM | 4.220 | Offeror shall describe how its proposed services collaborate with the SI and the State to capture pharmacy/drug code set information. |
| PBM | 4.221 | Offeror shall describe how its service maintain the drug set/file so that there is the capability of having additional data elements added to it in addition to those provided by the drug file vendor. |
| PBM | 4.222 | Offeror shall describe how its proposed services maintain drug reference files with NDCs from multiple sources (e.g., First Data Bank, Medi-Span). |
| PBM | 4.223 | Offeror shall describe how its proposed services provide the ability to override and modify data transferred from the drug file vendor. |
| PBM | 4.224 | Offeror shall describe how its proposed services capture and validate data for NDC, UPC, and HRI additions and updates. |

| Category | ID | Requirement Text |
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| PBM | 4.225 | Offeror shall describe how its proposed services ensure that the data drug set/file includes but is not limited to the following information for each code contained on the file: the code, itself (e.g., NDC, UPC, HRI); whether the code is for a drug or non-drug item; if for a drug item, whether the drug is legend or non-legend; whether the code is for a covered or non-covered service under each of the programs under New Mexico Medicaid; brand and generic name;  add date;  begin date;  effective date;  CMS termination date; obsolete date; specific therapeutic class codes and descriptions; route of administration; identification of strength, units, quantity, and dosage form on which price is based; previous NDC; minimum dosage units and days; maximum dosage units and days; generic code number (GCN); generic sequence number (GSN); DEA code; unlimited date-specific pricing segments which include all prices needed to adjudicate drug claims in accordance with State policy; indicators for multiple dispensing fees; date-specific and/or State-specific restrictions on conditions to be met for a claim to be paid including but not limited to maximum/minimum days' supply, quantities, preferred versus non-preferred indicators, step therapy, place of service, and combinations thereof; name of manufacturer and manufacturer/labeler code(s); quantity field (allowing for decimal units); indicators for controlled drugs, over-the-counter (OTC) drugs, EPSDT, co pays, manual review, Medicare, long term review, and family planning;  pricing unit indicators;  DESI/LTE ("less than effective" drugs) indicator; unit dose indicator and any/all other elements as determined by the State. |
| PBM | 4.226 | Offeror shall describe how its proposed services determine and specify on the drug file the brand/generics status of drugs that do not, according to drug file information, match the State's brand/generic algorithm. |
| PBM | 4.227 | Offeror shall describe how its proposed services utilize the drug file to identify repackaged products. |

| Category | ID | Requirement Text |
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| PBM | 4.228 | Offeror shall describe how its proposed services provide automatic drug update logic for drug elements with matching logic for coverage, step limits, associations, and pricing. |
| PBM | 4.229 | Offeror shall describe how its proposed services update the drug file for any HIC3, GCN, GSN, or NDC that are used in the configuration of the covered benefits to ensure correct claims processing. |
| PBM | 4.230 | Offeror shall describe how its proposed services ensure that all drug file updates conform to the parameters of the covered benefits plan. |
| PBM | 4.231 | Offeror shall describe how its proposed services report and post NDC termination dates and DESI flags (1962 Drug Efficacy and Safety Index) from the CMS file and update the appropriate coverage or pricing data on the drug record. |
| PBM | 4.232 | Offeror shall describe how its proposed services maintain a crosswalk of NDC and J codes to corresponding diagnosis codes, to determine appropriate drug utilization. |
| PBM | 4.233 | Offeror shall describe how its proposed services maintain all historical and current dispensing fees, by date span, as established by the State. |
| PBM | 4.234 | Offeror shall describe how its proposed services allow for online updates and changes to dispensing fees by Provider type, plan type and total prescription volume. |
| PBM | 4.235 | Offeror shall describe how its proposed services calculate and support variable dispensing fees as defined by the State. |
| PBM | 4.236 | Offeror shall describe how its proposed services ensure that dispensing fees are applied to detailed claim lines fully and solely in accordance with New Mexico Medicaid rules and policies and are reimbursed only to Provider types entitled to receive dispensing fees. |
| PBM | 4.237 | Offeror shall describe how its proposed services validate units between CMS and the Enterprise drug reference data (e.g., First Data Bank, Medi-Span) and provide automated |

| Category | ID | Requirement Text |
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| | | conversions where needed. |
| PBM | 4.238 | Offeror shall describe how its proposed services associate National Drug Codes (NDCs) with their therapeutic indicators. |
| PBM | 4.239 | Offeror shall describe how its proposed services provide real-time access to the Enterprise's drug file or maintain an up to date copy for POS use. |
| PBM | 4.240 | Offeror shall describe how its proposed services maintain the drug reference files (e.g., First Data Bank, Medi-Span) for claim pricing at all State-defined and Federal-defined claim levels using "lower of" logic, claim editing capabilities, and detailed claims history in the PBM. |
| PBM | 4.241 | Offeror shall describe how its proposed services perform automated mass, or manual, updates to Pharmacy Provider rate information. |
| PBM | 4.242 | Offeror shall describe how its proposed services performs mass updates to reference files as defined by the Enterprise. |
| PBM | 4.243 | Offeror shall describe how its proposed services provide and maintain documentation for all structured data (e.g., file layouts for pricing tables, Provider tables, Member data tables). |
| PBM | 4.244 | Offeror shall describe how its proposed services allow authorized users to view, search, and query fields and, provide reports and documentation associated with these fields. |
| PBM | 4.245 | Offeror shall describe how its proposed services establish, in collaboration with the DS Module, a comprehensive quarterly pharmacy benefit status report with an executive summary to include, but not be limited to, assessment of progress achieving strategic objectives, pharmacy utilization trends expressed in terms of cost, volume and quality, identified critical issues with proposed resolutions, cost |

| Category | ID | Requirement Text |
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| | | containment recommendations and other information as required by the State. |
| PBM | 4.246 | Offeror shall describe how its proposed services provide data to the Enterprise to develop, produce, and maintain all reporting functions, files and data elements to meet current and future Federal and State reporting requirements, rules and regulations. |
| PBM | 4.247 | Offeror shall describe how proposed services capture and provide, to the Enterprise, all required data used to produce financial and utilization reports to facilitate cost reporting and financial monitoring of benefits and services. |
| PBM | 4.248 | Offeror shall describe how its proposed services provide detail and summary reports for all denied, adjusted, paid and reported claims, as requested by the State. |
| PBM | 4.249 | Offeror shall describe how its proposed services analyze data as requested by the New Mexico Medicaid DUR Board or as requested by the State. |
| PBM | 4.250 | Offeror shall describe how its proposed service provides complete transparency of all data fields in reports generated by the PBM (e.g., providing the State with SQL, pseudo code, narrative description, some combination thereof) to document completely the algorithms and formulas used in all reported fields and computed variables, analytic protocols and assumptions. |
| PBM | 4.251 | Offeror shall describe how its proposed services include routine exception reports reflecting differences between the CMS rebate drug file and the POS drug database. |
| PBM | 4.252 | Offeror shall describe how its proposed services generate utilization summaries for disputed NDCs and submit to the State. |
| PBM | 4.253 | Offeror shall describe how its proposed services generate reports to support the State's role in maintaining awareness of, and accountability for, the status of the rebate accounts. |

| Category | ID | Requirement Text |
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| PBM | 4.254 | Offeror shall describe how its proposed services allow an online query against NDCs, and user-defined drug codes, and dates of service reflecting various pricing methodologies and the CMS rebate amount per unit and retrieve the requested data for online viewing to support the manage drug rebate process. |
| PBM | 4.255 | Offeror shall describe how its proposed services provide the data to generate a quarterly CMS report indicating drug rebate receivables and automate the Manage Drug Rebate process to reconcile the ending balance of uncollected rebates from both the FFS and MCO reports and the data should be netted into one report. |
| PBM | 4.256 | Offeror shall describe how its proposed services generate User-defined reports to monitor the status of invoice or NDC detail (e.g., amount invoiced, outstanding receivables, number of disputes received and resolved, amount collected in disputed and non-disputed items). |
| PBM | 4.257 | Offeror shall describe how its proposed services produce pro-DUR adjudication reports that identify Providers with high use of pro-DUR override codes. |
| PBM | 4.258 | Offeror shall describe how its proposed services coordinate with the State to provide all necessary information, such that all required State and/or Federal reports pertaining to the State's Federal rebate program (e.g., Federal rebates, Diabetic Supply Program Rebate) are submitted within State defined quality and timeliness standards. |
| PBM | 4.259 | Offeror shall describe how its proposed services report on pharmacy-related HEDIS and/or HEDIS-like measures (e.g., Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis, Pharmacotherapy of COPD Exacerbation, Use of Appropriate Medications for People with Asthma, Antidepressant Medication Management, and Follow-up Care for Children Prescribed ADHD Medication) for the New Mexico Medicaid population. |

| Category | ID | Requirement Text |
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| PBM | 4.260 | Offeror shall describe how its proposed services develop, provide, and post the CMS DUR Annual Report and any other pharmacy benefit-related DUR documents in collaboration with the State. |
| PBM | 4.261 | Offeror shall describe how its proposed services generate a medical policy report for drug claims that demonstrates, for Federal reporting purposes, that drug claims do not exceed the Federal Maximum Allowable Cost (MAC). |
| PBM | 4.262 | Offeror shall describe how its proposed services supply appropriate safeguards to protect the confidentiality of eligibility information and conform to all State and Federal confidentiality laws, and to ensure that State and Federal HIPAA data security standards are met. |
| PBM | 4.263 | Offeror shall describe how its proposed services create and maintain role-based PBM user profiles and allow for direct data entry into the PBM when data is not received in the system. |
| PBM | 4.264 | Offeror shall describe how its proposed services provide an approach to PBM configuration that can be updated and expanded to support changing Enterprise needs. |
| PBM | 4.265 | Offeror shall describe how its proposed services provide messages, alerts, and a "System is down" webpage to notify users about System changes and PBM downtimes. |
| PBM | 4.266 | Offeror shall describe how its proposed services make all system changes necessary to support PBM processing. |
| PBM | 4.267 | Offeror shall describe how its proposed services develop, produce, publish and maintain all applicable User Guide/ Help updates and frequently asked questions (FAQs) on the PBM. |
| PBM | 4.268 | Offeror shall describe how its proposed services collaborate with the State and other Contractors to provide technical assistance to establish and support integration with the PBM. |

| Category | ID | Requirement Text |
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| PBM | 4.269 | Offeror shall describe how its proposed services provide the ability to identify the source of data and the date added to the PBM. |
| PBM | 4.270 | Offeror shall describe how its proposed services provide and maintain current PBM documentation (e.g., PBM database schema, data dictionaries, entity-relationship diagrams, complete PBM architecture and Configuration diagrams, network diagrams, interface standards for the entire PBM) including those supporting Proprietary Contractor Material; however, this does not include proprietary information related to Commercial-Off-The-Shelf (COTS) products. Offeror commits to provide and maintain all service delivery documentation related to the design of each module/ component and its interaction with other modules/components as required for certification. |
| PBM | 4.271 | Offeror shall describe how its proposed services collaborate, track and maintain documentation (e.g., system, project, Provider communication materials, version history) with the State and SI Contractor. |
| PBM | 4.272 | Offeror shall describe how its proposed services perform online end-to-end processing and testing of a claim (process flow) through the PBM. |
| PBM | 4.273 | Offeror shall describe how its proposed services maintain the appropriate level of knowledgeable staff who are capable of testing, validating and documenting operational impacts of changes to the PBM. |
| PBM | 4.274 | Offeror shall describe how its proposed services conduct testing with E-Prescribing vendors and become certified to exchange data with those vendors. |
| PBM | 4.275 | Offeror shall describe how its proposed services provide an unlimited free-form text note within the PBM for various functions (e.g., prior authorizations, case management) accessible by authorized PBM users |

| Category | ID | Requirement Text |
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| PBM | 4.276 | Offeror shall describe how its proposed services provide Member's TPL information to other TPL Contractors, pharmacies or DUR Contractors. |
| PBM | 4.277 | Offeror shall describe how its proposed services capture and maintain Member's current and historical TPL health insurance eligibility and coverage provided by other Contractors and alert Providers of TPL coverage when billing a claim. |
| PBM | 4.278 | Offeror shall describe how its proposed services maintain cost avoidance and Third-Party Liability (TPL) edits that are supported by State approved, NCPDP-compliant code set. |
| PBM | 4.279 | Offeror shall describe how its proposed services provide functionality for authorized PBM users to contact the Contractor for PBM support and other questions (e.g., telephone, "Live Chat", instant messaging, email, text). |
| PBM | 4.280 | Offeror shall describe how its proposed services provides a forum for authorized PBM users to post inquiries, to respond to other posters and to create topical "threads" on problems with the capability to find posts and threads by date or relevance. |
| PBM | 4.281 | Offeror shall describe how its proposed services allows users to subscribe to, and unsubscribe from, publications and content, such as threads and hot topics, and to receive notification (e.g., email, SMS IM, web, other media) when additions or changes are made to subscribed content. |
| PBM | 4.282 | Offeror shall describe how its proposed services provides access to the following Pharmacy content: web announcements; training schedules and enrollment; various forms including PA form; information on maximum allowable costs; information on prescriber lists; and pharmacy meetings. |
| PBM | 4.283 | Offeror shall describe how its proposed services provide reports, approved by the State to the Enterprise for inclusion |

| Category | ID | Requirement Text |
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| | | on the web portal. |
| PBM | 4.284 | Offeror shall describe how its proposed services develop, maintain, track and publish all publications (e.g., manuals, bulletins, billing instructions, notices, policy, postings, newsletters). |
| PBM | 4.285 | Offeror shall describe how its proposed services manage, publish, update, index, and provide electronic public access via the web portal to all pharmacy related program communications, guides, forms, and files. |
| PBM | 4.286 | Offeror shall describe how its proposed services support an online Provider complaint tracking, resolution, and reporting process that allows the Contractor to proactively identify trends and provide reports to the State per agreed upon schedule. |
| PBM | 4.287 | Offeror shall describe how its proposed services provide a repository for all policy decisions, actions, and outcomes related to drug policy. |
| PBM | 4.288 | Offeror shall describe how its proposed services provide online access to data (e.g., claims, CMS listing of manufacturers with drug rebate agreements, CMS listing of quarterly unit rebate amounts, quarterly rebate invoiced amounts at the National Drug Code [NDC] level, NDC Drug file, Provider file, procedure code file, the crosswalk between NDC and procedure code). |
| PBM | 4.289 | Offeror shall describe how its proposed services allow authorized users to access rebate information and drug file via the web portal. |
| PBM | 4.290 | Offeror shall describe how its proposed services document claims/encounters billing processes, policies and procedures and make available online to users and Providers. |
| PBM | 4.291 | Offeror shall describe how its proposed services automatically and securely route grievances and appeal requests to the authorized PBM users or user groups for |

| Category | ID | Requirement Text |
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| | | multiple levels of review, per business rules. |
| PBM | 4.292 | Offeror shall describe how its proposed services configures communication delivery mechanism alerts and notifications. |
| PBM | 4.293 | Offeror shall describe how its proposed services provides a PBM workflow that supports assignments and execution for all essential components of the business processes. |
| PBM | 4.294 | Offeror shall describe how its proposed services provide and support access to workflow monitoring that includes indicators and statistics by sub process, organization, or individual staff. |

*Table 8 Drug Rebate Requirements*

| Category | ID | Requirement Text |
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| Drug Rebate | 5.001 | Offeror shall describe how its proposed services maintain a history of the extracts of pharmacy claims required by the drug manufacturer rebate process. Claims must include all NDC and other data needed to support the rebate process (e.g., period covered, NDC number, total units paid, product). |
| Drug Rebate | 5.002 | Offeror shall describe how its proposed services provide the capability to transmit detailed drug claim listings, including pharmacy TPL, to manufacturers electronically. |
| Drug Rebate | 5.003 | Offeror shall describe how its proposed services identify, validate, and perform adjustments and corrections to paid claims, when billing errors are discovered through the rebate dispute resolution process, and notify the billing Provider. |
| Drug Rebate | 5.004 | Offeror shall describe how its proposed services maintain an electronic file of all paid pharmacy claims and encounters with disputed products (NDCs) for the rebate quarter under review to facilitate dispute research and resolution. |

| Category | ID | Requirement Text |
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| Drug Rebate | 5.005 | Offeror shall describe how its proposed services provide the capability for inclusion or exclusion of unit type conversion factors for drug unit type mismatches between the pharmacy claim unit types paid, and the drug manufacturer unit rebate amount types on the CMS quarterly file. |
| Drug Rebate | 5.006 | Offeror shall describe how its proposed services allow inclusion and exclusion of claims from the rebate program as defined by the State (e.g., NDC, Members, program types, Providers, Provider types, 340B Providers, threshold) and allow routine updates of the rebate exclusion list as program parameters change. |
| Drug Rebate | 5.007 | Offeror shall describe how its proposed services limit payments of pharmacy claims to drugs that are manufactured by companies on the CMS listing of manufacturers with drug rebate agreements, except as directed by the State. |
| Drug Rebate | 5.008 | Offeror shall describe how its services accept and store data for physician administered drugs (e.g., J codes), as directed by the State for rebate processing. |
| Drug Rebate | 5.009 | Offeror shall describe how its proposed services report all drug rebate data (e.g. like invoices, invoice adjustments, payments received, accounts receivable transactions, accounts payable transactions) to the Enterprise. |
| Drug Rebate | 5.010 | Offeror shall describe how its proposed services verify that manufacturers are paying the contracted per-unit amounts. |
| Drug Rebate | 5.011 | Offeror shall describe how its proposed services identify and report Providers that are public health service entities (as identified by CMS) that have separate agreements with manufacturers, under the Veterans Health Act of 1993, with effective dates. |
| Drug Rebate | 5.012 | Offeror shall describe how its proposed services compare NDC unit rebate amounts supplied by the manufacturer directly with the same information supplied by CMS and identify differences. |

| Category | ID | Requirement Text |
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| Drug Rebate | 5.013 | Offeror shall describe how its proposed services validate Provider 340B status compliance using Provider's 340B status information and deny any claims that does not meet policy or requirement and exclude from Drug Rebate invoicing. |
| Drug Rebate | 5.014 | Offeror shall describe how its proposed services respond to all Medicaid drug program related inquiries, including surveys, from drug manufacturers and any entity acting on behalf of a drug manufacturer, as well as any other interested parties as requested by the State. |
| Drug Rebate | 5.015 | Offeror shall describe how its proposed services provide the State with a copy of CMS pharmacy-related communications (e.g., manufacturer or labeler code changes, DESI code changes, product deletions, labeler terminations, new manufacturer or labelers) within one (1) business day of receipt by the Contractor of such information. |
| Drug Rebate | 5.016 | Offeror shall describe how its services provide the State with an analysis, within three (3) business day of receipt by the Contractor of CMS pharmacy-related information, that specifies if action by the State or PBM or other Contractor is required and, if so, what that action is, by what entity it must be undertaken, and by when it must be completed. |
| Drug Rebate | 5.017 | Offeror shall describe how its proposed services capture and store unit rebate amount (URA) data from CMS then calculate and apply any modifications needed when the quantity standards vary between the URA and the claims. |
| Drug Rebate | 5.018 | Offeror shall describe how its proposed services capture and store all data related to drug rebate processing, including historical data, with functionality to easily query and access the data. |
| Drug Rebate | 5.019 | Offeror shall describe how its proposed services record all receipts of rebate payments, made to the State, distinguishing between Federal and State rebates and between rebates for claims and rebates for encounters and apply to correct invoice (e.g., appropriate calendar quarter, invoice and manufacturer or |

| Category | ID | Requirement Text |
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| | | labeler). |
| Drug Rebate | 5.020 | Offeror shall describe how its proposed services represent the State in dispute resolution meeting with manufacturer or labelers. |
| Drug Rebate | 5.021 | Offeror shall describe how its proposed services maintain a history of the data used to support the State in case of a drug manufacturer dispute over the rebate invoice. |
| Drug Rebate | 5.022 | Offeror shall describe how its proposed services maintain NDC level information on the drug rebate accounts receivable. |
| Drug Rebate | 5.023 | Offeror shall describe how its proposed services support manual rebate updating, overriding the CMS quarterly update, for specific drugs and at the manufacturer (labeler) level across all NDCs for that manufacturer. |
| Drug Rebate | 5.024 | Offeror shall describe how its proposed services accept and maintain online CMS's current rebate agreement data, including contact information, from the quarterly CMS file. |
| Drug Rebate | 5.025 | Offeror shall describe how its proposed services provide the capability for the State to access and retrieve drug rebate information electronically in a format defined by the Enterprise. |
| Drug Rebate | 5.026 | Offeror shall describe how its proposed services maintain multiple effective date spans on the drug manufacturer records in the POS system to identify situations where a manufacturer becomes ineligible to participate in the drug rebate program for a period (as identified by CMS and the State). |
| Drug Rebate | 5.027 | Offeror shall describe how its proposed services provide the capability of an automatic default of the unit rebate amount to the most recently paid rebate amount. |

| Category | ID | Requirement Text |
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| Drug Rebate | 5.028 | Offeror shall describe how its services provide the capability to automatically determine the amount of rebate due from each manufacturer; based on quantity of units paid for each NDC (both original and adjusted claims), rebate amounts, data specific interest rate and prior period adjustments, per data received from CMS. |
| Drug Rebate | 5.029 | Offeror shall describe how its proposed services maintain an automated drug rebate tracking system for disputes that identifies and tracks non-responsive manufactures and allows responding manufactures to submit disputes electronically. |
| Drug Rebate | 5.030 | Offeror shall describe how its proposed services automatically calculate interest due on quarterly rebate amounts per Federal Regulations. |
| Drug Rebate | 5.031 | Offeror shall describe how its proposed services maintain a process to track drug rebate activities by NDC, by manufacturer, including billing of manufacturers and tracking collection of rebates. |
| Drug Rebate | 5.032 | Offeror shall describe how its proposed services separately identify and report drug rebate amounts invoiced and received by program and Medicaid Eligibility Group (MEG). |
| Drug Rebate | 5.033 | Offeror shall describe how its proposed services perform drug rebate activities (e.g., produce drug rebate invoices on a quarterly basis, produce all reports and invoice relating to drug rebates, respond to all drug manufacturer inquiries regarding drug rebate invoices) on all eligible claims/encounters. |
| Drug Rebate | 5.034 | Offeror shall describe how its proposed services ensure receipt and proper disposition of all rebate-related information from CMS, either received directly from CMS or the State; this requirement includes maintaining appropriate and accurate information pertaining to unit rebate amounts, as well as other data elements necessary for the generation of accurate rebate invoices. |

| Category | ID | Requirement Text |
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| Drug Rebate | 5.035 | Offeror shall describe how its proposed services perform all aspects of the formalized dispute resolution process, with direction from the State, CMS or both to include complying with all future CMS Drug Rebate releases and clinical review of disputes. |
| Drug Rebate | 5.036 | Offeror shall describe how its proposed services provide necessary support to the State in cases of formal appeal of a rebate invoice by a manufacturer. |
| Drug Rebate | 5.037 | Offeror shall describe how its proposed services ensure that the rebate functionality includes these features: a) HCPCS code to NDC matching; b) Unit dosage conversion; c) Accumulation of interest; d) d) Identify NDCs that are not covered under a rebate agreement; e) Support user-configurable claim selection criteria (e.g. flag, indicators) for selecting and including claims in the drug rebate system and the ability to modify, calculate and summarize claims data for incorporation in the invoice generation process; f) Allow a unit of measure conversion factor for those drugs billed with the NCPDP or J-Code units of measure where the CMS rebate unit of measure is different; g) Invoice drug rebates for NDC and quantity information submitted on professional and outpatient claims; h) Allow authorized users to access drug rebate claims online; i) Link all adjustment activity to the quarter in which the original invoice was mailed; j) Track adjustments, post payments and post credits based on State-defined criteria for rebates; k) Preserve the characteristics of the invoice and corresponding claim data as it appeared in the period in which it was originally reported; l) Generate on demand manufacturer or labeler-specific summaries of invoice registers using current quarter data, prior period adjustments and total invoice amounts; m) Exclude State-specified drugs that are covered but should not be invoiced; n) Record invoice payments by manufacturer or labeler and NDC, including the balance forward, interest calculations and total due; o) Reconcile payments to invoices and resolve discrepancies. |
| Drug Rebate | 5.038 | Offeror shall describe how its proposed services manage Drug Rebate Recoveries based on the information provided by the |

| Category | ID | Requirement Text |
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| | | MCOs. |
| Drug Rebate | 5.039 | Offeror shall describe how its proposed services provide multiple methodologies (e.g., percentage and actual), for allocation of the drug rebates to program funding source(s) and identify drug rebate amounts by benefit program. |
| Drug Rebate | 5.040 | Offeror shall describe how its proposed services support automated generation of the Drug Rebate Electronic Invoice File for each drug manufacturer with current rebate information, with the ability to generate and distribute (electronically and on paper) via the Enterprise IP. |
| Drug Rebate | 5.041 | Offeror shall describe how its proposed services provide control reports to the State to support the tracking of rebate recoveries. |
| Drug Rebate | 5.042 | Offeror shall describe how its proposed services ensure rebates are posted to the Accounts Receivables System and reconciled with the invoice within one business day of receipt. |
| Drug Rebate | 5.043 | Offeror shall describe how its proposed services identify and report inconsistencies between rebate amount due and amount paid to pharmacy, including pharmacy TPL, prior to invoice generation. |
| Drug Rebate | 5.044 | Offeror shall describe how its proposed services allow rebate adjustments and payments to be applied at the NDC level and to report accordingly. |
| Drug Rebate | 5.045 | Offeror shall describe how its proposed services maintain drug rebate data, invoices and correspondence for the duration required to meet State and Federal regulations and policies. |
| Drug Rebate | 5.046 | Offeror shall describe how its proposed services allows access to claim level drug rebate information on-line. |
| Drug Rebate | 5.047 | Offeror shall describe how its proposed services provide the ability to perform ad hoc queries of drug rebate information. |
| Drug Rebate | 5.048 | Offeror shall describe how its proposed services update drug rebate information related to a claim when the claim is updated |

| Category | ID | Requirement Text |
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| | | in the Enterprise. |
| Drug Rebate | 5.049 | Offeror shall describe how its proposed services upload external drug rebate data into the reference file (e.g. manufacturer or labeler contact information). |
| Drug Rebate | 5.050 | Offeror shall describe how its proposed services automatically setup Accounts Receivables at the Manufacturer or Labeler level for drug manufacturers invoiced for rebates. |
| Drug Rebate | 5.051 | Offeror shall describe how its proposed services produce a periodic statement of accounts for outstanding drug rebate debt including interest calculated based on CMS rules. |
| Drug Rebate | 5.052 | Offeror shall describe how its proposed services records and tracks manufacturer disputes of drug rebate invoices at the NDC detail level. |
| Drug Rebate | 5.053 | Offeror shall describe how its proposed services conduct the diabetic supply rebate programs in accordance with all applicable State and Federal laws and policies, including the reconciliation of drug manufacturer payments to invoices, the timely issuance of correct invoices, active and aggressive pursuit of resolution to any and all disputes that may arise, and aggressive pursuit and collection of any unpaid and undisputed invoiced amounts. |
| Drug Rebate | 5.054 | Offeror shall describe how its proposed services coordinate with appropriate CMS staff and, as necessary, appropriate contacts for pharmaceutical manufacturers when the Contractor determines that necessary CMS information pertaining to any given manufacturer's rebate-qualified drugs is missing, incomplete, or otherwise inaccurate. |
| Drug Rebate | 5.055 | Offeror shall describe how its proposed services provide the drug rebate reconciliation within thirty (30) days after the end of each quarter and meet State standards for quality and timeliness. |

| Category | ID | Requirement Text |
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| Drug Rebate | 5.056 | Offeror shall describe how its proposed services provide the necessary technical assistance to all entities having rebate data, to ensure that all necessary data is available to the PBM component for the purpose of invoicing for rebates. |
| Drug Rebate | 5.057 | Offeror shall describe how its proposed services manages the State's diabetic supply rebate program in compliance with the State Rebate Agreement for the Diabetic Supply Program and do so in a manner that maximizes rebate returns to the State |
| Drug Rebate | 5.058 | Offeror shall describe how its proposed services automatically generate delinquent letters to manufacturers who have not paid the invoice within thirty-eight (38) days. |
| Drug Rebate | 5.059 | Offeror shall describe how its proposed services maintain and display an audit trail of all changes made to invoices and flag invoice records that have been changed to facilitate future processing. |
| Drug Rebate | 5.060 | Offeror shall describe how its proposed services maintain and display original and corrected invoice records for State-defined reports. |
| Drug Rebate | 5.061 | Offeror shall describe how its proposed services compare invoices to remittance advices returned by the manufacturer to determine which NDC line items are paid or in dispute. |
| Drug Rebate | 5.062 | Offeror shall describe how its proposed services recalculate invoices as directed by the State, if the amount the manufacturer submits is different from the invoice. |
| Drug Rebate | 5.063 | Offeror shall describe how its proposed services maintain, at a minimum, twelve (12) quarters of drug rebate/invoice information to accommodate prior period adjustment processing. |
| Drug Rebate | 5.064 | Offeror shall describe how its proposed services provide an automated method of checking invoices to determine if any unit rebate amounts are zero. If more than two quarters have an URA of zero, then issue an alert prior to invoice generation. |

| Category | ID | Requirement Text |
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| Drug Rebate | 5.065 | Offeror shall describe how its proposed services provide the capability to exclude from drug rebate invoices (e.g., units paid to public health service entities that have separate drug rebate agreements with manufacturers in accordance with the Veterans Health Act, 340B Providers, minimum threshold). |
| Drug Rebate | 5.066 | Offeror shall describe how its proposed services provide automatic and, on an exception basis, manual processes to reconcile amounts paid to amounts invoiced by NDC line item. |
| Drug Rebate | 5.067 | Offeror shall describe how its proposed services identify and generate invoices for HCPCS codes on rebatable drugs billed on the CMS 1500. |
| Drug Rebate | 5.068 | Offeror shall describe how its proposed services generate and submit rebate invoices to manufacturers, on a schedule as determined by CMS. |
| Drug Rebate | 5.069 | Offeror shall describe how its proposed services automatically create a new accounts receivable record for each drug rebate invoice generated by the system and integrates with the IP. |
| Drug Rebate | 5.070 | Offeror shall describe how its proposed services display, at a minimum, the following information on all drug invoices: a) Manufacturer name b) Manufacturer address c) Invoice number d) Date invoice created e) Date invoice mailed f) Period covered g) OMB Format Number h) NDC number i) Drug name j) Messages k) Rebate amount per unit from CMS tape l) Total units reimbursed per NDC m) Total rebate claimed per NDC n) Total reimbursement amount o) Correction flag p) Grand totals q) TPL portion paid r) Beneficiary ID and plan s) Date of Service t) Quantity. |
| Drug Rebate | 5.071 | Offeror shall describe how its proposed services enable the automated retrieval of interest rates, calculation, invoicing, and reporting of interest amounts on outstanding balances related to the drug rebate program. |

| Category | ID | Requirement Text |
|----------|-----|------------------|
| Drug Rebate | 5.072 | Offeror shall describe how its proposed services generate drug rebate invoices that list claims at the summary level by rebate type (e.g., J codes, primary, 340B, medical supply) and Provider billing type (e.g., professional, institutional outpatient, and pharmacy). |
| Drug Rebate | 5.073 | Offeror shall describe how its proposed services include the capability to convert the drug database unit and quantity used for invoicing to those used by CMS. |
| Drug Rebate | 5.074 | Offeror shall describe how its proposed services invoice and accept payments from drug manufacturers both electronically and through manual check receipt. |
| Drug Rebate | 5.075 | Offeror shall describe how its proposed services capture, or convert electronically, the prior quarter adjustment statement (PQAS) and reconciliation of state invoices (ROSIs), perform line item match by NDC, link to the invoice and identify disputes. |
| Drug Rebate | 5.076 | Offeror shall describe how its proposed services monitor information (e.g., manufacturer data, interest rates, unit conversion) provided by CMS, used in generating rebate invoices, to validate that the information is complete and accurate. |
| Drug Rebate | 5.077 | Offeror shall describe how its proposed services ensure that necessary communication occurs with any other necessary contractors, regarding the inclusion of applicable procedure codes for rebates invoicing purposes, both State and Federal. |
| Drug Rebate | 5.078 | Offeror shall describe how its proposed services contact pharmacy Providers in instances in which the PBM component determines, through rebates invoicing processes and procedures, that the Provider's claim(s) data is aberrant or otherwise questionable. |
| Drug Rebate | 5.079 | Offeror shall describe how its proposed services provide reconciliation between the drug rebates received by the PBM, amounts transferred to the State and the amount reported on |

| Category | ID | Requirement Text |
|----------|-----|------------------|
| | | the CMS-64.9R form for the quarter. |
| Drug Rebate | 5.080 | Offeror shall describe how its proposed services provide an electronic file of all rebate (Federal and State) invoicing, prior period adjustments and collections by National Drug Code on a quarterly basis in a format defined by the State. |
| Drug Rebate | 5.081 | Offeror shall describe how its proposed services provide all necessary support, documentation, and testimony if a drug manufacturer dispute, or other rebate-related action, proceeds to administrative or judicial review. |
| Drug Rebate | 5.082 | Offeror shall describe how its proposed services explain, in writing, all instances in which a quarter-to-quarter variation equal to or exceeding fifteen percent (15%) occurs, in terms of either units invoiced or dollars collected, the reason(s) for the variance, and convey this information to the State for inclusion with the CMS-64.9R submission. |
| Drug Rebate | 5.083 | Offeror shall describe how its proposed services create and maintain on-line Drug Rebate reports which allow users to choose from multiple pre-built defined parameters, singularly or in combination, to generate user customized results that help users monitor the daily operations of the Rebate System. Online reports shall include historical rebate data and the most current data. Reports shall include but are not limited to: Account Receivable Summary by Manufacturer; Dispute Amount; Dispute Code; Batch Total; Check and Claims Balancing. |
| Drug Rebate | 5.084 | Offeror shall describe how its proposed services include managed care encounters in drug rebate processing. |
| Drug Rebate | 5.085 | Offeror shall describe how its proposed services provides drug rebate adjustment reason code(s). |

*Table 9 Data Exchange and Reporting Requirements*

| Category | ID | Requirement |
|---|---|---|
| Data Exchange and Reporting | 6.001 | Offeror shall have described how its proposed services receive warrant data for tracking and processing (e.g., cashed, voided, uncashed, stale-dated, cancelled, process replacements for lost or stolen warrants) warrants or payments and update records. |
| Data Exchange and Reporting | 6.002 | Offeror shall describe how its proposed services provide the data for reconciling claims payment information or capitation with the State accounting system. |
| Data Exchange and Reporting | 6.003 | Offeror shall describe how its proposed services provide the data to deliver and maintain RA and EOB per State and Federal defined requirements. Offeror should specify if its proposed services currently generate RAs or EOBs and if so provide samples. |
| Data Exchange and Reporting | 6.004 | Offeror shall describe how its proposed services provide the data to generate, transmit or deliver (paper or electronic), maintain and report remittance advices (in a HIPAA approved format) including Federally required reason codes to explain claims adjudication and adjustment results even when payment amount is zero. |
| Data Exchange and Reporting | 6.005 | Offeror shall describe how its proposed services provide TPL data to providers on the remittance advice. |
| Data Exchange and Reporting | 6.006 | Offeror shall describe how its proposed services provide the data for the 1099 and corrected 1099 data files. |
| Data Exchange and Reporting | 6.007 | Offeror shall describe how its proposed services provide the data to produce and distribute multiple different creditable coverage certificates. |
| Data Exchange and Reporting | 6.008 | Offeror shall describe how its proposed services provide the detailed data for payment generation (e.g., Capitation, RAs, Invoices, EOB, Check Stub) in State-approved electronic. |
| Data Exchange and Reporting | 6.009 | Offeror shall describe how its proposed services provide data to accommodate the generation and distribution of REOMB(s), as defined by the State. Offeror should specify if its proposed services currently generates an REOMB and if so |

| Category | ID | Requirement |
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| | | provide a sample. |
| Data Exchange and Reporting | 6.010 | Offeror shall describe how its proposed services provide the ability to add, modify, and maintain messages, message codes and configurable message business rules (e.g., EOB, REOMB, RA) in real time. |
| Data Exchange and Reporting | 6.011 | Offeror shall describe how its proposed services include messages (e.g., EOB, RA, REOMB) with the claims record. |
| Data Exchange and Reporting | 6.012 | Offeror shall describe how its proposed services provide EOB, RA, and REOMB data to allow for distribution to multiple locations. |
| Data Exchange and Reporting | 6.013 | Offeror shall describe how its proposed services provide data to report garnishments of a provider's payment. |
| Data Exchange and Reporting | 6.014 | Offeror shall describe how its proposed services produce claim data (e.g., summary and individual provider payments) with provider-specific information to support AP and AR processes where the claim payment detail amounts are equal to the total payment request amount. |
| Data Exchange and Reporting | 6.015 | Offeror shall describe how its proposed services provide data for a supplemental RA, for providers' subject to withholdings, that details their deductions. If the Offeror's Solution currently provides a supplemental, RA the Offeror should provide a sample. |
| Data Exchange and Reporting | 6.016 | Offeror shall describe how its proposed services generate RAs that reflect detailed claim information (e.g., EOB codes, co-pay detail, patient liability, client contribution, paid in full, type of gross adjustment, cost sharing initiative information, header level, line level detail) for all claim status types. |
| Data Exchange and Reporting | 6.017 | Offeror shall describe how its proposed services include and provide non-claim financial information (e.g., case management fees, payouts, recoupments) and related summary information (e.g., gross totals, net totals, time-period to date totals) for RAs, EOBs, and REOMBs. |

| Category | ID | Requirement |
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| Data Exchange and Reporting | 6.018 | Offeror shall describe how its proposed services suppress or allow production of RAs, EOBs, REOMBs or specific data based on member and service characteristics (e.g., history-only adjustments) as defined by the State. |
| Data Exchange and Reporting | 6.019 | Offeror shall describe how its proposed services provide the data to allow for the distribution of payments to a specified location and generation of multiple paper or electronic RAs, EOBs, REOMBs for distribution to same and/or other locations. |
| Data Exchange and Reporting | 6.020 | Offeror shall describe how its proposed services retain and provide claims operations, balancing and control reports including but not limited to reports that reconcile all claims entered to the processing cycles, input and output counts and claims inventory reports that account for all claims and claim types. |
| Data Exchange and Reporting | 6.021 | Offeror shall describe how its proposed services develop, deliver and maintain business service administration, performance and reconciliation reports (e.g., workflow activity including volume of work completed, encounter timeliness, average processing time by department, workgroup, individual, document type, accuracy rates, usage rate, discrepancies from the claim reconciliation process, including claims denied or suspended, retroactive changes including a list of current reports) and provide samples in the response. |
| Data Exchange and Reporting | 6.022 | Offeror shall describe how its proposed services tabulate and report, by State defined criteria, claims that were rejected due to processing errors. |
| Data Exchange and Reporting | 6.023 | Offeror shall describe how its proposed services provide authorized Users the ability to run reports available from its service based on user defines criteria (e.g., date range, provider number(s), report type, adjustment reason code). |
| Data Exchange and Reporting | 6.024 | Offeror shall describe how its proposed services provide dashboard capabilities that display real-time reporting with the flexibility to drill down or review different combinations of variables. Offeror should describe its Solution's current |

| Category | ID | Requirement |
|---|---|---|
| | | dashboard features. |
| Data Exchange and Reporting | 6.025 | Offeror shall describe how its proposed services provide data for audits and cost settlements for those providers that receive cost-based reimbursement or negotiated rates (e.g., incentive payments, hospitals, Nursing Facilities [NF], Rural Health Clinics [RHC], Federally Qualified Health Centers [FQHC]). |
| Data Exchange and Reporting | 6.026 | Offeror shall describe how its proposed services track, update and report the claims inventory (e.g., processed, suspended, paid, denied) after each claims processing cycle. |
| Data Exchange and Reporting | 6.027 | Offeror shall describe how its proposed services provide all financial data to the Enterprise. |
| Data Exchange and Reporting | 6.028 | Offeror shall describe how its proposed services provide reports available from its service; an inventory of all reports currently available from its service with a synopsis of their content; and in flexible formats for exporting and importing. |
| Data Exchange and Reporting | 6.029 | Offeror shall describe how its proposed services provide Extract, Transform and Load (ETL) of all required data and attachments from the Enterprise in accordance with Program, State and Federal policies. |
| Data Exchange and Reporting | 6.030 | Offeror shall describe how its proposed services retain and provide real-time data for a master set of processes and reports (e.g., audit, Federal required, State required, claims, financial, Payment Error Rate Measurement [PERM] report, member specific, provider specific, CMS 372, CMS 64, CMS 21, CMS 416, Medicaid Eligibility Quality Control [MEQC], Surveillance and Utilization Review [SURS], SURS-type anomaly,  OIG, Medicaid Fraud Control Unit [MFCU], drug rebate, Medicaid Statistical Information System (MSIS), Transformed MSIS, Title XIX, Title IV-E, Management and Administrative Reporting (MAR), Healthcare Effectiveness Data and Information Set (HEDIS). |
| Data Exchange and Reporting | 6.031 | Offeror shall describe how its proposed services electronically respond to the Enterprise for all electronic data and report |

| Category | ID | Requirement |
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| | | requests. |
| Data Exchange and Reporting | 6.032 | Offeror shall describe how its proposed services capture and use Enterprise programs and services funding streams match rate data (e.g., Federal, State, other). |
| Data Exchange and Reporting | 6.033 | Offeror shall describe how its proposed services provide data to the Enterprise to trigger State-defined notifications and alerts (e.g., special payment criteria outside of standard business rules, review and approval, pricing, financial, data contradiction, eligibility segments, payment anomalies, needed rate and risk calculations, data driven events, final budget approvals, approaching budget thresholds, needed budget forecasts, update activities, State-defined financial criteria). |
| Data Exchange and Reporting | 6.034 | Offeror shall describe how its proposed services capture, track and provide detailed data on all specialty payments (e.g., gross adjustments, custody medical, waiver programs). |
| Data Exchange and Reporting | 6.035 | Offeror shall describe how its proposed services provide data to the Enterprise to decrement or dedecrement utilization in order to update authorizations based upon claims processing (e.g., paid, denied, adjusted, voided). |
| Data Exchange and Reporting | 6.036 | Offeror shall describe how its proposed services create, report, and transmit daily transactions to the Enterprise (e.g., warrants [EFT/printed], direct deposit, debit cards, AR/AP adjustments). |
| Data Exchange and Reporting | 6.037 | Offeror shall describe how its proposed services provide and transmits unclaimed funds data to the Enterprise containing the applicable information (e.g., stale-dated checks, disbursements on address hold, receipts on distribution hold, unidentified receipts). |
| Data Exchange and Reporting | 6.038 | Offeror shall describe how its proposed services identify and refer quality assurance suspect claims and attachments (e.g., PI, lock-in, fraud and abuse, TPL, payment anomalies, "pay and report" indicator) based upon State-approved criteria. |
| Data Exchange and | 6.039 | Offeror shall describe how its proposed services provide the |

| Category | ID | Requirement |
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| Reporting | | Enterprise, in a predefined, agreed upon format or medium, potential PI case data (e.g., nature of the situation, supporting details necessary to further pursue the matter, use of override codes, provider information, low and high variances, claim information, single Provider for multiple visits on the same day to a single Member, diagnosis and procedure that indicates an emergency that occurred within one [1] day of a similar claim from the same Provider and the same Member, duplicate episodes of care) for transmission to the State, the MFCU or Enterprise QA Contractor, the health plan, the component area, and any other applicable Stakeholder. |
| Data Exchange and Reporting | 6.040 | Offeror shall describe how its proposed services provide the Enterprise with claims data for those that require review (e.g., prepayment, medical, Program Integrity, Program Management) per State-defined criteria (e.g., procedure/service code, diagnosis code, modifiers, Providers, Member, configurable thresholds). |
| Data Exchange and Reporting | 6.041 | Offeror shall describe how its proposed services identify and refer claims that require authorization, after thresholds have been met. |
| Data Exchange and Reporting | 6.042 | Offeror shall describe how its proposed services produce data for covered services and capitation payments cash repletion requests. |
| Data Exchange and Reporting | 6.043 | Offeror shall describe how its proposed services generate, deliver and maintain data or reports to allow authorized users to review timed (e.g., monthly, quarterly, annually) funding stream (e.g. grants, entitlements, funding participation) requests. |
| Data Exchange and Reporting | 6.044 | Offeror shall describe how its proposed services produce, maintain, and provide, to the Enterprise, all Federal and State tax forms, reports and data. Offeror shall provide an inventory of all Federal and State tax forms and report currently available from its service with a synopsis of their content. |
| Data Exchange and | 6.045 | Offeror shall describe how its proposed services notify the State of any backup withholding dollars for transmission by |

| Category | ID | Requirement |
|---|---|---|
| Reporting | | the State to the IRS. |
| Data Exchange and Reporting | 6.046 | Offeror shall describe how its proposed services retrieve data that has been stored from its original transaction. |
| Data Exchange and Reporting | 6.047 | Offeror shall describe how its proposed services receive Enterprise data including updates (e.g., provider, member, benefit data, rates, codes) used in financial business processes (e.g., claims, pricing, incentive payments, auditing). |
| Data Exchange and Reporting | 6.048 | Offeror shall describe how its proposed services develop and maintain data capture forms used to support HIPAA transaction sets pertinent to FS and any relevant business function requested by the State. |
| Data Exchange and Reporting | 6.049 | Offeror shall describe how its proposed services receive budget data used across Enterprise systems. |
| Data Exchange and Reporting | 6.050 | Offeror shall describe how its proposed services test, create, receive and comply with HIPAA transactions (e.g., HL7, ANSI X12N 837, ANSI X12N 835, ANSI X12N 278) and any paper (e.g., National Uniform Billing Committee [NUBC], National Uniform Claim Committee [NUCC], HCFA 1500, CMS 1500, UB040, ADA) claims. |
| Data Exchange and Reporting | 6.051 | Offeror shall describe how its proposed services validate data against State defined business rules. |
| Data Exchange and Reporting | 6.052 | Offeror shall describe how its proposed services receive remittance advice data from claims following HIPAA compliant and Enterprise standards. |
| Data Exchange and Reporting | 6.053 | Offeror shall describe how its proposed services capture Provider cost settlement data. |
| Data Exchange and Reporting | 6.054 | Offeror shall describe how its proposed services capture and use DRG information (e.g., base rates, capital, medical education, weights, average length of stay, outliers). |
| Data Exchange and Reporting | 6.055 | Offeror shall describe how its proposed services support multiple rates for the same service and varying benefit plans |

| Category | ID | Requirement |
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| | | across programs. |
| Data Exchange and Reporting | 6.056 | Offeror shall describe how its proposed services support a variety of service pricing data to encompass programs that use different price structures other than Medicaid. |
| Data Exchange and Reporting | 6.057 | Offeror shall describe how its proposed services integrate via the ESB with other internal/external systems (e.g., other fiscal agents, SHARE, PBM, drug rebate) to exchange financial data (e.g., collections, disbursements, reconciliation). |
| Data Exchange and Reporting | 6.058 | Offeror shall describe how its proposed services provide data or those services currently available for analytics, monitoring, and reporting capabilities (e.g., trends in accounts payable such as, but not limited to, showing increases/decreases and cumulative year-to-date figures after each claims processing cycle) to assist in the management of its business services across all FS functionality. |
| Data Exchange and Reporting | 6.059 | Offeror shall describe how its proposed services integrate with the SI for document management and data exchange. |
| Data Exchange and Reporting | 6.060 | Offeror shall describe how its proposed service's web application can be integrated using standards-based Presentation Layer Services (e.g. Web Services for Remote Portlets or WSRP 2.0) for consumption of the dashboard and other FS features by the Unified Portal and the CCSC. |
| Data Exchange and Reporting | 6.061 | Offeror shall acknowledge their affirmative obligation to work with other modules and share information and data with the Data Services module which will be responsible for all federal and state reporting as well as providing Dashboards for the State. |

The Requirements listed below are mandatory for all components of the FS and tools the Contractor shall provide.

*Table 10 FS General Requirements*

| Category | ID | Requirement |
|---|---|---|
| Strategy and Project Management | 7.001 | Offeror shall describe how its proposed services integrate the service configuration with the HHS 2020 EPMO processes and standards necessary to meet Federal and State regulatory and policy requirements. |
| Strategy and Project Management | 7.002 | Offeror shall describe how its proposed services ensure that Offeror has sufficient appropriately trained and experienced staff to successfully configure, provide and operate the Financial Services through maintenance and operations. |
| Strategy and Project Management | 7.003 | Offeror shall describe how its proposed services provide full access to work products at all stages of FS configuration and operations to HSD, the IV&V Contractor and/or any oversight agent designated by the State or CMS. |
| Strategy and Project Management | 7.004 | Offeror shall describe how its proposed services perform all configuration necessary to provide all approved FS. Offeror shall describe how its proposed services follow industry standard configuration methodologies appropriate to provide defect free business services. |
| Strategy and Project Management | 7.005 | Offeror shall describe how its proposed services comply with the State EPMO's Project Management standards. These expectations include integration with SI combine plans:<br>• Requirements Management including a Traceability Matrix<br>• Business Services Management<br>• Quality Management and Assessment<br>• Schedule Management and Release Planning<br>• Communications Management<br>• Change Management<br>• Risk, Issue and Action Item Management<br>• Configuration Management<br>• Test Planning and Performance<br>• Data Conversion Planning as required<br>• Security Management/Privacy Planning<br>• WBS/Schedule and Reporting |

| Category | ID | Requirement |
|---|---|---|
| | | • Staffing and Training Plans<br>•Business Continuity, Backup and Disaster Recovery Planning and Testing<br>• Implementation/Migration/Transition Planning<br>• Meeting Planning and Administration<br>• Document/Deliverable Management<br>• Disengagement Transition Planning |
| Strategy and Project Management | 7.006 | Offeror shall describe its experience with a Disengagement Transition Plan. Offeror is expected to exercise best efforts and cooperate fully to affect an orderly transition and commit to a no-cost-to-State resolution of malfunctions or omissions identified by the State as critical to transition throughout the transition period and up to ninety (90) days after contract termination. |
| Strategy and Project Management | 7.007 | Offeror shall describe how its proposed services provide a flexible approach whereby additional functional area capabilities can be added without stress or interruption to its Business Services or to other MMISR modules and services. |
| Strategy and Project Management | 7.008 | Offeror shall describe how its proposed services:<br>a. Implement an active, independent Quality Management (QM) program throughout the contract life;<br>b. Monitors FS to assess performance and identify potential quality issues;<br>c. Define and adhere to best practices to provide defect free business services;<br>d. Work with the State to achieve CPI (e.g., streamline costs, reduce risks, streamline processes, increase efficiency), and measure and report on effectiveness of new approaches or processes; and<br>e. Report regularly upon QM activities, including but not limited to work performed, detailed analyses of QM findings, statistics related to the findings, CAPs and status. |
| Strategy and Project Management | 7.009 | Offeror shall describe how its proposed services effectively meet the HHS 2020 Vision and the State's chosen approach to MMISR, while identifying risks or trade-offs and making informed recommendations for an approach. |

| Category | ID | Requirement |
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| Strategy and Project Management | 7.010 | Offeror shall describe how its proposed services will demonstrate readiness to the State and its IV&V Contractor prior to operation. |
| Strategy and Project Management | 7.011 | Offeror shall describe how its proposed services allow for and implement changes, enhancements and updates to FS, workflows (within FS and across modules and stakeholders via the IP) and business processes for efficient alignment with the HHS 2020 Architecture and the needs of the State at no additional cost to the State and without degradation to core responsibilities or negative impact to other module and BPO Contractors. |
| Strategy and Project Management | 7.012 | Offeror shall describe how its proposed services comply with the SI's processes, standards and Shared Core Services, and how Offeror will coordinate integration with the SI Contractor. |
| Strategy and Project Management | 7.013 | Offeror shall describe how its proposed services engage Stakeholders in ensuring the business needs and requirements are met. |
| Strategy and Project Management | 7.014 | Offeror shall describe how its proposed services provide the State with timely responses and CAPs for any audit or review findings and ensure that all its subcontractors also comply with such CAPs. Offeror's Business Services must ensure that quarterly status updates are provided for each CAP until the CAP is complete and findings are remediated. |
| Strategy and Project Management | 7.015 | Offeror shall describe how its proposed services transfer all records, data and reports relating to the State after final payment is made under the Contract resulting from this procurement. When an audit, litigation, or other action involving or requiring access to records is initiated prior to the final payment made under the Contract, Offeror shall commit to clearly mark any related physical records prior to transfer. The transfer shall occur at a time and manner agreed to by the State. |
| Strategy and Project Management | 7.016 | Offeror shall describe how its proposed services will store on the State Microsoft SharePoint site or the HHS 2020 Document Library or other such designated location all Project artifacts and documents. |

| Category | ID | Requirement |
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| Strategy and Project Management | 7.017 | Offeror is encouraged but is not required to use Microsoft Office Suite, Microsoft Visio, Microsoft Project or other such designated tools. Offerors shall provide assurance that its proposed Business Services will comply with HHS 2020 EPMO tools and processes. |
| Strategy and Project Management | 7.018 | Offeror shall acknowledge its responsibility to adhere to and comply with the requirements contained herein and, in the SOW, (APPENDIX G). |
| Strategy and Project Management | 7.019 | Offeror shall describe how its proposed services ensure that all Contractor PMO plans comply and integrate with HHS 2020 Master EPMO Plan. |
| Strategy and Project Management | 7.020 | Offeror shall acknowledge that its services will be made available to the State, Stakeholder partners, State Contractors and modular Contractors without a fee or charge throughout all stages of development and operations. |
| Strategy and Project Management | 7.021 | Offeror shall describe how its proposed services review policy changes for impact to the business services and make recommendations for necessary changes (e.g. edits, audits, process flows). |
| Service Expectations | 8.001 | Offeror shall describe how its proposed services integrate with the SI's Integration Platform |
| Service Expectations | 8.002 | Offeror shall describe how its proposed services maintain availability 24 hours a day, 7 days a week, 365 days a year for 99.999% of the time except for agreed upon maintenance windows. |
| Service Expectations | 8.003 | Offeror shall describe how its proposed services are complete services that provide for the future needs of the MMISR Framework and that comply with CMS guidance on modularity and integration. |
| Service Expectations | 8.004 | Offeror shall describe how its proposed services provide Stakeholders with access to FS information. |
| Service Expectations | 8.005 | Offeror shall describe how its proposed services prevent deletion or damage of FS data. |

| Category | ID | Requirement |
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| Service Expectations | 8.006 | Offeror shall describe how its proposed services handle the anticipated data and resource volumes for FS. |
| Service Expectations | 8.007 | Offeror shall describe how its proposed services acquire and deliver the most currently available data. |
| Service Expectations | 8.008 | Offeror shall describe how its proposed services comply with FS SLAs (see Appendix K - HHS 2020 Performance Measures.) |
| Service Expectations | 8.009 | Offeror shall describe how its proposed services will comply with the required Enterprise architecture. Offeror shall provide examples of the architectural artifacts that are required as part of CMS certification with their response. |
| Service Expectations | 8.010 | Offeror shall describe how its proposed services integrate with Business Continuity (BC), Backup, and Disaster Recovery (DR) plans and meet SLA's defined in Appendix K - HHS 2020 Performance Measures. |
| Service Expectations | 8.011 | Offeror shall describe how its proposed services coordinate with the SI Contractor, for data exchange including metadata. |
| Service Expectations | 8.012 | The Offeror shall describe how its proposed services provide the required FS data to the State. |
| Service Expectations | 8.013 | Offeror shall describe how its proposed services align and comply with all HIPAA Privacy and any applicable Security Compliance Regulations as though it were a Covered Entity. 14 - HHS 2020 Security Privacy and Standards and Addendum 21 – HHS 2020 Security and Standards. |
| Service Expectations | 8.014 | Offeror shall describe how its proposed services follow and implement the State-approved Data Governance directives/policies and how it will support the Enterprise DGC. |
| Service Expectations | 8.015 | Offeror shall describe how the proposed services meet its security obligations as described in 14 - HHS 2020 Security Privacy and Standards and Addendum 21 – HHS 2020 Security and Standards and how it ensures that its subcontractors meet the same standards. |
| Service Expectations | 8.016 | Offeror shall describe how its proposed services provide the State, at a minimum, an annual report from a qualified, |

| Category | ID | Requirement |
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| | | independent, external IT Security Contractor for a Vulnerability Assessment and Network Penetration Test covering all Contractor and subcontractor networks that will access State data and information. |
| Service Expectations | 8.017 | Offeror shall acknowledge that no State data will reside or be accessed off shore by any Contractor or subcontractor staff. |
| Service Expectations | 8.018 | Offeror shall describe how its proposed services comply, at minimum, with State and Federal security requirements and policies in coordination with the security plan established by the State and SI Contractor (see Addendum 14 - HHS 2020 Security Privacy and Standards and Addendum 21 – HHS 2020 Security and Standards in the procurement library). |
| Service Expectations | 8.019 | Offeror shall describe how its proposed services use configuration to meet the business needs, State and Federal requirements and policies. |
| Service Expectations | 8.020 | Offeror shall describe how its proposed services perform testing that complies with security standards (e.g., HIPAA, HITRUST, Addendum 14 - HHS 2020 Security Privacy and Standards and Addendum 21 – HHS 2020 Security and Standards in the procurement library) and incorporates industry best practices to provide defect operations. |
| Service Expectations | 8.021 | Offeror shall describe how its proposed services support State-led UAT. |
| Service Expectations | 8.022 | Offeror shall describe how its proposed services establish and manage qualitative analytic capabilities for the services. |
| Service Expectations | 8.023 | Offeror shall describe how its proposed services provide performance reporting. |
| Service Expectations | 8.024 | Offeror shall describe how its proposed services structure audit trail records, the fields and the formats it will audit, how it controls access to audit information and services and provides to the State. |

| Category | ID | Requirement |
|---|---|---|
| Service Expectations | 8.025 | Offeror shall describe how its proposed services provide audits of all steps where source documents are reviewed to the point where the document process ends and how it maintains and sends the audit points to the audit service of the SI module. |
| Service Expectations | 8.026 | Offeror shall describe how its proposed services audit all actions by all Users and all systems, including view only, of the FS components. |
| Service Expectations | 8.027 | Offeror shall describe how its proposed services retain data (audit records, claims, encounters, payments) per State requirements. |
| Service Expectations | 8.028 | Offeror shall describe how its proposed services control access to data and when controls are violated, the actions taken. |
| Service Expectations | 8.029 | Offeror shall describe how its proposed services will transfer to the State, or its designee, all licenses and software, within one hundred-twenty (120) days of receipt of transfer request from the State. |
| Service Expectations | 8.030 | Offeror shall describe how its proposed services maintain current versions and licenses for all software encompassed within its Services, and how it will implement all patches on a timely basis. |
| Service Expectations | 8.031 | Offeror shall describe how its proposed services use the State specified style guide to accomplish a common State User experience across the modules a (UI). |
| Service Expectations | 8.032 | Offeror shall describe its BRE and how it captures and uses configurable business rules to assist the State in achieving MITA Maturity Level 4 while assuring compliance with State and Federal policies. |
| Service Expectations | 8.033 | Offeror shall describe how its proposed services provide business rules to the State in a language that business people can interpret and electronic format compatible with the State's BRE (currently Corticon and Oracle Business Rules). |
| Service Expectations | 8.034 | Offeror shall describe how its proposed services provide and integrate (e.g., retrieve, send, consume, share, store, maintain the current version) its standardized business rules data with the State's common business rule repository (Corticon and Oracle Business Rules). |

| Category | ID | Requirement |
|---|---|---|
| Service Expectations | 8.035 | Offeror shall describe how its proposed services provide a User FS help desk that has access during State business hours and responds to help requests in a timely and effective manner. Offeror shall describe how its help desk will integrate with the State's help desk. |
| Service Expectations | 8.036 | Offeror shall describe how its proposed services provide Stakeholder access to FS Project SMEs who have expertise in the proposed services throughout the life of the Contract resulting from this procurement. |
| Service Expectations | 8.037 | Offeror shall describe how SMEs are provided to support end Users and may be asked to assist in performing associated tasks across the Enterprise. SMEs must have the following health insurance or Medicaid expertise:<br><br>• Accounting and Fiscal Agency and Billing and Payment Receipts SMEs must have experience and knowledge of accounting standards and processes to assure Enterprise requirements Service Level Agreements (SLAs) and Key Performance Indicators (KPIs) are achieved; (e.g., Lead Accountant [specialization in Government Accounting with Health Care preferred])<br><br>• Claims Processing SMEs must have experience and knowledge of medical and non-medical claims, including timesheet, electronic visit verification (EVV) integration and invoice generated HIPAA 837 transactions, standards and processes across multiple programs to assure Enterprise requirements, SLAs and KPIs are achieved;<br><br>• Data Exchange and Reporting SMEs must have experience and knowledge of standard interfaces, SOA and ESB integration to assure Enterprise requirements, SLAs and KPIS are achieved;<br><br>• Certified Professional Coder (American Health Information Management Association (AHIMA) Certified Coding Specialist- Physician-based (CCS-P®) equivalent or better<br><br>• Project Management staff (e.g., Project Executive, Project |

| Category | ID | Requirement |
|---|---|---|
| | | Manager, Implementation/Integration Manager, Data Manager/Data Base Administrator, Training Manager, Test and Quality Assurance Manager, Security Manager, Project Leads/Business Managers for Certification of each of the three FS components, CMS Certification Lead Analyst, Program/Policy SME) that may be required to continue through operations. |
| Service Expectations | 8.038 | Offeror shall describe how its proposed services provide SME assistance to the Enterprise in researching PI and audit discrepancies and findings. |
| Service Expectations | 8.039 | Offeror shall describe how its proposed Solution Services will accomplish the following: Authentication, Authorization, Data Confidentiality, Data integrity, Privacy, Audits, and Protection against attacks and provide integration with the SSO capabilities and security requirements as defined and implemented by the SI Contractor. |
| Service Expectations | 8.040 | Offeror shall describe how its proposed services manage (e.g., obtain, update, archive, share with Enterprise, associate date spans, allow inquiry, report requests, provide code narrative descriptions) reference files or data and use in processing (e.g., HIPAA defined code sets, diagnosis codes, procedure codes, revenue codes, all five Medicaid NCCI methodologies must be incorporated into MMIS. The MCDNCCI methodology files are located on the Medicaid Integrity Institutes (MII) secure web site. These files are updated on a quarterly basis). |
| Service Expectations | 8.041 | Offeror shall describe how its proposed services manage revenue codes and provides online update and inquiry access, including: (a) Coverage information; (b) Restrictions; (c) Service limitations; (d) Automatic error codes; (e) Pricing data; and |

| Category | ID | Requirement |
|---|---|---|
| | | (f) Effective dates for all items. |
| Service Expectations | 8.042 | Offeror shall describe how its proposed services translate ICD-9 codes to ICD-10, and adjust for any future updates based on General Equivalence Mappings (GEMs) crosswalk developed by CMS. |
| Service Expectations | 8.043 | Offeror shall describe how its proposed services will accomplish the following: Authentication, Authorization, Data Confidentiality, Data integrity, Privacy, Audits, and Protection against attacks and provide integration with the SSO capabilities and security requirements as defined and implemented by the SI Contractor. |
| Service Expectations | 8.044 | Offeror shall describe how its proposed services perform field validations (e.g., alphanumeric, alphabetic, numeric, field length, date format, date, codes, NCPDP). |
| Service Expectations | 8.045 | Offeror shall describe how its proposed services remain informed on reference data pertinent to the module (e.g., national code sets, transactions, values and coding systems at the national level, rates, PA codes, revenue codes, Enterprise stakeholder-specific reference data), assesses the impact of changes and updates on Enterprise exceptions, payment and other module services and coordinates their introduction into the Enterprise ecosystem with input and approval from the Enterprise. |
| Service Expectations | 8.046 | Offeror shall describe how reference data history will be managed and maintained to include previous reference data and relevant date spans based on State retention policies. |
| Support and Maintenance | 9.001 | Offeror shall describe how its proposed services coordinate with the SI Contractor, for data exchange. |
| Support and Maintenance | 9.002 | Offeror shall describe how its proposed services provide for State access to an up to date impact analysis, "what if" testing environment that mirrors production, for testing of any proposed business rule or configuration (e.g., edits, benefit plan, reference, rates, pricing). |

| Category | ID | Requirement |
|---|---|---|
| Testing | 10.001 | Offeror shall describe how it will maintain and protect testing datasets to provide restoration of test data to known points in time and maintain sufficient recent claims data (DOS) for purposes of testing Offeror shall ensure that its testing datasets are not comprised of live production data. Offeror also shall take steps to ensure that testing data or datasets are not entered into production services. |
| Testing | 10.002 | Offeror shall acknowledge its obligation to provide a comprehensive Test Plan for testing of all FS services components (including with providers) which complies with the content requirements found in Section 7 (Testing) of APPENDIX G of this RFP. Offeror must acknowledge that the Test Plan is subject to State approval. |
| Testing | 10.003 | Offeror shall describe how its proposed Solution will ensure that all source code has Unit Test Code and that output from Unit Testing will be made available to the State EPMO. |
| Testing | 10.004 | Offeror shall describe how its proposed Solution will ensure that all module components pass unit testing before being promoted to the shared environments of the MMISR Framework. |
| Testing | 10.005 | Offeror shall describe how its proposed Business Services supports State-led UAT. |
| Training | 11.001 | Offeror shall describe how its proposed services provide training and knowledge transfer programs for State Users. Offeror shall describe its plans for assessing training effectiveness. |
| Training | 11.002 | Offeror shall describe how its proposed services provide training materials, knowledge transfer materials, and other documentation (e.g., User guides, on-line help). Offeror shall include samples of training material in its proposal submission. |
| Training | 11.003 | Offeror shall describe how its proposed services provide for initial and ongoing training and documentation for knowledge transfer to ensure appropriate and maximal use by Users. The proposed services shall provide for instructor-led (either online or on site) and on-demand, self-paced training. |

| Category | ID | Requirement |
|---|---|---|
| Certification | 12.001 | Offeror shall provide with the RFP response Certification artifacts/evidence samples for at least: Accounting and Fiscal Agency tasks; claims intake, adjudication and pricing tasks, Pharmacy Benefit Management and reporting information back to the state. Offeror is encouraged to provide samples of Certification in other areas (e.g., security, 508, HIPAA). |
| Certification | 12.002 | Offeror shall describe how its proposed services assist the State in documenting business processes as described by CMS with respect to MITA. Offeror shall acknowledge its understanding that the State expects to achieve MITA Level 4 by the end of the HHS 2020 Project and shall conduct such mapping as may be necessary to demonstrate Offeror's understanding of the expectations of the State and CMS. |
| Certification | 12.003 | Offeror shall describe how its proposed services develop and update all required documentation for the CMS EPLC phases including recommended exit criteria for determining that a phase is complete. |
| Certification | 12.004 | Offeror shall describe how its proposed services comply with all applicable Federal, State or other regulations, guidance and laws, including Section 508 on ADA compliance. Offeror shall acknowledge that it is required to provide a complete Section 508 Assessment Package. |
| Certification | 12.005 | Offeror shall describe how its proposed services comply with State and/or Federal system certification requirements. Offeror shall describe its proposed plan for meeting the CMS Certification Requirements, MITA Maturity Levels, the Seven Conditions and Standards of CMS, and other certification requirements. Offeror will be required to perform all services necessary to fully configure FS, comply with all of the relevant SRC requirements to support attainment of CMS Certification or other oversight certification. |
| Certification | 12.006 | Offeror shall acknowledge compliance to all applicable CMS MECT checklist requirements, for which it is primarily responsible and agrees to provide all the necessary artifacts for IV&V Quarterly reports, CMS reviews and Certification. Offeror shall acknowledge that they will comply with all SRC's in the |

| Category | ID | Requirement |
|----------|-----|-------------|
|  |  | MECT at the time of CMS Certification. Offeror shall refer to Addendum 18 in the Procurement Library as a living document which can change due to CMS updates to the MECT or the State updating the document at their discretion. |

In addition to responding to the numbered requirements above in this APPENDIX, Offeror is required to respond to the following:

1. Describe at least two successful recent BPO projects, comparable to the FS procurement and modular in nature, on which your organization provided Business Services as the prime contractor. Describe how each experience shaped your services, what lessons were learned, and what outcomes were achieved for the client's project. Address how you will leverage previous engagement experience to perform the FS Contractor role for this Project.

2. Present your proposed staffing and key personnel models for this Project (as described in the Scope of Work found in APPENDIX G).

A. Describe how your proposed staffing model will deliver the required expertise (stated or implied) over the Project life, how a sufficient number of skilled staff will be deployed on the Project, and how the team will be structured to effectively perform the required work. This staffing model is expected to demonstrate an understanding of FS requirements, including consideration of how FS fits within the MMISR Solution and approach, as well as how it fits within HHS 2020. Additionally, the Offeror shall demonstrate an approach for accessing appropriate subject matter expertise to address Project-related requirements or requirements that CMS imposes or recommends throughout the Project life.

B. Identify (by name and expertise) subject matter experts (SMEs) who will be part of the FS team. Explain what types of additional expertise are available from within the Offeror's organization and how these experts will be accessed for this Project.

C. Provide a resume for each recommended Key Personnel.

D. Provide an assurance that the Key Personnel who are proposed by Offeror will in fact be the Personnel for the initial year of the contract (except due to uncontrollable circumstances defined by Offeror and agreed to by the State).

E. Identify any subcontractor(s) who will participate in an awarded contract and describe its organization's experience and the services they will perform in to meet the FS requirements.

F. Describe how you will have sufficient resources and staff to start FS operations within thirty (30) calendar days of contract award and to be operational within sixty (60) calendar days of award.

3. Provide a Work Plan timetable for FS integration. Identify the assumptions underlying your Work Plan timetable and for the items below from your proposal:

A. Approach for FS operations and maintenance;

B. Approach for integrating with the HHS 2020 EPMO tasks;

C. Approach for providing HHS 2020 integration support; and

D. Approach for business service configuration.

4. Explain any requirements or expectations for support from HSD personnel and/or from other MMISR Contractors or Stakeholders.

5. Explain how your business services enable cost-effective, high-quality FS operations and maintenance and ensure cost-effective, over the life of the contract. Explain how your approach will result in satisfaction of the CMS and State expectation that Benefit Management Services will focus on ensuring the integrity and interoperability of the MMISR Solution.

6. Explain your ability and willingness to meet the preliminary set of SLAs and LDs in Appendix K - HHS 2020 Performance Measures. During contract negotiations, the Contractor and State will collaborate to define the SLAs which will be included in the contract. Offeror should understand and agree there will be SLAs that cannot be defined during contract negotiations for operations and will require future Contractor and State collaboration.

**APPENDIX I - Sample Contract**
STATE OF NEW MEXICO

HUMAN SERVICES DEPARTMENT

PROFESSIONAL SERVICES CONTRACT #_____

THIS AGREEMENT is made and entered into by and between the State of New Mexico, **Human Services Department**, hereinafter referred to as the "HSD," or "Procuring Agency "and [Insert Contractor Name], hereinafter referred to as the "Contractor," and collectively referred to as "Parties."

WHEREAS, pursuant to the Procurement Code, NMSA 1978 13-1-28 *et. seq.* and Procurement Code Regulations, NMAC 1.4.1 *et. seq.* the Contractor has held itself out as an entity with the ability to provide the required Services to implement the Scope of Work as contained herein and the Procuring Agency has selected the Contractor as the offeror most advantageous to the State of New Mexico; and

WHEREAS, all terms and conditions of the XX-XXX-XXXX-XXXX and the Contractor's response to such document(s) are incorporated herein by reference; and

NOW, THEREFORE, THE FOLLOWING TERMS AND CONDITIONS ARE MUTUALLY AGREED BETWEEN THE PARTIES:

## ARTICLE 1 – DEFINITIONS

**"Acceptance" or "Accepted"** shall mean the approval, after Quality Assurance, of all Deliverables by an Executive Level Representative of the HSD.

"**Application Deployment Package**" shall mean the centralized delivery of business-critical applications including the source code (for custom software), documentation, executable code and deployment tools required to successfully install application software fixes including additions, modifications, or deletions produced by the Contractor.

"**Agency**" means the Human Services Department.

**"ASPEN"** means New Mexico's Automated System Program and Eligibility Network.

"**Authorized Purchaser**" means an individual authorized by a Participating Entity to place orders against the Contract resulting from this procurement.

"**Business Days**" means Monday through Friday, 7:30 a.m. (MST or MDT) to 5:30 p.m. except for federal or state holidays.

"**Change Request**" shall mean the document utilized to request changes or revisions in the Scope of Work – Exhibit A, attached hereto and incorporated herein.

"**Chief Information Officer ("CIO")**" shall mean the Cabinet Secretary/CIO of the Department of Information Technology for the State of New Mexico or Designated Representative.

"**Close of Business**" means 5:30 PM MST or MDT.

"**CMS**" means the Federal Center for Medicare and Medicaid Services, an agency of the US Department of Health and Human Services.

"**Confidential Information**" means any communication or record (whether oral, written, electronically stored or transmitted, or in any other form) that consists of: (1) confidential client information as such term is defined in State or Federal statutes and/or regulations; (2) all non-public State budget, expense, payment and other financial information; (3) all attorney-client privileged work product; (4) all information designated by the HSD or any other State agency as confidential, including all information designated as confidential under federal or state law or regulations; (5) unless publicly disclosed by the HSD or the State of New Mexico, the pricing, payments, and terms and conditions of this Agreement, and (6) State information that is utilized, received, or maintained by the HSD, the Contractor, or other participating State agencies for the purpose of fulfilling a duty or obligation under this Agreement and that has not been publicly disclosed.

"**Contract**" means this Agreement including any Exhibits, Appendices, Statements of Work, the Business Associate Agreement, and any other attachments to this Agreement or incorporated into the Agreement by reference.

"**Default**" or "**Breach**" shall mean a violation of this Agreement by either failing to perform one's own contractual obligations or by interfering with another Party's performance of its obligations.

"**Deliverable**" shall mean the outputs of the Services under this Agreement and the Scope of Work by the Contractor as defined under this Agreement as specified in the Scope of Work.

"**Determination**" means the written documentation of a decision of a procurement officer, including findings of fact required to support a decision. A determination becomes part of the procurement file to which it pertains.

"**Desirable**" means the terms "may", "can", "should", "preferably", or "prefers" identify a discretionary item or factor.

"**DFA**" shall mean the Department of Finance and Administration; "DFA/CRB" shall mean the Department of Finance and Administration, Contracts Review Bureau.

"**DoIT**" shall mean the Department of Information Technology.

"**Electronic Document Management**" means document imaging, scanning and management.

**"Enhancement"** means any modification including addition(s), modification(s), or deletion(s) that, when made or added to the program, materially changes its or their utility, efficiency, functional capability, or application, but does not constitute solely an error correction.

"**Enterprise**" means the full spectrum of NM HHS systems and agencies (departments/divisions) engaged in this Project.

**"Escrow"** shall mean a legal document (such as the software source code) delivered by the Contractor into the hands of a third party, and to be held by that party until the performance of a condition is Accepted; in the event Contractor fails to perform, the HSD receives the legal document, in this case, Source Code.

**"Executive Level Representative"** shall mean the individual empowered with the authority to represent and make decisions on behalf of the HSD's executives or his/her designated representative.

**"Framework"** means the fundamental structure to support the development of the HHS 2020 Solution. The Framework acts as the architectural support for the modules, services and applications, ESB, Web services, service layers, commonly shared Core Services, etc.

**"GRT"** shall mean New Mexico gross receipts tax.

"**HHS**" means Health and Human Services and includes all State agencies delivering HHS-related services: Department of Health (DOH), HSD, Aging and Long Term Services Department (ALTSD), Children Youth and Families Department (CYFD).

"**Hourly Rate**" means the proposed fully loaded maximum hourly rates that include travel, per diem, fringe benefits and any overhead costs for Contractor personnel and if appropriate, subcontractor personnel.

"**HSD**" means the New Mexico State Human Services Department.

"**Intellectual Property**" shall mean any and all proprietary information developed pursuant to the terms of this Agreement.

**"IRS"** shall mean the federal Internal Revenue Service.

"**ISO**" shall mean the HSD ITD Information Security Officer.

"**IT**" means information technology.

"**ITD**" shall mean the HSD Information Technology Division.

**"ITB"** means Invitation to Bid as defined in statute and rule.

"**IV&V**" means Independent Validation and Verification as defined in Federal regulations and

by the New Mexico Department of Information Technology (DoIT).

"**Mandatory**" means the terms "must", "shall", "will" and "required" identify a required item or factor.

"**Minor Technical Irregularities**" include anything in a proposal that does not affect the price, quality, quantity or any other mandatory requirement.

"**MITA**" means Medicaid Information Technology Architecture.

"**MITA SS-A**" means the MITA State Self-Assessment.

"**MMIS**" means the New Mexico Medicaid Management Information System that helps manage the State's Medicaid program and Medicaid business functions.

"**MMISR**" means the MMIS Replacement system and Project, as explained in the RFP.

"**NMSPA**" means New Mexico State Purchasing Agent or the purchasing agent for the State of New Mexico or a designated representative. May be used interchangeably with "SPA" of State Purchasing Agent.

"**Performance Bond**" shall mean a surety bond which guarantees that the Contractor will fully perform the Contract and guarantees against breach of contract.

"**Price Agreement**" means a definite or indefinite quantity contract that requires the Contractor to furnish items of tangible personal property, services or construction to a State agency or a local public body that issues a purchase order, if the purchase order is within the quantity limitations of the contract, if any.

"**Procurement Manager**" means any person or designee authorized by a State agency or local public body to enter into or administer contracts and to make written determinations with respect thereto.

"**Procuring Agency**" means the New Mexico Human Services Department.

"**Project**" when capitalized, refers to the MMIS Replacement effort, and it incorporates the HHS 2020 Framework, modules and services as defined in this RFP. It also includes all the work required to make the systems and services a reality for HSD and its partners. When "project" is used in a lower-case manner, it refers to a discrete process undertaken to solve a well-defined goal or objective with clearly defined start and end times, defined tasks and a budget that is separate from the overall Project budget. A Project terminates when its defined scope or goal is achieved, and acceptance is given by the project's sponsor. The Project will terminate when the Framework is fully implemented, has been certified by CMS, and meets all the conditions and requirements established by the State.

**"Quality Assurance"** shall mean a planned and systematic pattern of all actions necessary to provide adequate confidence that a Deliverable conforms to established requirements, customer needs, and user expectations.

**"SCS"** means CMS' Seven Conditions and Standards.

"**Services**" means the services to be provided by Contractor under this Agreement as more particularly described in the RFP and any Scope of Work.

**"Service-Level Agreements (SLAs)"** means an agreement that defines the level of service expected from the service provider.

"**Scope of Work**" means a document signed by the Parties that specified (i) the obligations of each Party; (ii) the schedule for Contractor's commencement of the services; (iii) any Deliverables; (iv) a reference to this Agreement and its Effective Date; and (v) any other information deemed necessary by the Parties.

**"Software"** shall mean all operating system and application software used by the Contractor or any of its permitted Subcontractors in connection with the services delivered under this Agreement.

"**Software Maintenance**" shall mean the set of activities which result in changes to the originally Accepted (baseline) product set. These changes consist of corrections, insertions, deletions, extensions, and Enhancements to the baseline system.

**"Solution"** means any combination of design, software, services, tools, systems, processes, knowledge, experience, resources, expertise or other assets that the State, the MMIS and the respective modular contractors use or provide to meet the business needs of the Project.

"**Source Code**" shall mean the human-readable programming instructions organized into sets of files which represent the business logic for the application which might be easily read as text and subsequently edited, requiring compilation or interpretation into binary or machine-readable form before being directly useable by a computer.

**"SPA"** mean the State Purchasing Agent for the State of New Mexico or his/her Designated Representative.

"**SPD**" means State Purchasing Division of the New Mexico State General Services Department.

"**State (the State)**" means the State of New Mexico.

"**State Agency**" means any department, commission, council, board, committee, institution, legislative body, agency, government corporation, educational institution or official of the executive, legislative or judicial branch of the government of this state. "State agency" includes the Purchasing Division of the General Services Department and the State Purchasing Agent but does not include local public bodies.

"**State Purchasing Agent**" means the Director of the Purchasing Division of the New Mexico General Services Department.

"**Turnover Plan"** means the written plan developed by the Contractor and approved by the HSD in the event that the work described in this Agreement transfers to another vendor or the HSD.

## ARTICLE 2 SCOPE OF WORK

Scope of Work. The Contractor shall perform the Services as outlined in the Scope of Work, attached hereto as Exhibit A and incorporated herein by reference.

A. Performance Measures. The Contractor shall perform to the satisfaction of the HSD the Performance Measures set forth in Exhibit C, as determined within the sole discretion of the HSD. In the event the Contractor fails to obtain the results described in Exhibit C, the HSD may provide written notice to the Contractor of the Default and specify a reasonable period of time in which the Contractor shall advise the HSD of specific steps it will take to achieve these results and the proposed timetable for implementation. Nothing in this Section shall be construed to prevent the HSD from exercising its rights pursuant to Article 6 or Article 16.

B. Schedule. The Contractor shall meet the due dates, as set forth in Exhibit A, which shall not be altered or waived by the HSD without prior written approval, through the Amendment process, as defined in Article 25.

C. License. [**CHOICE #1** – If a software license is required, use the following language.] Contractor hereby grants Procuring Agency a [**CHOICE #2**- If a perpetual license is required, use the following language] non-exclusive, irrevocable, perpetual license to use, modify, and copy the following Software: [Insert name of software and patent number if applicable]

[**CHOICE #3**- If the license is required for the term of the Agreement, use the following language] non-exclusive, irrevocable, license to use, modify, and copy the [Insert name of Software and patent number if applicable] Software and any and all updates, corrections and revisions as defined in Article 2 and Exhibit A, for the term of this Agreement.

D. The right to copy the Software is limited to the following purposes: archival, backup and training. All archival and backup copies of the Software are subject to the provisions of this Agreement, and all titles, patent numbers, trademarks, copyright and other restricted rights notices shall be reproduced on any such copies.

1. Contractor agrees to maintain, at Contractor's own expense, a copy of the Software Source Code to be kept by an escrow agent and to list the HSD as an

authorized recipient of this Source Code. The Source Code shall be in magnetic form on media specified by the HSD. The escrow agent shall be responsible for storage and safekeeping of the magnetic media. Contractor shall replace the magnetic media no less frequently than every six (6) months to ensure readability and to preserve the Software at the current revision level. Included with the media shall be all associated documentation which will allow the HSD to top load, compile and maintain the software in the event of a Breach.

2. If the Contractor ceases to do business or ceases to support this Project or Agreement and it does not make adequate provision for continued support of the Software it provided the HSD; or, if this Agreement is terminated, or if the Contractor Breaches this Agreement, the Contractor shall make available to the HSD: 1) the latest available Software program Source Code and related documentation meant for the Software provided or developed under this Agreement by the Contractor and listed as part of the Services; 2) the Source Code and compiler/utilities necessary to maintain the system; and, 3) related documentation for Software developed by third parties to the extent that the Contractor is authorized to disclose such Software. In such circumstances, HSD shall have an unlimited right to use, modify and copy the Source Code and documentation.

[*CHOICE #4 – replaces ALL language in C above if no license*: Not Applicable. The Parties agree there is no License.]

E.  Source Code. [**CHOICE #1 – *If for a maintenance and operations contract, use the following language.*** The Contractor shall deliver any and all software developed as a result of maintenance releases by the Contractor. The Application Deployment Package must be able to reproduce a fully operational application that includes all base application functionality, all cumulative release functionality and including the functionality, as documented, verified and supported by the Contractor, which comprises the new application release.]

[**CHOICE #2 – *If Contractor will hold software in escrow, use the following language:*** For each maintenance release, the Application Deployment Package shall be updated and shall be kept by an identified escrow agent at the Contractor's expense. The Application Deployment Package shall be in magnetic or digital form on media specified by the HSD. The escrow agent shall be responsible for storage and safekeeping of the storage media. The HSD shall be listed with said escrow agent as an authorized recipient of the storage media which shall contain the most recent application maintenance release deployment package.]

[**CHOICE #3** – *If Contractor will not hold software in escrow, use the following language*: For each maintenance release, the Application Deployment Package shall be updated and shall be delivered to the HSD's at the Contractor's expense. The Application Deployment Package shall be in magnetic or digital form on media specified by the HSD and shall be updated with each new application release deployment package at the Contractor's expense.]

[**CHOICE #4:** Not Applicable. The Parties agree there is no Source Code.]

F.    The HSD's Rights.

1.  Rights to Software. [**CHOICE #1** – *If the HSD has right to the Software, use the following language:* The HSD will own all right, title, and interest in and to the HSD's Confidential Information, and the Deliverables, provided by the Contractor, including without limitation the specifications, the work plan, and the Custom Software, except that the Deliverables will not include third party software and the associated documentation for purposes of this Section. The Contractor will take all actions necessary and transfer ownership of the Deliverables to the HSD, without limitation, the Custom Software and associated Documentation on Final Acceptance or as otherwise provided in this Agreement.]

    [**CHOICE #2:** Not Applicable. The Parties agree the HSD does not have rights to the Software.]

2.  Proprietary Rights. The Contractor will reproduce and include the State of New Mexico's copyright and other proprietary notices and product identifications provided by the Contractor on such copies, in whole or in part, or on any form of the Deliverables.

3.  Rights to Data. [**CHOICE #1** – *If the HSD has right to the data, use the following language:* Any and all data stored on the Contractor's servers or within the Contractors custody that is required to be gathered or stored to execute this Agreement, is the sole property of the HSD. The Contractor, subcontractor(s), officers, agents and assigns shall not make use of, disclose, sell, copy or reproduce the HSD's data in any manner, or provide to any entity or person outside of the HSD without the express written authorization of the HSD.]

[**CHOICE #2:** Not Applicable. The Parties agree the HSD does not have rights to the data.]

## ARTICLE 3 COMPENSATION

A.    Compensation Schedule. The HSD shall pay to the Contractor based upon fixed prices

for each Deliverable, per the schedule outlined in Exhibit A, less retainage, if any, as identified in Paragraph D.

B.  Payment. The total compensation under this Agreement shall not exceed [**Insert Dollar Amount and confirm matches Exhibit A amount**] [including New Mexico gross receipts tax.]

This amount is a maximum and not a guarantee that the work assigned to be performed by Contractor under this Agreement shall equal the amount stated herein. The Parties do not intend for the Contractor to continue to provide Services without compensation when the total compensation amount is reached. Contractor is responsible for notifying the HSD when the Services provided under this Agreement reach the total compensation amount. In no event will the Contractor be paid for Services provided in excess of the total compensation amount without this Agreement being amended in writing prior to performance of any services in excess of the total compensation amount listed herein.

Payment shall be made upon Acceptance of each Deliverable according to Article 4 and upon the receipt and Acceptance of a detailed, certified Payment Invoice. Payment will be made to the Contractor's designated mailing address. In accordance with Section 13-1-158 NMSA 1978, payment shall be tendered to the Contractor within thirty (30) days of the date of written certification of Acceptance. All Payment Invoices MUST BE received by the HSD no later than fifteen (15) days after the end of the fiscal year in which services were delivered. Payment Invoices received after such date WILL NOT BE PAID.

C.  Taxes. [**CHOICE #1**- *Use if Agreement is between two public entities:* Not Applicable; contract is between two public entities.]

[**CHOICE #2** - *Use if Agreement is between public and private entity:* The payment of taxes for any money received under this Agreement shall be the Contractor's sole responsibility and should be reported under the Contractor's Federal and State tax identification number(s).

Contractor and any and all subcontractors shall pay all Federal, state and local taxes applicable to its operation and any persons employed by the Contractor. Contractor shall require all subcontractors to hold the HSD harmless from any responsibility for taxes, damages and interest, if applicable, contributions required under Federal and/or state and local laws and regulations and any other costs, including transaction privilege taxes, unemployment compensation insurance, Social Security and Worker's Compensation.

D.   Retainage. [**CHOICE #1**: The HSD shall retain [*INSERT % - recommended percentage is 20% and confirm matches retainage in Exhibit A*] of the fixed-price Deliverable cost for each Deliverable that is the subject of this Agreement as security for full performance of this Agreement. All amounts retained shall be released to the Contractor upon Acceptance of the final Deliverable.]

[**CHOICE #2**: Not applicable; the Parties agree there is no retainage.]

E.   Performance Bond. [**CHOICE #1:** If the amount of the Agreement exceeds $1Million OR, if the Agreement is for custom developed software/application, OR for Commercial Off the Shelf (COTS) software with greater than 20% Enhancement, OR for any other critical project execution concerns, use the following language: Contractor shall execute and deliver to HSD, contemporaneously with the execution of this Agreement, a Performance Bond in the amount of [**Insert Total Amount** of agreed upon Performance Bond] in the name of the HSD. The Performance Bond shall be in effect for the duration of this Agreement and any renewals thereof. The required Performance Bond shall be conditioned upon and for the full performance, Acceptance and actual fulfillment of each and every Deliverable, term, condition, provision, and obligation of the Contractor arising under this Agreement. The HSD's right to recover from the Performance Bond shall include all costs and damages associated with the transfer of Services provided under this Agreement to another Contractor or to the State of New Mexico as a result of Contractor's failure to perform.]

[**CHOICE #2:** Not Applicable. The Parties agree there is no Performance Bond.]

### ARTICLE 4 ACCEPTANCE

A.   Submission. Contractor will make the Deliverable(s) available for use by HSD on the due date for the Deliverable(s) as required in Exhibit A, Scope of Work. Additionally, if required by the HSD, the Contractor will submit any draft versions of the Deliverable(s), or portions thereof, on a date or schedule approved by the HSD.

Upon written acceptance by the HSD of the final Deliverable(s) submitted by the Contractor, as set forth in Article 2 and Exhibit A, Contractor shall submit to HSD a Payment Invoice with a description of the Deliverable(s). Each Payment Invoice shall be for an amount up to the not-to-exceed fixed Deliverable(s) price as set forth in Article 2 and Exhibit A.

B.   Acceptance. In accord with Section 13-1-158 NMSA 1978, the Executive Level

Representative, shall determine if the final Deliverable(s) provided meets specifications. No payment shall be made for any final Deliverable until the individual final Deliverable that is the subject of the Payment Invoice has been Accepted, in writing, by the Executive Level Representative. To Accept the Deliverable(s), the Executive Level Representative, in conjunction with the Project Manager, will assess the Quality Assurance level of the Deliverable(s) and determine, at a minimum, that the Deliverable(s):

1. Complies with the Deliverable(s) requirements as defined in Article 2 and Exhibit A;
2. Complies with the terms and conditions of procurement [*insert name of procurement as listed in recitals above*;
3. Meets the performance measures for the Deliverable(s) and this Agreement;
4. Meets or exceeds the generally accepted industry standards and procedures for the Deliverable(s); and
5. Complies with all the requirements of this Agreement.

If the final Deliverable(s) is deemed Acceptable under Quality Assurance by the Executive Level Representative or their Designated Representative, the Executive Level Representative will notify the Contractor of Acceptance, in writing, within 15 Business Days from the date the Executive Level Representative receives the Deliverable(s).

C.      Rejection. Unless the Executive Level Representative gives notice of rejection within the 15 Business Day Acceptance period, the final Deliverable(s) will be deemed to have been Accepted.

If the final Deliverable(s) is deemed unacceptable under Quality Assurance, 15 days from the date the Executive Level Representative receives the final Deliverable(s) and accompanying Payment Invoice, the Executive Level Representative will send a consolidated set of comments indicating issues, unacceptable items, and/or requested revisions accompanying the rejection.

Upon rejection and receipt of comments, the Contractor shall have ten (10) Business Days to resubmit the final Deliverable(s) to the Executive Level Representative with all appropriate corrections or modifications made and/or addressed. The Executive Level Representative will again determine whether the final Deliverable(s) is Acceptable under Quality Assurance and will provide a written determination within 15 Business Days of receipt of the revised or amended Deliverable(s).

If the final Deliverable(s) is once again deemed unacceptable under Quality Assurance and thus rejected, the Contractor shall provide a remediation plan that shall include a timeline for corrective action acceptable to the Executive Level Representative. The Contractor shall also be subject to all damages and remedies attributable to the late delivery of the final Deliverable(s) under the terms of this Agreement and available at law or equity.

In the event that a final Deliverable must be resubmitted more than twice for Acceptance, the Contractor shall be deemed in breach of this Agreement. The HSD may seek any and all damages and remedies available under the terms of this Agreement and available at law or equity. Additionally, the HSD may terminate this Agreement.

## ARTICLE 5 TERM

[**CHOICE #1**- *If the Agreement is based on a state wide price agreement and is for professional services only*: THIS AGREEMENT SHALL NEITHER BE EFFECTIVE NOR BINDING UNTIL APPROVED BY THE DoIT and DFA/CRB.]

[**CHOICE #2**- *If the Agreement is based on a state wide price agreement and is only for tangible property and/or services, use the following language*: THIS AGREEMENT SHALL NEITHER BE EFFECTIVE NOR BINDING UNTIL APPROVED BY THE DoIT AND SPD, AS APPLICABLE.]

[**CHOICE #3**- *If the Agreement is NOT based on a state wide price agreement and is for professional services only, use the following language*: THIS AGREEMENT SHALL NEITHER BE EFFECTIVE NOR BINDING UNTIL APPROVED BY THE DoIT AND DFA/CRB.]

[**CHOICE #4**- *If the Agreement is NOT based on a state wide price agreement and is for only tangible property and does not include professional services, use the following language*: THIS AGREEMENT SHALL NEITHER BE EFFECTIVE NOR BINDING UNTIL APPROVED BY THE DoIT AND THE STATE PURCHASING AGENT.]

[**CHOICE #5**- *If the Agreement is NOT based on a state wide price agreement and is for both professional services and tangible property/services, use the following language*: THIS AGREEMENT SHALL NEITHER BE EFFECTIVE NOR BINDING UNTIL APPROVED BY THE DoIT AND THE STATE PURCHASING AGENT.]

This Agreement shall terminate on [*Insert Termination Date*], unless terminated pursuant to Article 6. In accordance with NMSA 1978, § 13-1-150, no contract term for a professional services contract, including extensions and renewals, shall exceed four years, except as set forth in NMSA 1978, § 13-1-150. [*IF the term of the agreement is greater than four years AND the agreement falls within exceptions to this code, then we can replace the sentence beginning "In accordance…" with the following:* This Agreement falls within the exception to the four-year limitation, established by NMSA 1978, § 13-1-150(B)(1) for services required to support or operate federally certified Medicaid, financial assistance and child support enforcement management information or payment systems.

# ARTICLE 6 TERMINATION

A.    Grounds. The HSD may terminate this Agreement for convenience or cause. The Contractor may only terminate this Agreement based upon the HSD's uncured, material breach of this Agreement in accordance with Section 6 C below.

B.    Change in Law/Appropriations. By the HSD, if required by changes in State or federal law, or because of court order, or because of insufficient appropriations made available by the United States Congress and/or the New Mexico State Legislature for the performance of this Agreement or at the direction of CMS. The HSD's decision as to whether sufficient appropriations are available shall be accepted by the Contractor and shall be final.

C.    Notice; Opportunity to Cure for Cause

1. Except as otherwise provided in Paragraph (C)(4), the HSD shall give Contractor written notice of termination at least thirty (30) days prior to the intended date of termination, which notice shall (i) identify all the Contractor's alleged material breaches of this Agreement upon which the termination is based and (ii) state what the Contractor must do to cure such material breaches.

2. Contractor shall give HSD written notice of termination at least thirty (30) days prior to the intended date of termination, which notice shall (i) identify all the HSD's material breaches of this Agreement upon which the termination is based and (ii) state what the HSD must do to cure such material breaches.

3. Contractor's notice of termination shall only be effective (i) if the HSD does not cure all material breaches within the thirty (30) day notice period or (ii) in the case of material breaches that cannot be cured within thirty (30) days, the HSD does not, within the thirty (30) day notice period, notify the Contractor of its intent to cure and begin with due diligence to cure the material breach.

4. Notwithstanding the foregoing, this Agreement may be terminated immediately upon written notice to the Contractor (i) if the Contractor becomes unable to perform the services contracted for, as determined by the HSD; (ii) if, during the term of this Agreement, the Contractor is suspended or debarred by the State Purchasing Agent; or (iii) the Agreement is terminated pursuant to Subsection B, above, "Change in Law/Appropriations", of this Agreement.

D.    Liability. Except as otherwise expressly allowed or provided under this Agreement, or by a Turnover Plan approved by HSD, the HSD's sole liability upon termination shall be to pay for acceptable work performed prior to the Contractor's receipt or issuance of a notice of termination; provided, however, that a notice of termination shall not nullify or

otherwise affect either party's liability for pre-termination defaults under or breaches of this Agreement. The Contractor shall submit an invoice for such work within thirty (30) days of receiving or sending the notice of termination, or within any time so specified by an approved Turnover Plan. *THIS PROVISION IS NOT EXCLUSIVE AND DOES NOT WAIVE THE HSD'S OTHER LEGAL RIGHTS AND REMEDIES CAUSED BY THE CONTRACTOR'S DEFAULT/BREACH OF THIS AGREEMENT.*

## ARTICLE 7 TERMINATION MANAGEMENT

A.   Contractor. In the event this Agreement is terminated for any reason, or upon expiration, and in addition to all other rights to property set forth in this Agreement, the Contractor shall:

1.   Transfer, deliver, and/or make readily available to the HSD property, in any form, in which the HSD has an interest pursuant to the terms of this Agreement, and any and all data, Know How, Intellectual Property, inventions or property of the HSD. Such property shall include, but shall not be limited to, the most recent versions of all files, software and documentation, whether provided by HSD or created by the Contractor under this Agreement;

2.   Incur no further financial obligations for materials, Services, or facilities under the Agreement without prior written approval of the HSD;

3.   Continue all work required by the Agreement, in accordance with the terms of the Agreement, between the date of receipt or transmission of any notice of termination and the effective date of termination, unless and until specifically directed to immediately cease such work, in writing, by HSD. Contractor shall terminate all purchase orders or procurements and any subcontractors unless otherwise so directed by HSD, or unless necessary to complete work that HSD has not directed the Contractor to cease prior to the effective date of termination. In the event that the timeline for, or the amount of, compensation needs to be adjusted in light of a termination, the same shall be addressed in a Turnover Plan;

4.   Take such action as the HSD may direct for the protection and preservation of all property and all records, which in the sole discretion of HSD, are related to or required by this Agreement. All such items shall be immediately provided to HSD, upon request, at no cost to HSD, unless otherwise agreed to by HSD;

5.   Unless otherwise agreed to in writing by HSD, agree that HSD is not liable for any costs arising out of termination;

6.   Acknowledge that continuity in administration of government functions is the essence of this Agreement, and that in order to ensure such continuity Contractor

shall cooperate fully in the closeout or transition of any activities arising pursuant to this Agreement;

7. In the event that this Agreement is terminated due to the Contractor's course of performance, negligence or willful misconduct and that course of performance, negligence, or willful misconduct results in reductions in the HSD's receipt of program funds from any governmental agency, the Contractor shall remit to the HSD the full amount of the reduction within thirty (30) days of receipt of written request by HSD. This obligation shall survive the term of this Agreement;

8. Should this Agreement terminate due to the Contractor's Default, the Contractor shall reimburse the HSD for all costs arising from hiring new Contractor/subcontractors if it is reasonably necessary for HSD to hire other Contractors/subcontractors to ensure continuation of the government project that is the subject of this Agreement. Such costs shall include, but not be limited to, the difference between any rates the Contractor was to receive pursuant to this Agreement and the rates charged by any replacement Contractor. Contractor shall make such payment within thirty (30) days of receipt of written request by HSD. This obligation shall survive the term of this Agreement;

9. In the event that this Agreement is terminated for any reason, or upon its expiration, the Contractor shall develop a Turnover Plan, if so requested by HSD. If terminated by HSD, HSD shall make such a request in the notice of termination provided to the Contractor. The Contractor shall provide the Turnover Plan in the format and in accordance with the timeline specified by HSD. The Turnover Plan provided by the Contractor to HSD shall address all issues specified by HSD. The Turnover Plan shall not be effective until and unless approved in writing by HSD.

B. HSD. In the event this Agreement is terminated for any reason, or upon expiration, and in addition to all other rights to property set forth in this Agreement, the HSD shall:

1. Retain ownership of all work products and documentation created solely for the HSD pursuant to this Agreement; and

2. Pay the Contractor all amounts due for Services Accepted prior to the effective date of such termination or expiration.

## ARTICLE 8 INDEMNIFICATION

A. General. [**CHOICE 1:** *Use if the Agreement is between private and public entities:* The Contractor shall defend, indemnify and hold harmless the HSD, the State of New Mexico

and its employees from all actions, proceedings, claims, demands, costs, damages, attorneys' fees and all other liabilities and expenses of any kind from any source which may arise out of the performance of this Agreement, caused by the negligent act or failure to act of the Contractor, its officers, employees, servants, subcontractors or agents, during the time when the Contractor, its officer, agent, employee, servant or subcontractor thereof has or is performing Services pursuant to this Agreement. In the event that any action, suit or proceeding related to the Services performed by the Contractor or any officer, agent, employee, servant or subcontractor under this Agreement is brought against the Contractor, the Contractor shall, as soon as practicable, but no later than two (2) Business Days after it receives notice thereof, notify, by certified mail, the legal counsel of the HSD, the Risk Management Division of the New Mexico General Services Department, and the DoIT.

[**CHOICE #2:** *Use if the Agreement is between two public entities:* Neither party shall be responsible for liability incurred as a result of the other Party's acts or omissions in connection with this Agreement. Any liability incurred in connection with this Agreement is subject to the immunities and limitations of the New Mexico Tort Claims Act, Sections 41-4-1, et seq.]

B. [**USE WITH CHOICE #1:** *Use if the Agreement is between private and public entities:* The indemnification obligation under this Agreement shall not be limited by the existence of any insurance policy or by any limitation on the amount or type of damages, compensation or benefits payable by, or for, Contractor, or any subcontractor, and shall survive the termination of this Agreement. Money due or to become due to the Contractor under this Agreement may be retained by the HSD, as necessary, to satisfy any outstanding claim that the HSD may have against the Contractor.

## ARTICLE 9 INTELLECTUAL PROPERTY

[*CHOICE #1* – If purchasing only IT hardware/equipment, use the following language: Ownership. Not Applicable. The Parties agree there is no Intellectual Property.]

[*CHOICE #2 - Use this provision if HSD is to own the Intellectual Property:*

Ownership. Any and all Intellectual Property, including but not limited to copyright, patentable inventions, patents, trademarks, trade names, service marks, and/or trade secrets created or conceived pursuant to, or as a result of, performance of this Agreement, shall be work made for hire and the HSD shall be considered the creator and owner of such Intellectual Property. Any and all Know How created or conceived pursuant to, or as a result of, performance of this Agreement, shall be work made for hire and the HSD shall be considered the creator and owner of such Know How. The HSD shall own the entire right, title and interest to the Intellectual Property and Know How worldwide, and, other than in the performance of this Agreement, the

Contractor, subcontractor(s), officers, agents and assigns shall not make use of, or disclose the Intellectual Property and Know How to any entity or person outside of the HSD without the express written authorization of the HSD. Contractor shall notify the HSD, within fifteen (15) Business Days, of the creation of any Intellectual Property by it or its subcontractor(s). Contractor, on behalf of itself and any subcontractor(s), agrees to execute any and all document(s) necessary to assure that ownership of the Intellectual Property vests in the HSD and shall take no affirmative actions that might have the effect of vesting all or part of the Intellectual Property in any entity other than the HSD. If, by judgment of a court of competent jurisdiction, Intellectual Property or Know How are not deemed to be created or owned by the HSD, Contractor hereby acknowledges and agrees to grant to the HSD and the State of New Mexico, a perpetual, non-exclusive, royalty free license to reproduce, publish, use, copy and modify the Intellectual Property and Know How.]

[**CHOICE #3**- *If the Contractor will own the Intellectual Property then delete the above language and insert the following language:*

Ownership. Contractor hereby acknowledges and grants to the HSD and the State of New Mexico, a perpetual, non-exclusive, royalty free license to reproduce, publish, use, copy and modify the Intellectual Property and Know How created or conceived pursuant to, or as a result of, performance of this Agreement.]


## <u>ARTICLE 10 INTELLECTUAL PROPERTY INDEMNIFICATION</u>

A.      <u>Intellectual Property Indemnification</u>. The Contractor shall defend, at its own expense, the HSD, the State of New Mexico and/or any other State of New Mexico body against any claim that any product or service provided under this Agreement infringes any patent, copyright or trademark, and shall pay all costs, damages and attorney's fees that may be awarded as a result of such claim. In addition, if any third party obtains a judgment against the HSD based upon the Contractor's trade secret infringement relating to any product or Services provided under this Agreement, the Contractor agrees to reimburse the HSD for all costs, attorneys' fees and the amount of the judgment.

To qualify for such defense and/or payment, the HSD shall:

1.      Give the Contractor written notice, within forty-eight (48) hours, of its notification of any claim;
2.      Work with the Contractor to control the defense and settlement of the claim; and
3.      Cooperate with the Contractor, in a reasonable manner, to facilitate the defense or settlement of the claim.


B.      <u>HSD Rights</u>. If any product or service becomes, or in the Contractor's opinion is likely to

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become, the subject of a claim of infringement, the Contractor shall, at its sole expense:

1. Provide the HSD the right to continue using the product or service and fully indemnify the HSD against all claims that may arise out of the HSD's use of the product or service;

2. Replace or modify the product or service so that it becomes non-infringing; or

3. Accept the return of the product or service and refund an amount equal to the value of the returned product or service, less the unpaid portion of the purchase price and any other amounts, which are due to the Contractor. The Contractor's obligation will be void as to any product or service modified by the HSD to the extent such modification is the cause of the claim.

## ARTICLE 11 WARRANTIES

A. <u>General</u>. The Contractor hereby expressly warrants the Deliverable(s) as being correct and compliant with the terms of this Agreement, the Contractor's official published specification and technical specifications of this Agreement and all generally accepted industry standards. This warranty encompasses correction of defective Deliverable(s) and revision(s) of the same, as necessary, including deficiencies found during testing, implementation, or post-implementation phases.

B. <u>Software</u>. [*CHOICE #1- Use if only purchasing or developing software:* The Contractor warrants that any software or other products delivered under this Agreement shall comply with the terms of this Agreement, Contractor's official published specification(s) and technical specifications of this Agreement and all generally accepted industry standards. The Contractor further warrants that the software provided under this Agreement will meet the applicable specifications for [*INSERT # of years - recommend 6mo.-2yrs.*] years after Acceptance by the Executive Level Representative and implementation by the HSD.

If the software fails to meet the applicable specifications during the warranty period, the Contractor will correct the deficiencies, at no additional cost to the HSD, so that the software meets the applicable specifications.]

[*CHOICE #2:* Not Applicable. The Parties agree there is no Software.**]**

## ARTICLE 12 CONTRACTOR PERSONNEL

A. <u>Key Personnel</u>.

1.     Contractor's key personnel shall not be diverted from this Agreement without the prior written approval of the HSD. Key personnel are those individuals considered by the HSD to be mandatory to the work to be performed under this Agreement. **[If Key Personnel are identified:** Key personnel shall be:

[*Insert Contractor Staff Name(s) or use Exhibit*]

2.     Process in the Event of Replacement or Diversion:

a.     The Contractor agrees that no Key Personnel shall be diverted or replaced within the first year of the performance of this Agreement, except for a catastrophic event such as illness, accident or death.

b.     If thereafter, one or more of the Key Personnel, for any reason, becomes or is expected to become unavailable for work under this Agreement for a continuous period exceeding twenty (20) business days, the Contractor shall immediately notify HSD and shall submit a written replacement request to HSD. Such request shall provide a detailed explanation of the circumstances necessitating the proposed substitution. The replacement request shall contain a complete resume for the proposed substitute, as well as any other information requested by HSD that HSD deems necessary to evaluate the appropriateness of the proposed substitution and the impact of any such substitution on the performance of the Agreement. Additionally, HSD shall, upon request, be provided with a timely opportunity to interview the proposed substitute before the substitute joins the project.

c.     If, in the sole discretion of HSD, it is determined that one or more Key Personnel who have not been replaced or diverted are devoting substantially less effort to the work than originally anticipated, or if any one or more of the Key Personnel are not, in the sole opinion of HSD, meeting HSD's performance requirements, HSD shall so notify the Contractor. Upon receipt of a notification of request for replacement from HSD, the Contractor shall follow the replacement request process appearing above.

d.     Under no circumstances shall Contractor divert or otherwise replace Key Personnel without the prior written consent of HSD. In the event that any substitution of Key Personnel becomes necessary for any reason discussed above, or for any other reason, Contractor must complete the above replacement request process and must obtain the written approval of HSD, in such a manner as to ensure that prior approved substitute Key Personnel will be in place within ten (10) business days of the receipt of the replacement request notification by either the Contractor or HSD, unless

otherwise agreed to in writing by HSD. Changes of Key Personnel pursuant to this Article shall not be subject to the amendment process of Article 25 herein.

B.    <u>Non-Key Personnel Changes.</u> Replacement of any personnel shall be made with personnel of equal ability, experience, and qualification; personnel may be replaced only with prior approval by HSD's Executive-Level Representative. For all personnel, the HSD reserves the right to require submission of their resumes prior to approval. If the number of Contractor's personnel assigned to the Project is reduced for any reason, Contractor shall, within ten (10) Business Days of the reduction, replace with the same or greater number of personnel with equal ability, experience, and qualifications, subject to HSD approval. The HSD, in its sole discretion, may approve additional time beyond the ten (10) Business Days for replacement of personnel. The Contractor shall take all necessary steps to find an acceptable and appropriate replacement person and shall include in its status reports information on its efforts and progress in finding replacement(s) and the effect of the absence of the personnel on the progress of the Project. The Contractor shall also make interim arrangements to assure that the Project progress is not affected by the loss of personnel.

C.    The HSD reserves the right to require a change in Contractor's personnel if the assigned personnel are not, in the sole opinion of the HSD, meeting the HSD's expectations. Such personnel changes shall not be subject to the amendment process of Article 25 herein.

## ARTICLE 13 STATUS OF CONTRACTOR

[**CHOICE #1**- *Use if only purchasing IT hardware/equipment:* Not Applicable.]

A.    <u>Independent Contractor.</u> The Contractor and its agents and employees are independent contractors performing professional Services for the HSD and are not employees of the State of New Mexico. The Contractor and its agents and employees shall not accrue leave, retirement, insurance, bonding, use of state vehicles, or any other benefits afforded to employees of the State of New Mexico as a result of this Agreement. The Contractor acknowledges that all sums received hereunder are personally reportable by it for income tax purposes as self-employment or business income and are reportable for self-employment tax.

B.    <u>Subject of Proceedings.</u> Contractor warrants that neither the Contractor nor any officer, stockholder, director or employee of the Contractor, is presently subject to any litigation or administrative proceeding before any court or administrative body which would have an adverse effect on the Contractor's ability to perform under this Agreement; nor, to the best knowledge of the Contractor, is any such litigation or proceeding presently threatened against it or any of its officers, stockholders, directors or employees. If any such proceeding is initiated or threatened during the term of this Agreement, the

Contractor shall immediately disclose such fact to the HSD.

## ARTICLE 14 CHANGE MANAGEMENT

A.  Changes. Contractor may not make changes within the Scope of Work as defined by Article 2 and Exhibit A, unless Contractor has received written approval for such changes from the Executive Level Representative, pursuant to the "Change Request Process" below.

Such changes may include, but not be limited to, deletion of deliverables or tasks as deemed appropriate by the HSD. Additionally, such changes, pursuant to this provision, may only be made to Tasks or Sub-Tasks as defined in Exhibit A and may not be made to the following, which shall only be made by amendment to the Agreement, pursuant to Article 25:

1.  Deliverable requirements as outlined in Exhibit A;
2.  Due date of any Deliverable as outlined in Exhibit A;
3.  Compensation of any Deliverable, as outlined in Exhibit A;
4.  Agreement compensation, as outlined in Article 3; or
5.  Agreement termination, as outlined in Article 6.

B.  Change Request Process. A Change Request may be initiated by either the Contractor or the HSD. In the event that circumstances warrant a change to accomplish the Scope of Work as described above, a Change Request shall be submitted that meets the following criteria:

1.  The Project Manager, after consultation with the Contractor, shall draft a written Change Request for review and approval by the Executive Level Representative to include:

    a.  Name of the person requesting the change;
    b.  Summary of the required change;
    c.  Start date for the change;
    d.  Reason and necessity for change;
    e.  Elements to be altered; and
    f.  Impact of the change.

3.  The Executive Level Representative shall provide a written decision on the Change Request to the Contractor within a maximum of ten (10) Business Days of receipt of the Change Request. All decisions made by the Executive Level Representative are final. Change Requests, once approved, become a part of the

Agreement and become binding as a part of the original Agreement.


## ARTICLE 15 INDEPENDENT VERIFICATION AND VALIDATION

**[CHOICE #1 for NON IV&V CONTRACTS]:** If Independent Verification and Validation (IV&V) professional Services are used or required to be used for the Project associated with this Agreement, the Contractor hereby agrees to cooperate with the IV&V vendor. Such cooperation shall include, but is not limited to:

1. Providing the Project documentation;
2. Allowing the IV&V vendor to attend the Project meetings; and
3. Supplying the IV&V vendor with any other material as directed by the Project Manager.

**[CHOICE #2 for IV&V CONTRACTS]:** If this Agreement is for IV&V professional Services then the Contractor agrees to:

1. Submit all reports directly to the Department of Information Technology, Project Oversight and Compliance Division (ivandv.reports@state.nm.us) according to the DoIT IV&V Reporting Template and Guidelines found on the DoIT website, http://www.doit.state.nm.us/project_templates.html, and copy the HSD.

2. Use a report format consistent with the current DoIT IV&V Reporting Template and Guidelines found on the DoIT website, http://www.doit.state.nm.us/project_templates.html.


## ARTICLE 16 DEFAULT/BREACH

In case of Default and/or Breach by the Contractor, for any reason whatsoever, the HSD and the State of New Mexico may procure the goods or Services from another source and hold the Contractor responsible for any resulting excess costs and/or damages, including but not limited to, direct damages, indirect damages, consequential damages, special damages and the HSD and the State of New Mexico may also seek all other remedies under the terms of this Agreement and under law or equity. This remedy shall be in addition to, and not in lieu of, any remedy exercised by the HSD pursuant to Article 7, Termination Management.


## ARTICLE 17 EQUITABLE REMEDIES

Contractor acknowledges that its failure to comply with any provision of this Agreement will cause the HSD irrevocable harm and that a remedy at law for such a failure would be an

inadequate remedy for the HSD, and the Contractor consents to the HSD's obtaining from a court of competent jurisdiction, specific performance, or injunction, or any other equitable relief in order to enforce such compliance. HSD's rights to obtain equitable relief pursuant to this Agreement shall be in addition to, and not in lieu of, any other remedy that HSD may have under applicable law, including, but not limited to, monetary damages.

## ARTICLE 18 LIABILITY

Contractor shall be liable for damages arising out of injury to persons and/or damage to real or tangible personal property at any time, in any way, if and to the extent that the injury or damage was caused by or due to the fault or negligence of the Contractor or a defect of any equipment provided or installed, provided in whole or in part by the Contractor pursuant to the Agreement. Contractor shall not be liable for damages arising out of, or caused by, alterations made by the HSD to any equipment or its installation or for losses caused by the HSD's fault or negligence.

Nothing in this Agreement shall limit the Contractor's liability, if any, to third parties and/or employees of the HSD or the State of New Mexico, or any remedy that may exist under law or equity in the event a defect in the manufacture or installation of the equipment, or the negligent act or omission of the Contractor, its officers, employees, or agents, is the cause of injury to such person.

Nothing in this Agreement shall limit the Contractor's liability, if any, related to any breach of privacy or security requirements related to Confidential Information.

## ARTICLE 19 ASSIGNMENT

The Contractor shall not assign or transfer any interest in this Agreement or assign any claims for money due or to become due under this Agreement without the prior written approval of this Agreement's approval authorities.

## ARTICLE 20 SUBCONTRACTING

A.      General Provision. The Contractor shall not subcontract any portion of this Agreement without the prior written approval of the HSD. No such subcontracting shall relieve the Contractor from its obligations and liabilities under this Agreement, nor shall any subcontracting obligate payment from the HSD.

B.      Responsibility for subcontractors. The Contractor must not disclose Confidential Information of the HSD or of the State of New Mexico to a subcontractor unless and until

such subcontractor has agreed in writing to protect the confidentiality of such Confidential Information in the manner required of the Contractor under this Agreement, **[OPTIONAL: which may include execution of a Business Associate Agreement in substantial similarity to Exhibit (insert exhibit number), attached, where appropriate.]**

## ARTICLE 21 RELEASE

The Contractor's Acceptance of final payment of the amount due under this Agreement shall operate as a release of the HSD, its officers and employees, and the State of New Mexico from all liabilities, claims and obligations whatsoever arising from or under this Agreement.

## ARTICLE 22 CONFIDENTIALITY

Any Confidential Information provided to the Contractor by the HSD or, developed by the Contractor based on information provided by the HSD in the performance of this Agreement shall be kept confidential and shall not be made available to any individual or organization by the Contractor without the prior written approval of the HSD. Upon termination of this Agreement, Contractor shall deliver all Confidential Information in its possession to the HSD within thirty (30) Business Days of such termination. Contractor acknowledges that failure to deliver such Confidential Information to the HSD will result in direct, special and incidental damages.

## ARTICLE 23 CONFLICT OF INTEREST

A.    The Contractor represents and warrants that it presently has no interest and, during the term of this Agreement, shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance or services required under the Agreement.

B.    The Contractor further represents and warrants that it has complied with, and, during the term of this Agreement, will continue to comply with, and that this Agreement complies with all applicable provisions of the Governmental Conduct Act, Chapter 10, Article 16 NMSA 1978. Without in anyway limiting the generality of the foregoing, the Contractor specifically represents and warrants that:

1.    In accordance with NMSA 1978, § 10-16-4.3, the Contractor does not employ, has not employed, and will not employ during the term of this Agreement any Agency employee while such employee was or is employed by the Agency and participating directly or indirectly in the Agency's contracting process;

2.    This Agreement complies with NMSA 1978, § 10-16-7(A) because (i) the

Contractor is not a public officer or employee of the State; (ii) the Contractor is not a member of the family of a public officer or employee of the State; (iii) the Contractor is not a business in which a public officer or employee or the family of a public officer or employee has a substantial interest; or (iv) if the Contractor is a public officer or employee of the State, a member of the family of a public officer or employee of the State, or a business in which a public officer or employee of the State or the family of a public officer or employee of the State has a substantial interest, public notice was given as required by NMSA 1978, § 10-16-7(A) and this Agreement was awarded pursuant to a competitive process;

3. In accordance with NMSA 1978, § 10-16-8(A), (i) the Contractor is not, and has not been represented by, a person who has been a public officer or employee of the State within the preceding year and whose official act directly resulted in this Agreement and (ii) the Contractor is not, and has not been assisted in any way regarding this transaction by, a former public officer or employee of the State whose official act, while in State employment, directly resulted in the Agency's making this Agreement;

4. This Agreement complies with NMSA 1978, § 10-16-9(A)because (i) the Contractor is not a legislator; (ii) the Contractor is not a member of a legislator's family; (iii) the Contractor is not a business in which a legislator or a legislator's family has a substantial interest; or (iv) if the Contractor is a legislator, a member of a legislator's family, or a business in which a legislator or a legislator's family has a substantial interest, disclosure has been made as required by NMSA 1978, § 10-16-7(A), this Agreement is not a sole source or small purchase contract, and this Agreement was awarded in accordance with the provisions of the Procurement Code;

5. In accordance with NMSA 1978, § 10-16-13, the Contractor has not directly participated in the preparation of specifications, qualifications or evaluation criteria for this Agreement or any procurement related to this Agreement; and

6. In accordance with NMSA 1978, § 10-16-3 and § 10-16-13.3, the Contractor has not contributed, and during the term of this Agreement shall not contribute, anything of value to a public officer or employee of the Agency.

C. Contractor's representations and warranties in Paragraphs A and B of this Article 23 are material representations of fact upon which the Agency relied when this Agreement was entered into by the parties. Contractor shall provide immediate written notice to the Agency if, at any time during the term of this Agreement, Contractor learns that Contractor's representations and warranties in Paragraphs A and B of this Article 23 were erroneous on the effective date of this Agreement or have become erroneous by reason of

new or changed circumstances. If it is later determined that Contractor's representations and warranties in Paragraphs A and B of this Article 23 were erroneous on the effective date of this Agreement or have become erroneous by reason of new or changed circumstances, in addition to other remedies available to the Agency and notwithstanding anything in the Agreement to the contrary, the Agency may immediately terminate the Agreement.

## ARTICLE 24 RECORDS AND AUDIT

The Contractor shall maintain detailed records that indicate the nature and price of Services rendered during this Agreement's term and effect and retain them for a period of five (5) years from the date of final payment under this Agreement.

**[FOR CONTRACTORS SUBJECT TO FEDERAL 2 CFA 200 REGULATIONS (PUBLIC BENFIT PAYMENTS, RENUMBER ARTICLE AND ADD THE FOLLOWING:]**

B.      Contract for an independent audit in accordance with 2 CFR 200 at the Contractor's expense, as applicable or upon HSD request, submit its most recent 2 CFR 200 audit. The Contractor shall ensure that the auditor is licensed to perform audits in the State of New Mexico and shall be selected by a competitive bid process. The Contractor shall enter into a written contract with the auditor specifying the scope of the audit, the auditor's responsibility, the date by which the audit is to be completed and the fee to be paid to the auditor for this service. Single audits shall comply with procedures specified by the HSD. The audit of the contract shall cover compliance with Federal Regulations and all financial transactions hereunder for the entire term of the Agreement in accordance with procedures promulgated by 2 CFR 200 or by Federal program officials for the conduct and report of such audits. An official copy of the independent auditor's report shall be available to the HSD and any other authorized entity as required by law within (fifteen) 15 days of receipt of the final audit report. The Contractor may request an extension to the deadline for submission of the audit report in writing to the HSD for good cause and the HSD reserves the right to approve or reject any such request. The HSD retains the right to contract for an independent financial and functional audit for funds and operations under this Agreement if it determines that such an audit is warranted or desired.

C.      Upon completion of the audit under the applicable federal and state statutes and regulations, the Contractor shall notify the HSD when the audit is available for review and provide online access to the HSD, or the Contractor shall provide the HSD with four (4) originals of the audit report. The HSD will retain two (2) and one (1) will be sent to the HSD/Office of the Inspector General and one (1) to the HSD/Administrative Services Division/Compliance Bureau.

D.      Within thirty (30) days thereafter, or as otherwise determined by the HSD in writing, the Contractor shall provide the HSD with a response indicating the status of each of the exceptions or findings in the said audit report. If either the exceptions or findings in the audit are not resolved within thirty (30) days, the HSD has the right to reduce funding, terminate this Agreement, and/or recommend decertification in compliance with state and/or federal regulations governing such action.

E.      This audit shall contain the Schedule of Expenditures of Federal Awards for each program to facilitate ease of reconciliation by the HSD. This audit shall also include a review of the schedule of depreciation for all property or equipment with a purchase price of $5,000 or more pursuant to 2 CFR 200, specifically subpart F, §200.500, and appendices where appropriate.

F.      This audit shall include a report on compliance with requirements applicable to each major program and internal control over compliance in accordance with 2 CFR 200, specifically subpart F, §200.500 and appendices.


## ARTICLE 25 AMENDMENT

This Agreement, including any exhibit or appendix thereto, shall not be altered, changed, or amended except by an instrument in writing executed by the Parties hereto **[*If this contract is subject to CMS approval, add*: and CMS].** Where required by state authorities, no amendment shall be effective or binding unless approved by all of the approval authorities. Amendments specifically subject to approval of state authorities in addition to the HSD, include but are not limited to the following:

1. Deliverable requirements, as outlined in Exhibit A;
2. Due Date of any Deliverable, as outlined in Exhibit A;
3. Compensation of any Deliverable, as outlined in Exhibit A;
4. Agreement Compensation, as outlined in Article 3; or
5. Agreement termination, as outlined in Article 6.

All terms defined in the Governmental Conduct Act have the same meaning in this Article 23(B).


## ARTICLE 26 NEW MEXICO EMPLOYEES HEALTH COVERAGE

A.      If Contractor has, or grows to, six (6) or more employees who work, or who are expected to work, an average of at least 20 hours per week over a six (6) month period during the term of the contract, Contractor certifies, by signing this agreement, to have in place, and agree to maintain for the term of the contract, health insurance for those employees and offer that health insurance to those employees if the expected annual value in the

aggregate of any and all contracts between Contractor and the State exceed $250,000 dollars.

B.      Contractor agrees to maintain a record of the number of employees who have (a) accepted health insurance; (b) declined health insurance due to other health insurance coverage already in place; or (c) declined health insurance for other reasons. These records are subject to review and audit by a representative of the state.

C.      Contractor agrees to advise all employees of the availability of State publicly financed health care coverage programs by providing each employee with, as a minimum, the following web site link to additional information: http://insurenewmexico.state.nm.us/.

D.      For Indefinite Quantity, Indefinite Delivery contracts (state price agreements without specific limitations on quantity and providing for an indeterminate number of orders to be placed against it); Contractor agrees these requirements shall apply the first day of the second month after the Contractor reports combined sales (from state and, if applicable, from local public bodies if from a state price agreement) of $250,000.


## ARTICLE 27 NEW MEXICO EMPLOYEES PAY EQUITY REPORTING

A.      The Contractor agrees if it has ten (10) or more New Mexico employees OR eight (8) or more employees in the same job classification, at any time during the term of this Agreement, to complete and submit the PE10-249 form on the annual anniversary of the initial report submittal for Agreements up to one (1) year in duration. If Contractor has (250) or more employees Contractor must complete and submit the PE250 form on the annual anniversary of the initial report submittal for Agreements up to one (1) year in duration. For Agreements that extend beyond one (1) calendar year, or are extended beyond one (1) calendar year, Contractor also agrees to complete and submit the PE10-249 or PE250 form, whichever is applicable, within thirty (30) days of the annual Agreements anniversary date of the initial submittal date or, if more than 180 days has elapsed since submittal of the last report, at the completion of the Agreements, whichever comes first. Should Contractor not meet the size requirement for reporting as of the effective date of this Agreement but subsequently grows such that they meet or exceed the size requirement for reporting, Contractor agrees to provide the required report within ninety (90 days) of meeting or exceeding the size requirement. That submittal date shall serve as the basis for submittals required thereafter.

B.      Contractor also agrees to levy this requirement on any subcontractor(s) performing more than ten percent (10%) of the dollar value of this Agreement if said subcontractor(s) meets, or grows to meet, the stated employee size thresholds during the term of this Agreement. Contractor further agrees that, should one or more subcontractor not meet the

size requirement for reporting as of the effective date of this Agreement but subsequently grows such that they meet or exceed the size requirement for reporting, Contractor will submit the required report, for each such subcontractor, within ninety (90) calendar days of that subcontractor meeting or exceeding the size requirement. Subsequent report submittals, on behalf of each such subcontractor, shall be due on the annual anniversary of the initial report submittal. Contractor shall submit the required form(s) to the State Purchasing Division of the General Services Department, and other departments as may be determined, on behalf of the applicable subcontractor(s) in accordance with the schedule contained in this paragraph. Contractor acknowledges that this subcontractor requirement applies even though Contractor itself may not meet the size requirement for reporting and be required to report itself.

C.    Notwithstanding the foregoing, if this Agreement was procured pursuant to a solicitation, and if Contractor has already submitted the required report accompanying their response to such solicitation, the report does not need to be re-submitted with this Agreement.

## ARTICLE 28 – SEVERABILITY, MERGER, SCOPE, ORDER OF PRECEDENCE

A.    Severable. The provisions of this Agreement are severable, and if for any reason, a clause, sentence or paragraph of this Agreement is determined to be invalid by a court or agency or commission having jurisdiction over the subject matter hereof, such invalidity shall not affect other provisions of this Agreement, which can be given effect without the invalid provision.

B.    Merger/Scope/Order. This Agreement, inclusive of any attached exhibits, schedules, or appendices, including but not limited to those specifically listed below, constitutes the entire Agreement among the parties. All agreements, covenants and understanding between the Parties have been merged into this Agreement. No prior agreement or understanding, verbal or otherwise, of the Parties or their agents or assignees shall be valid or enforceable unless embodied in this Agreement. The terms and conditions as stated in the main agreement have precedence over any potentially conflicting terms and conditions in any exhibits, schedules, or appendices attached hereto, except where the Federal Supremacy clause requires otherwise.

In the event of any conflict among the documents and materials, the following order of precedence shall apply:

1.   The terms and conditions of this Agreement and its Exhibits;

2. The requirements as described in the Request for Proposal XX-XXX-XXXX-XXXX - and any RFP amendments issued.

3. The Services offered in the proposal submitted by the Contractor in Response to *RFP XX-XXX-XXXX-XXXX*;

## ARTICLE 29 NOTICES

All deliveries, notices, requests, demands or other communications provided for or required by this Agreement shall be in writing and shall be deemed to have been given when sent by registered or certified mail (return receipt requested), when sent by overnight carrier, or upon telephone confirmation by Contractor to the sender of receipt of a facsimile communication that is followed by a mailed hard copy from the sender. Notices shall be addressed as follows:

**For HSD**

[Insert: Name of Individual, Position
Division
E-mail Address
Telephone Number
Mailing Address.]

**For CONTRACTOR**

[Insert Name of Individual, Position,
Company Name,
E-mail Address,
Telephone Number,
Mailing Address.]

Any change to the Notice individual or the address, shall be effective only in writing.

## ARTICLE 30 GENERAL PROVISIONS

A. The Contractor agrees to abide by all federal and state laws and rules and regulations, and executive orders of the Governor of the State of New Mexico, including but not limited to:

1. Civil and Criminal Penalties. The Procurement Code, Sections 13-1-28 through 13-1-199 NMSA 1978, imposes civil and criminal penalties for its violation. In addition, the New Mexico criminal statutes impose felony penalties for illegal bribes, gratuities and kickbacks.

2.  Equal Opportunity Compliance. The Contractor agrees to abide by all federal and state laws and rules and regulations, and executive orders of the Governor of the State of New Mexico, pertaining to equal employment opportunity. In accordance with all such laws of the State of New Mexico, the Contractor agrees to assure that no person in the United States shall, on the grounds of race, religion, color, national origin, ancestry, sex, age, physical or mental handicap, serious medical condition, spousal affiliation, sexual orientation or gender identity, be excluded from employment with or participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity performed under this Agreement. If Contractor is found not to be in compliance with these requirements during the life of this Agreement, Contractor agrees to take appropriate steps to correct these deficiencies.

3.  Workers Compensation. The Contractor agrees to comply with state laws and rules applicable to workers compensation benefits for its employees. If the Contractor fails to comply with the Workers Compensation Act and applicable rules when required to do so, this Agreement may be terminated by the HSD.

B.  Applicable Law. The laws of the State of New Mexico shall govern this Agreement. Venue shall be proper only in a New Mexico court of competent jurisdiction in accordance with Section 38-3-1 (G) NMSA 1978. By execution of this Agreement, Contractor acknowledges and agrees to the jurisdiction of the courts of the State of New Mexico over any and all such lawsuits arising under or out of any term of this Agreement.

C.  Waiver. A party's failure to require strict performance of any provision of this Agreement shall not waive or diminish that party's right thereafter to demand strict compliance with that or any other provision. No waiver by a party of any of its rights under this Agreement shall be effective unless expressed and in writing, and no effective waiver by a party of any of its rights shall be effective to waive any other rights.

D.  Headings. Any and all headings herein are inserted only for convenience and ease of reference and are not to be considered in the construction or interpretation of any provision of this Agreement. Numbered or lettered provisions, sections and subsections contained herein, refer only to provisions, sections and subsections of this Agreement unless otherwise expressly stated.

## ARTICLE 31 SURVIVAL

The Articles entitled Intellectual Property, Intellectual Property Ownership, Confidentiality, and Warranties shall survive the expiration or termination of this Agreement. Software License and

Software Escrow agreements entered into in conjunction with this Agreement shall survive the expiration or termination of this Agreement.

[**OPTIONAL**: Other unexpired agreements, promises, or warranties that will survive the termination of this Agreement are: (*list here*)]

## ARTICLE 32 FORCE MAJEURE

Neither party shall be liable in damages or have any right to terminate this Agreement for any delay or Default in performing hereunder if such delay or Default is caused by conditions beyond its control including, but not limited to Acts of God, Government restrictions (including the denial or cancellation of any export or other necessary license), wars, insurrections and/or any other cause beyond the reasonable control of the party whose performance is affected.

## ARTICLE 33 DEBARMENT AND SUSPENSION

A.      Consistent with all applicable federal and/or state laws and regulations, , as applicable, and as a separate and independent requirement of this Agreement the Contractor certifies by signing this Agreement, that it and its principals, to the best of its knowledge and belief: (1) are not debarred, suspended, proposed for debarment, or declared ineligible for the award of contracts by any Federal department or agency; (2) have not, within a three-year period preceding the effective date of this Agreement, been convicted of or had a civil judgment rendered against them for: commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, state, or local) contract or subcontract; violation of Federal or state antitrust statutes relating to the submission of offers; or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, or receiving stolen property; (3) have not been indicted for, or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with, commission of any of the offenses enumerated above in this Paragraph A; (4) have not, within a three-year period preceding the effective date of this Agreement, had one or more public agreements or transactions (Federal, State or local) terminated for cause or default; and (5) have not been excluded from participation from Medicare, Medicaid or other federal health care programs pursuant to Title XI of the Social Security Act, 42 U.S.C. § 1320a-7.

B.      The Contractor's certification in Paragraph A, above, is a material representation of fact upon which the HSD relied when this Agreement was entered into by the parties. The Contractor's certification in Paragraph A, above, shall be a continuing term or condition of this Agreement. As such at all times during the performance of this Agreement, the Contractor must be capable of making the certification required in Paragraph A, above, as if on the date of making such new certification the Contractor was then executing this Agreement for the first time. Accordingly, the following requirements shall be read so as

to apply to the original certification of the Contractor in Paragraph A, above, or to any new certification the Contractor is required to be capable of making as stated in the preceding sentence:

1. The Contractor shall provide immediate written notice to the HSD's Program Manager if, at any time during the term of this Agreement, the Contractor learns that its certification in Paragraph A, above, was erroneous on the effective date of this Agreement or has become erroneous by reason of new or changed circumstances.

2. If it is later determined that the Contractor's certification in Paragraph A, above, was erroneous on the effective date of this Agreement or has become erroneous by reason of new or changed circumstances, in addition to other remedies available to the HSD, the HSD may terminate the Agreement.

C. As required by statute, regulation or requirement of this Agreement, and as contained in Paragraph A, above, the Contractor shall require each proposed first-tier subcontractor whose subcontract will equal or exceed $25,000, to disclose to the Contractor, in writing, whether as of the time of award of the subcontract, the subcontractor, or its principals, is or is not debarred, suspended, or proposed for debarment by any Federal department or agency. The Contractor shall make such disclosures available to the HSD when it requests subcontractor approval from the HSD. If the subcontractor, or its principals, is debarred, suspended, or proposed for debarment by any Federal, state or local department or agency, the HSD may refuse to approve the use of the subcontractor.

## ARTICLE 34 CERTIFICATION AND DISCLOSURE REGARDING PAYMENTS TO INFLUENCE CERTAIN FEDERAL TRANSACTIONS

A. The applicable definitions and exceptions to prohibited conduct and disclosures contained in 31 U.S.C. § 1352 and 45 C.F.R. Part 93, as applicable, are hereby incorporated by reference in subparagraph (B) of this certification.

B. The Contractor, by executing this PSC, certifies to the best of its knowledge and belief that:

1. No Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a

Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress on his or her behalf in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment or modification of any Federal contract, grant, loan, or cooperative agreement; and

2. If any funds other than Federal appropriated funds (including profit or fee received under a covered Federal transaction) have been paid, or will be paid, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress on his or her behalf in connection with this solicitation, the offeror shall complete and submit, with its offer, OMB standard form LLL, Disclosure of Lobbying Activities, to the Contracting Officer.

C. The Contractor shall require that the language of this certification be included in the award documents for all sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

D. This certification is a material representation of fact upon which reliance is placed when this Agreement is made and entered into. Submission of this certification is a prerequisite for making and entering into this Agreement imposed under 31 U.S.C. § 1352. It shall be a material obligation of the Contractor to keep this certification current as to any and all individuals or activities of anyone associated with the Contractor during the pendency of this Agreement. Any person who makes an expenditure prohibited under this provision or who fails to file or amend the disclosure form to be filed or amended by this provision, shall be subject to: (1) a civil penalty of not less than $10,000 and not more than $100,000 for such failure; and/or (2) at the discretion of the HSD, termination of the Agreement.

## ARTICLE 35 NON–DISCRIMINATION

A. The Contractor agrees to comply fully with Title VI of the Civil Rights Act of 1964, as amended; the Rehabilitation Act of 1973, Public Law 93-112, as amended; and the Americans With Disabilities Act of 1990, Public Law 101-336; in that there shall be no discrimination against any employee who is employed in the performance of this Agreement, or against any applicant for such employment, because of age, color, national

origin, ancestry, race, religion, creed, disability, sex, or marital status.

B.     This provision shall include, but not be limited to, the following: employment, promotion, demotion, or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training including apprenticeship.

C.     The Contractor agrees that no qualified handicapped person shall, on the basis of handicap, be excluded from participation or be denied the benefits of, or otherwise be subjected to discrimination under any program or activity of the Contractor. The Contractor further agrees to insert similar provisions in all subcontracts for services allowed under this Agreement under any program or activity.

D.     The Contractor agrees to provide meaningful access to services for individuals with Limited English Proficiency (LEP) in accordance with Executive Order 13166, "Improving Access to Services for Persons with Limited English Proficiency."

## ARTICLE 36 DRUG FREE WORKPLACE

A.     <u>Definitions</u>. As used in this paragraph—

    1.    "Controlled substance" means a controlled substance in schedules I through V of section 202 of the Controlled Substances Act, 21 U.S.C § 812, and as further defined in regulation at 21 CFR §§ 1308.11 - 1308.15.

    2.    "Conviction" means a finding of guilt (including a plea of *nolo contendere*) or imposition of sentence, or both, by any judicial body charged with the responsibility to determine violations of the Federal or State criminal drug statutes.

    3.    "Criminal drug statute" means a Federal or non-Federal criminal statute involving the manufacture, distribution, dispensing, possession, or use of any controlled substance.

    4.    "Drug-free workplace" means the site(s) for the performance of work done by the Contractor in connection with a specific contract where employees of the Contractor are prohibited from engaging in the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance.

    5.    "Employee" means an employee of a Contractor directly engaged in the performance of work under a Government contract. "Directly engaged" is defined to include all direct cost employees and any other Contractor employee who has other than a minimal impact or involvement in contract performance.

6. "Individual" means an offeror/contractor that has no more than one employee including the offeror/contractor.

B. The Contractor, if other than an individual, shall:

1. Publish a statement notifying its employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the Contractor's workplace and specifying the actions that will be taken against employees for violations of such prohibition;

2. Establish an ongoing drug-free awareness program to inform such employees about:

   a. The dangers of drug abuse in the workplace;

   b. The Contractor's policy of maintaining a drug-free workplace:

   c. Any available drug counseling, rehabilitation, and employee assistance programs; and

   d. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

3. Provide all employees engaged in performance of the contract with a copy of the statement required by subparagraph B. (1);

4. Notify such employees in writing in the statement required by subparagraph (B)(1) of this clause that, as a condition of continued employment on this Agreement, the employee will:

   a. Abide by the terms of the statement; and

   b. Notify the employer in writing of the employee's conviction under a criminal drug statute for a violation occurring in the workplace no later than 5 days after such conviction;

5. Notify HSD in writing within 10 days after receiving notice under (B) (4) (b) of this paragraph, from an employee or otherwise receiving actual notice of such conviction. The notice shall include the position title of the employee;

6. Within 30 days after receiving notice under B.(4)(b) of this paragraph of a conviction, take one of the following actions with respect to any employee who is convicted of a drug abuse violation occurring in the workplace:

   a. Taking appropriate personnel action against such employee, up to and including termination; or

   b. Require such employee to satisfactorily participate in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency; and

7. Make a good faith effort to maintain a drug-free workplace through implementation of B. (1) through B. (6) of this paragraph.

C.      The Contractor, if an individual, agrees by entering into this Agreement not to engage in the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance while performing this contract.

D.      In addition to other remedies available to the Procuring Agency, the Contractor's failure to comply with the requirements of subparagraph B or C of this paragraph will render the Contractor in default of this Agreement and subject the Contractor to suspension of payments under the Agreement and/or termination of the Agreement in accordance with paragraph 4, above.


## ARTICLE 37 FINDINGS AND SANCTIONS

A.      The Contractor agrees to be subject to the findings, sanctions and disallowances assessed or required as a result of audits pursuant to this agreement.


B.      The Contractor will make repayment of any funds expended by the HSD, subject to which an auditor acting pursuant to this Agreement finds were expended, or to which appropriate federal funding agencies take exception and request reimbursement through a disallowance or deferral based upon the acts or omissions of the Contractor that violate applicable federal statues and/or regulations.


C.      If the HSD becomes aware of circumstances that might jeopardize continued federal funding, the situation shall be reviewed and reconciled by a mutually agreed upon panel of Contractor and the HSD officials. If reconciliation is not possible, both parties shall present their view to the Director of the Administrative Services Division who shall determine whether continued payment shall be made.


## ARTICLE 38 PERFORMANCE

In performance of this Agreement, the Contractor agrees to comply with and assume responsibility for compliance by its employees, its subcontractors, and/or Business Associates (BA), as applicable, with the following requirements:

A.      All work will be performed under the supervision of the Contractor, the Contractor's employees, and the Contractor's subcontracted staff.

B.      Contractor agrees that, if Federal Tax Information (FTI) is introduced into Contractor's information systems, work documents, and/or other media by written agreement, any FTI as described in 26 U.S.C. § 6103, limited to FTI received from, or created on behalf of HSD by Contractor; Protected Health Information (PHI) as defined in 45 C.F.R. § 160.103, limited to PHI received from or created on behalf of HSD by Contractor; or Personally Identifiable Information (PII) as defined by the National Institute of Standards of Technology, limited to PII received from or created on behalf of HSD by Contractor

pursuant to the Services; all together referred to hereafter in Article 39 as Confidential Information, made available to Contractor shall be used only for the purpose of carrying out the provisions of this contract. Information contained in such material shall be treated as confidential and will not be divulged or made known in any manner to any person or entity except as may be necessary in the performance of this contract. Inspection by, or disclosure to, any person or entity other than an officer, employee, or subcontractor of the Contractor is prohibited.

C.      Contractor agrees that it will account for all Confidential Information upon receipt and store such Confidential Information in a secure manner before, during, and after processing. In addition, all related output will be given the same level of protection by the Contractor as required for the source material.

D.      The Contractor certifies that the Confidential Information processed during the performance of this Agreement will be deleted from, or otherwise wiped, removed, or rendered unreadable or incapable of reconstitution by known means on all electronic data storage components in Contractor's facilities, including paper files, recordings, video, written records, printers, copiers, scanners and all magnetic and flash memory components of all systems and portable media, and no output will be retained by the Contractor at the time the work is completed or when this Contract is terminated. If immediate purging of all electronic data storage components is not possible, the Contractor certifies that any Confidential Information remaining in any storage component will be safeguarded, using IRS Pub 1075 information storage safeguarding controls for FTI to prevent unauthorized disclosures beyond the term of this Agreement as long as Contractor is in possession of such Confidential Information.

E.      Any spoilage or any intermediate hard copy printout that may result during the processing of Confidential Information will be given to the HSD or his or her designee. When this is not possible, the Contractor will be responsible for the destruction (in a manner approved by the HSD) of the spoilage or any intermediate hard copy printouts and will provide the HSD or his or her designee with a statement containing the date of destruction, description of material destroyed, and the method used.

F.      All of Contractor's computer systems, office equipment, written records, and portable media receiving, processing, storing, or transmitting Confidential Information must meet the requirements defined in relevant federal regulations such as IRS Publication 1075, HIPAA Privacy Rule (45 CFR Part 160 and Subparts A and E of Part 164), HIPAA Security Rule (45 CFR Part 160 and Subparts A and C of Part 164), and/or any other Federal requirements that may apply to this contract. To meet functional and assurance requirements, the security features of the Contractor's environment must provide for security across relevant managerial, operational, and technical controls. All security features must be available and activated to protect against unauthorized use of and access to Confidential Information.

G.      No work involving Confidential Information furnished under this Agreement will be subcontracted without prior written approval of the HSD.

H.      The Contractor will maintain a list of its personnel, subcontractors, and/or business related entities with authorized access (electronic or physical) to HSD Confidential

Information. Such list will be provided to the HSD and, upon request, to the federal agencies as required.

I.    The Contractor will provide copies of signed acknowledgments for its staff and its subcontractors and/or Business Associates, to provide certification that relevant information security awareness and training was completed. These certifications will be provided to the HSD upon contract start and, at a minimum, annually thereafter during the term of this Agreement.

J.    Upon request, the Contractor will provide the HSD copies of current policies and/or summaries of its current plans that document Contractor's privacy and security controls as they relate to HSD Confidential Information. This includes, at a minimum, any System Security Plans which describe the administrative, physical, technical, and system controls to be implemented for the security of the Department's Confidential Information. The plan shall include the requirement for a Contractor notification to the Department Security Officer or Privacy Officer of breaches or potential breaches of information within 24 hours of their discovery.

K.    All incidents affecting the compliance, operation, or security of the HSD's Confidential Information must be reported to the HSD. The Contractor shall notify the HSD of any instances of security or privacy breach issues or non-compliance promptly upon their discovery, but no later than a period of 24 hours (as stated above). Notification shall include a description of the privacy and security non-compliance issue and corrective action planned and/or taken.

L.    The Contractor must provide the HSD with a summary of a corrective action plan (if any) to provide any necessary safeguards to protect PII from security breaches or non-compliance discoveries. The corrective action plan must contain a long term solution to possible future privacy and security threats to PII. In addition to the corrective action, the Contractor must provide daily updates as to the progress of all corrective measures taken until the issue is resolved. The Contractor shall be responsible for all costs of implementing the corrective action plan.

M.    All client files and patient records created or used to provide services under this Agreement, as between the parties, are at all times property of HSD. Upon HSD's request, all such client files and patient records shall be returned to HSD upon HSD's request or no later than the final agreed upon termination date of this contract.

## ARTICLE 39 CRIMINAL/CIVIL SANCTIONS

A.    Each officer, employee, and/or subcontractor of the Contractor to whom tax returns or tax return information is or may be disclosed shall be notified in writing by the Contractor that returns or return information disclosed to such officer or employee can be used only for a purpose and to the extent authorized herein, and that further disclosure of any such returns or return information for a purpose or to an extent unauthorized herein constitutes a felony punishable upon conviction by a fine of as much as $5,000 or imprisonment for as long as five years, or both, together with the costs of prosecution. Contractor shall also notify each such officer and employee that any such unauthorized future disclosure of returns or return information may also result in an award of civil damages against the

officer or employee in an amount not less than $1,000 with respect to each instance of unauthorized disclosure. These penalties are prescribed by Internal Revenue Code (IRC) Sections 7213 and 7431 and set forth at 26 CFR 301.6103(n)-1.

B.  Each officer, employee, and/or subcontractor to whom tax returns or tax return information is or may be disclosed shall be notified in writing by Contractor that any return or return information made available in any format shall be used only for the purpose of carrying out the provisions of this contract. Information contained in such material shall be treated as confidential and shall not be divulged or made known in any manner to any person except as may be necessary in the performance of this contract. Inspection by or disclosure to anyone without an official need to know may constitute a criminal misdemeanor punishable upon conviction by a fine of as much as $1,000.00 or imprisonment for as long as 1 year, or both, together with the costs of prosecution. Contractor shall also notify each such officer and employee that any such unauthorized inspection or disclosure of returns or return information may also result in an award of civil damages against the officer or employee in an amount equal to the sum of the greater of $1,000.00 for each act of unauthorized inspection or disclosure with respect to which such defendant is found liable or the sum of the actual damages sustained by the plaintiff as a result of such unauthorized inspection or disclosure plus in the case of a willful inspection or disclosure which is the result of gross negligence, punitive damages, plus the costs of the action. The penalties are prescribed by IRC Sections 7213A and 7431.

C.  Additionally, it is incumbent upon Contractor to inform its officers and employees of the penalties for improper disclosure imposed by the Privacy Act of 1974, 5 U.S.C.552a. Specifically, 5 U.S.C. 552a(i)(1), which is made applicable to contractors by 5 U.S.C. 552a(m)(1), provides that any officer or employee of a contractor, who by virtue of his/her employment or official position, has possession of or access to HSD records which contain individually identifiable information, the disclosure of which is prohibited by the Privacy Act or regulations established thereunder, and who knowing that disclosure of the specific material is so prohibited, willfully discloses the material in any manner to any person not entitled to receive it, shall be guilty of a misdemeanor and fined not more than $5,000. Furthermore, the Contractor will inform its officers and employees of the penalties imposed by the HIPAA Privacy Rule (45 CFR Part 160 and Subparts A and E of Part 164), and HIPAA Security Rule (45 CFR Part 160 and Subparts A and C of Part 164), which provide that any officer or employee of a contractor, who willfully discloses Protected Health Information in any manner to any person not entitled to receive it, may be subject to civil and criminal penalties of up to $50,000 and up to one year imprisonment.

D.  Contractor agrees that granting access to Confidential Information to any individual must be preceded by certifying that each individual understands the HSD's applicable security policy and procedures for safeguarding the Confidential Information. Contractors must maintain authorizations issued to such individuals to access Confidential Information

through annual recertification. The initial certification and recertification must be documented and placed in a file for the HSD's review. As part of the certification and at least annually afterwards, Contractor will be advised of the provisions of IRC Sections 7431, 7213, and 7213A (see Exhibit 6, IRC Sec. 7431 Civil Damages for Unauthorized Disclosure of Returns and Return Information and Exhibit 5, IRC Sec. 7213 Unauthorized Disclosure of Information). The training provided before the initial certification and annually thereafter must also cover the incident response policy and procedure for reporting unauthorized disclosures and data breaches per Section 10 of IRS Publication 1075.)

## ARTICLE 40 INSPECTION

The HSD and/or its regulating federal partners (such as IRS, CMS, FNS, etc.) shall have the right to send its officers and/or employees into the offices and plants of the Contractor for inspection of the facilities and operations provided for the performance of any work related to Confidential Information under this contract. On the basis of such inspection, the HSD and/or regulating federal partners may communicate specific measures to be performed or met by the Contractor as may be required in cases where the Contractor is found to be noncompliant with contract safeguard.

## ARTICLE 41 CONTRACTOR'S RESPONSIBILITY FOR COMPLIANCE WITH LAWS AND REGULATIONS

A.      The Contractor is responsible for compliance with applicable laws, regulations, and administrative rules that govern the Contractor's performance of the Scope of Work of this Agreement and Exhibit A, including but not limited to, applicable State and Federal tax laws, State and Federal employment laws, State and Federal regulatory requirements and licensing provisions.

B.      The Contractor is responsible for causing each of its employees, agents or subcontractors who provide services under this Agreement to be properly licensed, certified, and/or have proper permits to perform any activity related to the Scope of Work of this Agreement and Exhibit A.

C.      **[OPTIONAL:** If the Contractor's performance of its obligations under the terms of this agreement qualifies it as a Business Associate of the HSD as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and regulations promulgated thereunder, the Contractor agrees to execute the HSD Business Associate Agreement (BAA), attached hereto as Exhibit **(list exhibit number)**, and incorporated herein by this reference.]

## ARTICLE 42 CONTRACTOR'S RESPONSIBILITY FOR COMPLIANCE WITH

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**LAWS AND REGULATIONS RELATING TO INFORMATION SECURITY**

A.      The Contractor agrees to monitor and control all its employees, subcontractors, consultants, or agents performing the Services under this PSC in order to assure compliance with the following regulations and standards insofar as they apply to Contractor's processing or storage of HSD's Confidential Information or other data:

1.      The Federal Information Security Management Act of 2002 (FISMA);
2.      The Health Insurance Portability and Accountability Act of 1996 (HIPAA);
3.      The Health Information Technology for Technology for Economic and Clinical Health Act (HITECH Act);
4.      IRS Publication 1075 – Tax Information Security Guidelines for Federal, State and Local Agencies to include any Service Level Agreement requirements;
5.      Electronic Information Exchange Security Requirements, Guidelines, And Procedures For State and Local Agencies Exchanging Electronic Information With The Social Security Administration; and
6.      NMAC 1.12.20, *et seq.* "INFORMATION SECURITY OPERATION MANAGEMENT".

## ARTICLE 43 ENFORCEMENT

A party's failure to require strict performance of any provision of this Agreement shall not waive or diminish that party's right thereafter to demand strict compliance with that or any other provision. No waiver by a party of any of its rights under this Agreement shall be effective unless express and in writing, and no effective waiver by a party of any of its rights shall be effective to waive any other rights.

## ARTICLE 44 AUTHORITY

If Contractor is other than a natural person, the individual(s) signing this Agreement on behalf of Contractor represents and warrants that he or she has the power and authority to bind Contractor, and that no further action, resolution, or approval from Contractor is necessary to enter into a binding contract.

## ARTICLE 45 MEDIA

Contractor shall not release or distribute, via news media, social media, or any other consumable media source, any Agreement-related information, including but not limited to, information regarding Contractor's work under the terms of the Agreement, or the status of the work under the Agreement, without the prior express consent of HSD. The Contractor's request to release any Agreement information shall contain a copy of the specific information the Contractor is

seeking approval to release and a description of the intended form of release. This provision shall survive the term of this Agreement.

<mark>[*IF APPLICABLE, ADD ANY HSD SPECIFIC, GRANT SPECIFIC, OR CONTRACT SPECIFIC ARTICLES STARTING AT THIS POINT.*</mark>]

**The remainder of this page intentionally left blank.**

IN WITNESS WHEREOF, the Parties have executed this Agreement as of the date of signature by the DFA below:

By:     _____       Date:   _____
       HSD Cabinet Secretary

By:     _____       Date:   _____
       HSD Chief Financial Officer


Approved for legal sufficiency:

By:     _____       Date:   _____
       HSD General Counsel

By:     _____       Date:   _____
       Contractor


The records of the Taxation and Revenue Department reflect that the Contractor is registered with the NM Taxation and Revenue Department to pay gross receipts and compensating taxes:


CRS ID Number: _____


By: _____       Date: _____
      Tax and Revenue Department Representative


By: _____       Date: _____

      Department of Information Technology Cabinet Secretary


This Agreement has been approved by the DFA Contracts Review Bureau:


By:     _____       Date: _____

# EXHIBIT A - STATEMENT OF WORK (SOW)

## Exhibit B

### HIPAA Business Associate Agreement

This Business Associate Agreement ("BAA") is entered into between the New Mexico Human Services Department ("Department") and_____, hereinafter referred to as "Business Associate" , in order to comply with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as amended by Health Information Technology for Economic and Clinical Health Act of 2009 (the "HITECH Act"), including the Standards of the Privacy of Individually Identifiable Health Information and the Security Standards at 45 CFR Parts 160 and 164.

**BUSINESS ASSOCIATE**, by this PSC \_\_\_ has agreed to provide services to, or on behalf of the HSD which may involve the disclosure by the Department to the Business Associate (referred to in PSC \_\_\_\_ as "Contractor") of Protected Health Information. This Business Associate PSC is intended to supplement the obligations of the Department and the Contractor as set forth in PSC \_\_\_\_ and is hereby incorporated therein.

**THE PARTIES** acknowledge HIPAA, as amended by the HITECH Act, requires that Department and Business Associate enter into a written agreement that provides for the safeguarding and protection of all Protected Health Information which Department may disclose to the Business Associate, or which may be created or received by the Business Associate on behalf of the Department.

1. **Definition of Terms**
   a. Breach. "Breach" has the meaning assigned to the term breach under 42 U.S.C. § 17921(1) [HITECH Act § 13400 (1)] and 45 CFR § 164.402.
   b. Business Associate. "Business Associate", herein being the same entity as the Contractor in the same or Related Agreement, shall have the same meaning as defined under the HIPAA standards as defined below, including without limitation Contractor acting in the capacity of a Business Associate as defined in 45 CFR § 160.103.
   c. Department. "Department" shall mean in this agreement the State of New Mexico Human Services Department.
   d. Individual. "Individual" shall have the same meaning as in 45 CFR §160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR §164.502 (g).
   e. HIPAA Standards. "HIPAA Standards" shall mean the legal requirements as set forth in the Health Insurance Portability and Accountability Act of 1996, the Health Information Technology for Economic and Clinical Health Act of 2009, and the regulations and policy guidance, as each may be amended over time, including without limitation:
      1) Privacy Rule. "Privacy Rule" shall mean the Standards for Privacy

of Individually Identifiable Health Information in 45 CFR Part 160 and Part 164, Subparts A and E.

2) Breach Notification Rule. "Breach Notification" shall mean the Notification in the case of Breach of Unsecured Protected Health Information, 45 CFR Part 164, Subparts A and D

3) Security Rule. "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 CFR Parts 160 and 164, Subparts A and C, including the following:

   i. Security Standards. "Security Standards" hereinafter shall mean the Standards for the Protection of Electronic Protected Health Information at 45 CFR §164.306.

   ii. Administrative Safeguards. "Administrative Safeguards" shall mean the Standards for the Protection of Electronic Protected Health Information at 45 CFR §164.308.

   iii. Physical Safeguards. "Physical Safeguards" shall mean the Standards for the Protection of Electronic Protected Health Information at 45 CFR §164.310.

   iv. Technical Safeguards. "Technical Safeguards" shall mean the Standards for the Protection of Electronic Protected Health Information at 45 CFR §164.312.

   v. Policies and Procedures and Documentation Requirements. "Policies and Procedures and Documentation Requirements" shall mean the Standards for the Protection of Electronic Protected Health Information at 45 CFR §164.316.

f. Protected Health Information. "Protected Health Information" or "PHI" shall have the same meaning as in 45 CFR §160.103, limited to the information created, maintained, transmitted or received by Business Associate, its agents or subcontractors from or on behalf of Department.

g. Required By Law. "Required By Law" shall have the same meaning as in 45 CFR §164.103.

h. Secretary. "Secretary" shall mean the Secretary of the U. S. Department of Health and Human Services, or his or her designee.

i. Covered Entity. "Covered Entity" shall have the meaning as the term "covered entity" defined at 45 CFR §160.103, and in reference to the party to this BAA, shall mean the State of New Mexico Human Services Department.

Terms used, but not otherwise defined, in this BAA shall have the same meaning as those terms in the HIPAA Standards. All terms used and all statutory and regulatory references shall be as currently in effect or as subsequently amended.

2. Obligations and Activities of Business Associate
   a. <u>General Rule of PHI Use and Disclosure</u>. The Business Associate may use or disclose PHI it creates for, receives from or on behalf of, the Department to perform functions, activities or services for, or on behalf of, the Department in accordance with the specifications set forth in this BAA and in this PSC ____; provided that such use or disclosure would not violate the HIPAA Standards if done by the Department; or as Required By Law.
      i. Any disclosures made by the Business Associate of PHI must be made in accordance with HIPAA Standards and other applicable laws.
      ii. ii.    Notwithstanding any other provision herein to the contrary, the Business Associate shall limit uses and disclosures of PHI to the "minimum necessary," as set forth in the HIPAA Standards.
      iii. The Business Associate agrees to use or disclose only a "limited data set" of PHI as defined in the HIPAA Standards while conducting the authorized activities herein and as delineated in PSC ____, except where a "limited data set" is not practicable in order to accomplish those activities.
      iv. Except as otherwise limited by this BAA or PSC ____, Business Associate may use PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.
      v. Except as otherwise limited by this BAA or PSC ____, Business Associate may disclose PHI for the proper management and administration of the Business Associate provided that the disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.
      vi. Business Associate may use PHI to report violations of law to appropriate federal and state authorities, consistent with 45 CFR § 164.502(j).
      vii. Business Associate may use PHI to provide Data Aggregation services to the Department as permitted by the HIPAA Standards.
   b. <u>Safeguards</u>. The Business Associate agrees to implement and use appropriate Security, Administrative, Physical and Technical Safeguards, and comply where applicable with subpart C of 45 C.F.R. Part 164, to prevent use or disclosure of PHI

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other than as required by law or as provided for by this BAA or PSC ____. Business Associate shall identify in writing upon request from the Department all of those Safeguards that it uses to prevent impermissible uses or disclosures of PHI.

c. Restricted Uses and Disclosures. The Business Associate shall not use or further disclose PHI other than as permitted or required by this BAA or PSC ____, the HIPAA Standards, or otherwise as permitted or required by law. The Business Associate shall not disclose PHI in a manner that would violate any restriction which has been communicated to the Business Associate.

    i)       The Business Associate shall not directly or indirectly receive remuneration in exchange for any of the PHI unless a valid authorization has been provided to the Business Associate that includes a specification of whether the PHI can be further exchanged for remuneration by the entity receiving the PHI of that individual, except as provided for under the exceptions listed in 45 C.F.R. §164.502 (a)(5)(ii)(B)(2).

    ii)     Unless approved by the Department, Business Associate shall not directly or indirectly perform marketing to individuals using PHI.

d. Agents. The Business Associate shall ensure that any agents that create, receive, maintain or transmit PHI on behalf of Business Associate, agree in writing to the same restrictions and conditions that apply to the Business Associate with respect to PHI, in accordance with 45 C.F.R. § 164.502(e)(1)(ii), and shall make that agreement available to the Department upon request. Upon the Business Associate's contracting with an agent for the sharing of PHI, the Business Associate shall provide the Department written notice of any such executed agreement.

e. Availability of Information to Individuals and the Department. Business Associate shall provide, at the Department's request, and in a reasonable time and manner, access to PHI in a Designated Record Set (including an electronic version if required) to the Department or, as directed by the Department, to an Individual in order to meet the requirements under 45 CFR § 164.524. Within three (3) business days, Business Associate shall forward to the Department for handling any request for access to PHI that Business Associate receives directly from an Individual. If requested by the Department, the Business Associate shall make such information available in electronic format as required by the HIPAA Standards to a requestor of such information and shall confirm to the Department in writing that the request has been fulfilled.

f. Amendment of PHI. In accordance with 45 CFR § 164.526, Business Associate agrees to make any amendment(s) to PHI in a Designated Record Set that the Department directs or agrees to, at the request of the Department or an Individual, to fulfill the Department's obligations to amend PHI pursuant to the HIPAA Standards.

Within three (3) business days, Business Associate shall forward to the Department for handling any request for amendment to PHI that Business Associate receives directly from an Individual.

g. <u>Internal Practices</u>. Business Associate agrees to make internal practices, books and records, including policies, procedures and PHI, relating to the use and disclosure of PHI, available to the Department or to the Secretary within seven (7) days of receiving a request from the Department or receiving notice of a request from the Secretary, for purposes of the Secretary's determining the Department's compliance with the Privacy Rule.

h. <u>PHI Disclosures Recordkeeping</u>. Business Associate agrees to document such disclosures of PHI and information related to such disclosures as would be required for the Department to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with the HIPAA Standards and 45 CFR § 164.528. Business Associate shall provide such information to the Department or as directed by the Department to an Individual, to permit the Department to respond to an accounting request. Business Associate shall provide such information in the time and manner reasonably designated by the Department. Within three (3) business days, Business Associate shall forward to the Department for handling any accounting request that Business Associate directly receives from an individual.

i. <u>PHI Disclosures Accounting</u>. Business Associate agrees to provide to the Department or an Individual, within seven (7) days of receipt of a request, information collected in accordance with Section 2 (h) of this Agreement, to permit the Department to respond to a request for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528.

j. <u>Security Rule Provisions</u>. As required by 42 U.S.C. § 17931 (a) [HITECH Act Section 13401(a)] , the following sections as they are made applicable to business associates under the HIPAA Standards, shall also apply to the Business Associate: 1) Administrative Safeguards; 2) Physical Safeguards; 3) Technical Safeguards; 4) Policies and Procedures and Documentation Requirements; and 5) Security Standards. Additionally, the Business Associate shall either implement or properly document the reasons for non-implementation of all safeguards in the above cited sections that are designated as "addressable" as such are made applicable to Business Associates pursuant to the HIPAA Standards.

k. <u>Civil and Criminal Penalties</u>. Business Associate agrees that it will comply with the HIPAA Standards as applicable to Business Associates and acknowledges that it may be subject to civil and criminal penalties for its failure to do so.

l. <u>Performance of Covered Entity's Obligations</u>. To the extent the Business Associate is to carry out the Department's obligations under the HIPAA Standards, Business Associate shall comply with the requirements of the HIPAA Standards that apply to the Department in the performance of such obligations.

m.  Subcontractors. The Business Associate shall ensure that any subcontractors that create, receive, maintain or transmit PHI on behalf of Business Associate, agree in writing to the same restrictions and conditions that apply to the Business Associate with respect to PHI, with 45 C.F.R. § 164.502(e)(1)(ii), and shall make such information available to the Department upon request. Upon the Business Associate's contracting with an agent for the sharing of PHI, the Business Associate shall provide the Department written notice of any such executed agreement. Upon the Business Associate's contracting with a subcontractor for the sharing of PHI, the Business Associate shall provide the Department written notice of any such executed agreement.

3.  **Business Associate Obligations for Notification, Risk Assessment, and Mitigation**

During the term of this BAA or PSC ____, the Business Associate shall be required to perform the following pursuant to the Breach Notification Rule regarding Breach Notification, Risk Assessment and Mitigation:

Notification

a.  Business Associate agrees to report to the Department Contract Manager or HIPAA Privacy and Security Officer any use or disclosure of PHI not provided for by this BAA or PSC ____, and HIPAA Standards, including breaches of unsecured PHI as required by 45 C.F.R. § 164.410, as soon as it (or any employee or agent) becomes aware of the Breach, and in no case later than three (3) business days after it (or any employee or agent) becomes aware of the Breach, except when a government official determines that a notification would impede a criminal investigation or cause damage to national security.

b.  Business Associate shall provide the Department with the names of the individuals whose unsecured PHI has been, or is reasonably believed to have been, the subject of the Breach and any other available information that is required to be given to the affected individuals, as set forth in 45 CFR §164.404(c), and, if requested by the Department, provide information necessary for the Department to investigate promptly the impermissible use or disclosure. Business Associate shall continue to provide to the Department information concerning the Breach as it becomes available to it and shall also provide such assistance and further information as is reasonably requested by the Department.

Risk Assessment

c.  When Business Associate determines whether an impermissible acquisition, use or disclosure of PHI by an employee or agent poses a low probability of the PHI being compromised, it shall document its assessment of risk in accordance with

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45 C.F.R. § 164.402 (in definition of "Breach", ¶ 2) based on at least the following factors: (i) the nature and extent of the protected health information involved, including the types of identifiers and the likelihood of re-identification; (ii) the unauthorized person who used the protected health information or to whom the disclosure was made; (iii) whether the protected health information was actually acquired or viewed; and (iv) the extent to which the risk to the protected health information has been mitigated. . Such assessment shall include: 1) the name of the person(s) making the assessment, 2) a brief summary of the facts, and 3) a brief statement of the reasons documenting the determination of risk of the PHI being compromised. When requested by the Department, Business Associate shall make its risk assessments available to the Department.

d. If the Department determines that an impermissible acquisition, access, use or disclosure of PHI, for which one of Business Associate's employees or agents was responsible, constitutes a Breach, and if requested by the Department, Business Associate shall provide notice to the individuals whose PHI was the subject of the Breach. When requested to provide notice, Business Associate shall consult with the Department about the timeliness, content and method of notice, and shall receive the Department's approval concerning these elements. The cost of notice and related remedies shall be borne by Business Associate. The notice to affected individuals shall be provided as soon as reasonably possible and in no case later than 60 calendar days after Business Associate reported the Breach to the Department.

## Mitigation

e. In addition to the above duties in this section, Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI, by Business Associate in violation of the requirements of this Agreement, the Related Agreement or the HIPAA Standards. Business Associate shall draft and carry out a plan of corrective action to address any incident of impermissible use or disclosure of PHI. If requested by the Department, Business Associate shall make its mitigation and corrective action plans available to the Department.

f. The notice to affected individuals shall be written in plain language and shall include, to the extent possible, 1) a brief description of the Breach, 2) a description of the types of Unsecured PHI that were involved in the Breach, 3) any steps individuals can take to protect themselves from potential harm resulting from the Breach, 4) a brief description of what the Business Associate and the Department are doing to investigate the Breach, to mitigate harm to individuals and to protect against further Breaches, and 5) contact procedures for individuals to ask questions or obtain additional information, as set forth in 45 CFR

§164.404(c).

<u>Notification to Clients</u>

g.  Business Associates shall notify individuals of Breaches as specified in 45 CFR §164.404(d) (methods of individual notice). In addition, when a Breach involves more than 500 residents of a State or jurisdiction, Business Associate shall, if requested by the Department, notify prominent media outlets serving such location(s), following the requirements set forth in 45 CFR §164.406.

**4. Obligations of the Department to Inform Business Associate of Privacy Practices and Restrictions**

a.  The Department shall notify Business Associate of any limitation(s) in the Department's Notice of Privacy Practices, implemented in accordance with 45 CFR § 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of PHI.

b.  The Department shall notify Business Associate of any changes in, or revocation of, permission by an Individual to use or disclose PHI, to the extent that such changes may affect Business Associate's use or disclosure of PHI.

c.  The Department shall notify Business Associate of any restriction in the use or disclosure of PHI that the Department has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

d.  The Department shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by the Department.

**5. Term and Termination**

a.  <u>Term.</u> This BAA terminates concurrently with PSC ____, except that obligations of Business Associate under this BAA related to final disposition of PHI in this Section 5 shall survive until resolved as set forth immediately below.

b.  <u>Disposition of PHI upon Termination.</u> Upon termination of this PSC ____ and BAA for any reason, Business Associate shall return or destroy all PHI in its possession and shall retain no copies of the PHI. In the event that Business Associate determines that returning or destroying the PHI is not feasible, Business Associate shall provide to the Department notification of the conditions that make return or destruction of PHI not feasible. Upon mutual agreement of the Parties that return, or destruction of the PHI is infeasible, Business Associate shall agree, and require that its agents, affiliates, subsidiaries and subcontractors agree, to the extension of all protections, limitations and restrictions required of Business Associate hereunder, for so long as the Business Associate maintains the PHI.

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c. If Business Associate breaches any material term of this BAA, the Department may either:

i. provide an opportunity for Business Associate to cure the Breach and the Department may terminate this PSC ____ and BAA without liability or penalty in accordance with Article 6, Termination, of PSC ____, if Business Associate does not cure the breach within the time specified by the Department; or,

ii. immediately terminate this PSC ____ without liability or penalty if the Department determines that cure is not reasonably possible; or,

iii. if neither termination nor cure are feasible, the Department shall report the breach to the Secretary.

The Department has the right to seek to cure any breach by Business Associate and this right, regardless of whether the Department cures such breach, does not lessen any right or remedy available to the Department at law, in equity, or under this BAA or PSC ____, nor does it lessen Business Associate's responsibility for such breach or its duty to cure such breach.

## 6. Penalties and Training

Business Associate understands and acknowledges that violations of this BAA or PSC ____ may result in notification by the Department to law enforcement officials and regulatory, accreditation, and licensure organizations. If requested by the Department, Business Associate shall participate in training regarding use, confidentiality, and security of PHI.

## 7. Miscellaneous
   a. <u>Interpretation</u>. Any ambiguity in this BAA, or any inconsistency between the provisions of this BAA or PSC ____, shall be resolved to permit the Department to comply with the HIPAA Standards.
   b. <u>Business Associate's Compliance with HIPAA</u>. The Department makes no warranty or representation that compliance by Business Associate with this BAA or the HIPAA Standards will be adequate or satisfactory for Business Associate's own purposes or that any information in Business Associate's possession or control, or transmitted or received by Business Associate, is or will be secure from unauthorized use or disclosure. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI.

   c. <u>Change in Law</u>. In the event there are subsequent changes or clarifications of statutes, regulations or rules relating to this BAA or PSC ____, the Department shall notify Business Associate of any actions it reasonably deems necessary to comply with such changes, and Business Associate shall promptly take such actions. In the event there is a

change in federal or state laws, rules or regulations, or in the interpretation of any such laws, rules, regulations or general instructions, which may render any of the material terms of this BAA unlawful or unenforceable, or which materially affects any financial arrangement contained in this BAA, the parties shall attempt amendment of this BAA to accommodate such changes or interpretations. If the parties are unable to agree, or if amendment is not possible, the parties may terminate the BAA and PSC ____ pursuant to its termination provisions.

d. <u>No Third Party Beneficiaries</u>. Nothing express or implied in this BAA is intended to confer, nor shall anything herein confer, upon any person other than the Department, Business Associate and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

e. <u>Assistance in Litigation or Administrative Proceedings</u>. Business Associate shall make itself and any agents, affiliates, subsidiaries, subcontractors or workforce members assisting Business Associate in the fulfillment of its obligations under this BAA and PSC ____ available to the Department, at no cost to the Department, to testify as witnesses or otherwise in the event that litigation or an administrative proceeding is commenced against the Department or its employees based upon claimed violation of the HIPAA standards  or other laws relating to security and privacy, where such claimed violation is alleged to arise from Business Associate's performance under this BAA or PSC ____, except where Business Associate or its agents, affiliates, subsidiaries, subcontractors or employees are named adverse parties.

f. <u>Additional Obligations</u>. Department and Business Associate agree that to the extent not incorporated or referenced in any Business Associate PSC between them, other requirements applicable to either or both that are required by the HIPAA Standards, those requirements are incorporated herein by reference.

**APPENDIX J - Crosswalk FS RFP to CMS Draft RFP Template**

CMS has provided guidance on the Medicaid Enterprise Certification Toolkit (MECT) including "CMS Uniform RFP Guide, Version 4.2" and has allowed for variation in RFP creation. As NM State Procurements were in process at the time the guidance was provided this RFP is a variation and does not follow the Uniform RFP. This RFP combined with the Addendums, found in the Procurement Library, includes all of the sections of the MMIS Uniform RFP Guide. The table below reflects each section of the Uniform RFP Guide and where the section is addressed in this FS RFP or Addendum. It is expected each Contractor will review the Uniform RFP Guide in addition to reviewing this mapping.

*Table 11 Crosswalk FS RFP to CMS Draft RFP Template*

| # | Uniform RFP Guide | IP RFP Section # and Section Title |
|---|---|---|
| 1 | State Procurement Objectives | INTRODUCTION<br>PURPOSE OF THIS REQUEST FOR PROPOSALS<br><br>Addendum 20- HHS 2020 Vision and Architecture, HHS MMISR PROJECT VISION<br><br>Addendum 2 – HHS 2020 Background Information NM HHS and Medicaid, BACKGROUND INFORMATION – Business Objectives<br><br>APPENDIX G - DETAILED STATEMENT OF WORK |
| a | State Vision | II. MMISR APPROACH<br><br>Addendum 20- HHS 2020 Vision and Architecture, HUMAN SERVICES DEPARTMENT VISION<br><br>Addendum 2 – HHS 2020 Background Information NM HSD and Medicaid, HHS MMISR PROJECT VISION<br><br>APPENDIX G - DETAILED STATEMENT OF WORK |
| b | Business Objectives | Addendum 2 – HHS 2020 Background Information NM HHS and Medicaid, BACKGROUND INFORMATION – Business Objectives |

| # | Uniform RFP Guide | IP RFP Section # and Section Title |
|---|---|---|
| | | APPENDIX H - OFFEROR AND CONTRACTOR REQUIREMENTS |
| 2 | Technology Standards | II. MMISR APPROACH<br><br>Addendum 20- HHS 2020 Vision and Architecture, HHS 2020 Enterprise Architecture<br><br>APPENDIX H - OFFEROR AND CONTRACTOR REQUIREMENTS |
| a | CMS Requirements [Align with Seven Conditions and Standards] | Addendum 10 - CMS Seven Conditions and Standards<br><br>Addendum 20- HHS Vision and Architecture, HHS MMISR PROJECT VISION<br><br>APPENDIX G - DETAILED STATEMENT OF WORK |
| | 1) Modularity Standard | Addendum 10 - CMS Seven Conditions and Standards<br><br>Addendum 20- HHS Vision and Architecture, HHS MMISR PROJECT VISION<br><br>Addendum 20- HHS Vision and Architecture, HUMAN SERVICES DEPARTMENT VISION<br><br>II. MMISR APPROACH |
| | 2) MITA Condition | Addendum 10 - CMS Seven Conditions and Standards |

| # | Uniform RFP Guide | IP RFP Section # and Section Title |
|---|---|---|
| | | APPENDIX G – DETAILED STATEMENT OF WORK<br><br>APPENDIX H - OFFEROR AND CONTRACTOR REQUIREMENTS |
| | 3) Industry Standards Condition | II. MMISR APPROACH<br><br>Addendum 20- HHS Vision and Architecture, HHS 2020 Enterprise Architecture<br><br>Addendum 20- HHS Vision and Architecture, HUMAN SERVICES DEPARTMENT VISION<br><br>APPENDIX G - DETAILED STATEMENT OF WORK |
| | 4) Leverage Condition | Addendum 10 - CMS Seven Conditions and Standards<br><br>II. MMIS APPROACH, A. The MMISR Modules and Services Procurements<br><br>APPENDIX H - OFFEROR AND CONTRACTOR REQUIREMENTS |
| | 5) Business Rules Condition | Addendum 10 - CMS Seven Conditions and Standards<br><br>Addendum 20- HHS Vision and Architecture, HUMAN SERVICES DEPARTMENT VISION<br><br>II. MMIS APPROACH, A. The MMISR Modules and Services Procurements |

| # | Uniform RFP Guide | IP RFP Section # and Section Title |
|---|---|---|
| | | APPENDIX H - OFFEROR AND CONTRACTOR REQUIREMENTS |
| | 6) Reporting Condition | Addendum 10 - CMS Seven Conditions and Standards |
| | | APPENDIX G - DETAILED STATEMENT OF WORK |
| | | APPENDIX H OFFEROR AND CONTRACTOR REQUIREMENTS |
| | 7) Interoperability Condition | Addendum 10 - CMS Seven Conditions and Standards |
| | | Addendum 20- HHS Vision and Architecture, HHS MMISR PROJECT VISION |
| | | APPENDIX G - DETAILED STATEMENT OF WORK |
| b | State Technology Requirements [Optional] | APPENDIX G - DETAILED STATEMENT OF WORK 4. Data Governance |
| 3 | Scope of Work | III. CONTRACTOR ROLE |
| | | APPENDIX G - DETAILED STATEMENT OF WORK |
| | | APPENDIX H - OFFEROR AND CONTRACTOR REQUIREMENTS |
| | System Integrator Considerations | n/a for FS, addressed in SI RFP |
| 4 | Cost Module and | VII. RESPONSE SPECIFICATIONS A. COST - Offerors must complete the Cost Response as noted in APPENDIX |

| # | Uniform RFP Guide | IP RFP Section # and Section Title |
|---|---|---|
| | Budgeting Specifications | B.<br><br>APPENDIX B – COST RESPONSE FORM |
| | System Integrator Considerations | n/a for FS, addressed in SI RFP |
| 5 | Project Management and Governance | Addendum 20- HHS Vision and Architecture, HUMAN SERVICES DEPARTMENT VISION<br><br>Addendum 19 – HHS 2020 Organizational Chart, HHS 2020 STATE PROJECT MANAGEMENT OFFICE (PMO)<br><br>APPENDIX H - OFFEROR AND CONTRACTOR REQUIREMENTS |
| | System Integrator Considerations | n/a for FS, addressed in SI RFP |
| a | State Project Governance | APPENDIX H - OFFEROR AND CONTRACTOR REQUIREMENTS |
| b | Vendor Project Management | n/a for a BPO |
| 6 | Key Personnel | APPENDIX G - DETAILED STATEMENT OF WORK<br><br>APPENDIX H - OFFEROR AND CONTRACTOR REQUIREMENTS |
| | System Integrator Considerations | n/a for FS, addressed in SI RFP |
| 7 | Project Performance Standards | APPENDIX G - DETAILED STATEMENT OF WORK |

| # | Uniform RFP Guide | IP RFP Section # and Section Title |
|---|---|---|
| | | APPENDIX H - OFFEROR AND CONTRACTOR REQUIREMENTS<br><br>Appendix K - HHS 2020 FS Performance Measures |
| | System Integrator Considerations | n/a for FS, addressed in SI RFP |
| 8 | Contract Standards | APPENDIX I - SAMPLE CONTRACT |
| | ☐ Statement of contract termination procedures; | APPENDIX I - SAMPLE CONTRACT |
| | ☐ Statement that the prime contractor is responsible for contract performance, whether subcontractors are used; | VI. CONDITIONS GOVERNING THE PROCUREMENT,<br><br>C. GENERAL REQUIREMENTS<br><br>4. Subcontractors/Consent |
| | ☐ Requirement for a statement of corporate financial stability and/or for a performance bond; and | VII. RESPONSE SPECIFICATIONS, B. OTHER REQUIREMENTS<br><br>3. Financial Stability Documents<br>4. Performance Bond Capacity Statement |
| | Statement that the proposed contract will include provisions for retention of all ownership rights to the software by the State, if designed, developed, installed, or enhanced with FFP. (See 42 CFR 433.112 (b)(5) and (6), and 45 CFR 95.617(a)). | APPENDIX H - OFFEROR AND CONTRACTOR REQUIREMENTS |
| 9 | State Procurement | B. MMISR PROCUREMENT LIBRARY |

| # | Uniform RFP Guide | IP RFP Section # and Section Title |
|---|---|---|
| | Process | VI. CONDITIONS GOVERNING THE PROCUREMENT<br><br>VI B 7. Proposal Evaluation |
| a | CMS Language | V. MMISR PROCUREMENT LIBRARY<br><br>VI. CONDITIONS GOVERNING THE PROCUREMENT<br><br>VI B 7. Proposal Evaluation |
| | As outlined in Section 2, Chapter 11 of the State Medicaid Manual includes the following items:<br>− Listing and description of the reference material available to the contractor for use in preparation of proposals and/or in performance of the contract; | V. MMISR PROCUREMENT LIBRARY |
| | − Standard format and organization for the proposals including both work to be performed and cost statements; and | VI. CONDITIONS GOVERNING THE PROCUREMENT |
| | − Explanation of the proposal evaluation criteria and the relative importance of cost or price, technical, and other factors for purposes of proposal evaluation and | VI B 7. Proposal Evaluation |

| # | Uniform RFP Guide | IP RFP Section # and Section Title |
|---|---|---|
| | contract award. | |

## APPENDIX K – Performance Measures

The FS Contractor is responsible for meeting the requirements in this RFP, but Contractor will not be liable for any failure to meet performance measures or for associated liquidated damages resulting in whole or in part from events, causes, or responsibilities that are outside of FS Contractor's control. The Performance Measures in this APPENDIX are subject to revision during contract negotiation.

*Table 12 Performance Measures*

| Phase | # | Category | Performance Standard | Liquidated Damages |
|---|---|---|---|---|
| DDI/ OPS | 1 | Configuration Management | The FS Contractor will not perform any changes (including configurable items and business rules) which impact HSD without the prior written approval of HSD via the Change Control and Release Management processes. The Contractor must notify the EPMO when a SLA is not met or will not be met.<br><br>HSD will use an emergency approval process to expedite urgent changes necessary to support maximum system availability. | HSD may assess $5,000 per occurrence for FS Contractor's failure to obtain HSD prior written approval for changes.<br><br>This performance standard shall only apply after the MMISR Go-Live in accordance with the mutually agreed upon Project Schedule. |

| Phase | # | Category | Performance Standard | Liquidated Damages |
|---|---|---|---|---|
| OPS | 2 | Disaster Recovery | For the FS Module, the FS Contractor shall perform and pass the annual recovery and restoration testing that is outlined and accepted by HSD in the "Disaster Recovery Plan" Deliverable and notify the Enterprise when the SLA is not met.<br><br>FS Contractor will coordinate with the SI Contractor and its disaster recovery testing protocols related to  integration . The testing schedule will be mutually agreed upon by HSD and FS Contractor and notify the Enterprise when the SLA is not met. | HSD may assess $5,000 per business day for each day the passing completion of the test for the FS Module is beyond the scheduled test date. |
| DDI | 3 | Project Management | FS Contractor shall provide the Deliverables, per DED requirements that meet State approval, by the due dates as set forth in the approved Project Schedule or as otherwise mutually agreed upon and notify the Enterprise when the SLA is not or will not be met. | HSD may assess $1,000 per business day thereafter until the date that each specific Deliverable is delivered to HSD. |
| OPS | 4 | Project Management | The FS Contractor shall deliver to the HSD project manager, or designee, timely and accurate reports specific to each defined performance measure described in this table of performance measures. The reports shall be specific to the reporting time period and quantifiably specific to the measure being reported. Reports shall be based on a measuring and monitoring methodology and tools approved by HSD.<br><br>The FS Contractor and HSD will work together to develop a performance standards status report ("Dashboard" and/or "Scorecard"). | HSD may assess $100 per performance measurement per day for reports that are not presented to HSD by the agreed upon date and time for submission. |

| Phase | # | Category | Performance Standard | Liquidated Damages |
|-------|---|----------|----------------------|--------------------|
| DDI/ OPS | 5 | Staff Resource Management | The FS Contractor will replace Key Personnel according to the contract process. Replacement of Key Personnel will take place within thirty (30) calendar days of removal unless a longer period is approved by HSD. | HSD may assess up to $1,000 per Business Day for each Business Day beyond the thirty (30) calendar days allowed for replacement of Key Personnel. |
| DDI/ OPS | 6 | Staff Resource Management | Except as set forth in the Contract or due to a personnel resignation or termination, the FS Contractor shall not replace Key Personnel without prior written approval of HSD.<br><br>The list of Key Personnel during Contract will be mutually agreed upon by the HSD and FS Contractor. | HSD may assess up to a maximum of $10,000 per occurrence. |

| Phase | # | Category | Performance Standard | Liquidated Damages |
|---|---|---|---|---|
| OPS | 7 | System Availability | FS Contractor shall provide all components of the FS Module available for production processing 99.999% of the time, three-hundred sixty-five (365) days per year and notify the Enterprise when the SLA is not met. | HSD may assess liquidated damages per day as specified below when the average daily performance fails to meet the performance standard.<br><br>Availability drops below 99.999% to 99.99% (more than 864.3 ms and less than 8.66 seconds of downtime per 24-hour period): $5,000<br><br>Availability drops below 99.99% to 99.9% (more than 8.66 seconds and less than 1.44 minutes of downtime per 24-hour period): $7,500<br><br>Availability drops below 99;9% to 99% (more than 14.4 minutes of downtime per 24-hour period): $10,000<br><br>The assessment of Liquidated Damages for this performance standard shall only apply ninety (90) days after the MMISR Go Live in accordance with the mutually agreed upon Project Schedule. |
| OPS | 8 | Business | FS Contractor shall deliver the contracted fully functioning integrated FS Module services within thirty (30) days of the agreed Go-Live release date. | HSD may assess liquidated damages of $25,000/day for each day greater than thirty (30) days after agreed Go-Live event until the SLA is achieved. |

| Phase | # | Category | Performance Standard | Liquidated Damages |
|-------|---|----------|----------------------|--------------------|
| OPS | 9 | Business | FS Contractor shall fix any priority one (1) defects must be fixed within one (1) business day of reporting.<br><br>FS Contractor shall fix any priority two (2) defects must be fixed within five (5) business days.<br><br>FS Contractor shall fix any priority three (3) or four (4) defects must be fixed within 20 twenty (20) business days.<br><br>Priority levels will be determined during contract negotiations. | HSD may assess $1,000 per day per incident for priority one (1) defects.<br><br>HSD may assess $500 per day per incident for priority two (2) defects.<br><br>HSD may assess $100 per day per incident for priority three (3) or four (4) defects. |
| DDI | 10 | Business | The FS Contractor shall deliver its Services configured and ready for an acceptable UAT minor release (as agreed upon with the State) sufficient to ensure that all functions and components of the Contractor's Services are performing acceptably, as scheduled and notify the Enterprise when the SLA is not met.<br><br>Major and Minor release are to be defined during contract negotiations. | HSD may assess $1,000 per day per minor release delays. |
| DDI | 11 | Business | The FS Contractor shall deliver its Services configured and ready for an acceptable UAT major release (as agreed upon with the State), sufficient to ensure that all functions and components of the Contractor's Services are performing acceptably, as scheduled and notify the Enterprise when the SLA is not met.<br><br>Major and Minor release are to be defined during contract negotiations. | HSD may assess $10,000 per day per major release delays, not in compliance with performance measurement. |

| Phase | # | Category | Performance Standard | Liquidated Damages |
|-------|---|----------|----------------------|--------------------|
| OPS | 12 | Business | FS Contractor shall produce notification data and forward to the IP within twenty-four (24) hours of identifying the need to generate FS correspondence. | HSD may assess $100 per incident per notification not delivered in compliance with performance measurement. |
| OPS | 13 | Business | FS Contractor shall integrate production releases as scheduled and notify the EPMO when the SLA is or will not be met. | HSD may assess $1,000 per day per minor release incident, for delays, and $10,000 per day per major release incident for delays, not in compliance with performance measurement. |
| OPS | 14 | Business | FS Contractor shall provide an audit trail for all transactions (e.g., system, data) occurring in FS and notify the EPMO when the SLA is or will not be met. | HSD may assess $1,000 per incident per day not in compliance with performance measurement. |
| OPS | 15 | Business | FS Contractor shall assign funding source and account codes, for each line of all claims (e.g., Physician, Dental, PBM, Anesthesia, Personal Care Services) based upon State business rules and prior to final claim status (e.g., pay, partial pay, deny) and notify the EPMO when the SLA is or will not be met. | HSD may assess $1,000 per incident per day not in compliance with performance measurement. |
| OPS | 16 | Business | FS Contractor shall create and trigger generation of all assigned reports (e.g.1099's, W2s), in a compliant format, on or prior to required distribution dates and notify the EPMO when the SLA is or will not be met. | HSD may assess $5,000 per incident per day, plus all penalties applied, to the State, by other government agencies, not in compliance with performance measurement. |

| Phase | # | Category | Performance Standard | Liquidated Damages |
|-------|---|----------|---------------------|---------------------|
| OPS | 17 | Business | FS Contractor shall process 98% of "clean claims" to final status (pay, partial pay, deny) within twenty (20) calendar days of receipt and notify the EPMO when the SLA is or will not be met. | HSD may assess one dollar ($1.00) per claim per day not in compliance with performance measurement. |
| OPS | 18 | Business | FS Contractor shall enter financial transactions, including but not limited to payouts and recoupments, within one (1) business day of receipt and notify the EPMO when the SLA is not met. | HSD may assess $1,000 per incident not in compliance with performance measurement. |
| OPS | 19 | Business | FS Contractor shall provide to the IP the payment transaction file 24 hours prior to SHARE payment cycle run and notify the EPMO when the SLA is not met. | HSD may assess $5,000 per incident per day not in compliance with performance measurement. |
| OPS | 20 | Business | FS Contractor shall execute retroactive claim adjustment processing within one (1) business day of business rule defined automatic identification of claim requiring adjustment or receipt of the request from the Enterprise and notify the EPMO when the SLA is not met. | HSD may assess one dollar ($1.00) per claim per day not in compliance with performance measurement. |
| OPS | 21 | Business | FS Contractor shall perform EDI validation edit, within one (1) tenth of a second per transaction within the file, of receipt of file transaction and return the results to the IP within one (1) tenth of a second and notify the EPMO when the SLA is not met. | HSD may assess $1,000 per incident per day not in compliance with performance measurement. |
| OPS | 22 | Business | FS Contractor shall perform mass adjustments within five (5) business days of receipt of the request from the Enterprise and notify the EPMO when the SLA is or will not be met. | HSD may assess one dollar ($1.00) per claim per day not in compliance with performance measurement. |

| Phase | # | Category | Performance Standard | Liquidated Damages |
|-------|---|----------|---------------------|-------------------|
| OPS | 23 | Business | FS Contractor shall perform cash account reconciliation within one (1) day of receipt of a returned SHARE payment file and notify the EPMO when the SLA is not met. | HSD may assess $1,000 per incident per day not in compliance with performance measurement. |
| OPS | 24 | Business | FS Contractor shall perform a quarterly trial balance within forty-eight (48) hours of the state quarter end and notify the EPMO when the SLA is or will not be met. | HSD may assess $1,000 per incident per day not in compliance with performance measurement. |
| OPS | 25 | Business | FS Contractor shall perform an annual trial balance within two (2) business day of the state yearend and notify the EPMO when the SLA is not met. | HSD may assess $1,000 per incident per day not in compliance with performance measurement. |
| OPS | 26 | Business | FS Contractor shall perform a monthly trial balance within forty-eight (48) hours of the state month end and notify the EPMO when the SLA is or will not be met. | HSD may assess $1,000 per incident per day not in compliance with performance measurement. |
| OPS | 24 | Business | FS Contractor shall process and pay all correctly and timely submitted Mi Via timesheets and invoices in the next scheduled related payment cycle. | HSD may assess ten dollars ($10.00) per timesheet or invoice per day that payment is delayed. |
| OPS | 25 | Business | FS Contractor shall adjudicate ninety (90) percent of resolved problem claims within ten (10) business days of claim suspension date | HSD may assess ten dollars ($10.00) per claim per day that adjudication is delayed. |
| OPS | 26 | Business | FS Contractor shall resolve suspended claims within ten (10) business days of claim suspension date | HSD may assess ten dollars ($10.00) per claim per day that resolution is delayed. |
| OPS | 27 | Business | FS Contractor shall provide help desk support during all uptime hours for the system (e.g. 99.999% of the time). | HSD may assess ten dollars ($10.00) per minute per day that support is unavailable. |

| Phase | # | Category | Performance Standard | Liquidated Damages |
|-------|-----|----------|----------------------|--------------------|
| OPS | 28 | Business | FS Contractor shall ensure that the daily abandonment rate for the SDHCBS call center does not exceed five (5) percent, to be computed and reported monthly. | HSD may assess liquidated damages per month as specified below when the average monthly performance fails to meet the performance standard.<br><br>Abandonment rates between 5.0% and 9.99% per month: one thousand dollars ($1,000)<br><br>Abandonment rates between 10.0% and 14.99% per month: two thousand five hundred dollars ($2,500)<br><br>Abandonment rates 15.0% and above: five thousand dollars ($5,000) |

| Phase | # | Category | Performance Standard | Liquidated Damages |
|-------|---|----------|----------------------|--------------------|
| OPS | 29 | Business | FS Contractor shall answer eighty percent (80%) of monthly calls within sixty (60) seconds, to be computed and reported monthly. | HSD may assess liquidated damages per month as specified below when the average monthly performance fails to meet the performance standard.<br><br>Average Speed to Answer (ASA) percentage between 79.99% and 71.0% within sixty (60) seconds per month; one thousand dollars ($1,000)<br><br>Average Speed to Answer percentage between 70.99% and 65.0% within sixty (60) seconds per month; two thousand five hundred dollars ($2,500)<br><br>Average Speed to Answer percentage 64.99% or below within sixty (60) seconds per month and below; five thousand dollars ($5,000) |
| OPS | 30 | System Maintenance | Contractor shall analyze and propose a resolution to HSD for all module Severity One (1) incidents within four (4) hours from the time the Contractor is aware of the incident.<br><br>For the purposes of the SLA herein, Severity One (1) incidents shall be defined as mutually agreed upon prior to Go-Live. | HSD may assess $5,000 per day, when the resolution is not proposed to HSD per the performance standard.<br><br>The assessment of Liquidated Damages for this performance standard shall only apply ninety (90) days after the MMISR Go Live in accordance with the mutually agreed upon Project Schedule. |

| Phase | # | Category | Performance Standard | Liquidated Damages |
|---|---|---|---|---|
| OPS | 31 | System Maintenance | Contractor shall analyze and propose a resolution to HSD for all module Severity Two (2) incidents within four (4) days from the time the Contractor is aware of the incident.<br><br>For the purposes of the SLA herein, Severity Two (2) incidents shall be defined as mutually agreed upon prior to Go-Live. | HSD may assess $5,000 per day, when the resolution is not proposed to HSD per the performance standard.<br><br>The assessment of Liquidated Damages for this performance standard shall only apply ninety (90) days after the MMISR Go Live in accordance with the mutually agreed upon Project Schedule. |

| Phase | # | Category | Performance Standard | Liquidated Damages |
|---|---|---|---|---|
| OPS | 32 | PBM | Contractor shall adjudicate ninety-nine percent (99%) of pharmacy claims submitted via POS technology in real-time and notify the Enterprise when the SLA is not met. | HSD may assess $1,000 per incident not in compliance with performance measurement. |
| OPS | 33 | PBM | Contractor shall update codes J, Q, and I, within thirty (30) calendar days of when CMS posts the quarterly pricing updates to the CMS website and notify the Enterprise when the SLA is not met. | HSD may assess $1,000 per incident not in compliance with performance measurement. |
| OPS | 34 | PBM | Contractor shall provide the State with an analysis, within three (3) business days of receipt by the Contractor of CMS pharmacy-related information, that specifies if action by the State or PBM or other vendors is required and, if so, what that action is, by what entity it must be undertaken, and by when it must be completed and notify the Enterprise when the SLA is not met. | HSD may assess $1,000 per incident not in compliance with performance measurement. |

| OPS | 35 | PBM | Contractor shall produce drug rebate invoices within ten (10) business days of every quarter end and notify the Enterprise when the SLA is not met. | HSD may assess $1,000 per incident not in compliance with performance measurement. |
|-----|----|-----|----|----|
| OPS | 36 | PBM | Contractor shall provide the State with a monthly monitoring report regarding PBM phone statistics within fifteen (15) calendar days following the end of the month to include the following:<br><br>a) Monthly number of calls<br>b) Number of calls placed on hold<br>c) Average number of minutes on hold<br>d) Average number of minutes required to complete the authorization request<br>e) Monthly busy signal rate. | HSD may assess $1,000 per incident not in compliance with performance measurement. |