STATE OF MONTANA
REQUEST FOR PROPOSAL (RFP)

RFP Number: (insert)	**RFP Title: Claims Processing and Management Services Claims Processing and Management Services for Montana's Program for Automating and Transforming Healthcare (MPATH) Request for Proposal**

RFP Response Due Date and Time: (insert) 2:00 p.m., Mountain Time	**Number of Pages:** (insert)	**Issue Date:** (insert)

ISSUING AGENCY INFORMATION

Procurement Officer: Tia Snyder	**Department of Public Health and Human Services** **Phone: 406-444-0110** **Fax: 406-444-2529** **TTY Users, Dial 711**
Website: http://vendor.mt.gov/	

INSTRUCTIONS TO OFFERORS

Return Sealed Proposal to: **(insert agency name and address)**	**Mark Face of Envelope/Package with:** **RFP Number: (insert)** **RFP Response Due Date: (insert)**
Special Instructions:	

OFFERORS MUST COMPLETE THE FOLLOWING

Offeror Name/Address:	_____ **(Name/Title)** _____ **(Signature)** **Print name and title and sign in ink. By submitting a response to this RFP, offeror acknowledges it understands and will comply with the RFP specifications and requirements.**
Type of Entity (e.g., corporation, LLC, etc.)	**Offeror Phone Number:**
Offeror E-mail Address:	**Offeror FAX Number:**

OFFERORS MUST RETURN THIS COVER SHEET WITH RFP RESPONSE

Contents

Revision History

Date	Document Version	Revision Description	Author
8/16/2019	1.0	Final for Release	DPHHS

SECTION 1: INTRODUCTIONS AND INSTRUCTIONS

1.1 INTRODUCTION

The STATE OF MONTANA, Department of Public Health and Human Services ("State," “Department,” or “DPHHS”) is seeking a Contractor to provide Claims Processing and Management Services to support the receipt, adjudication and editing, pricing and payment for health care claims. A more complete description of the solution and services to be provided are found in Section 3 – Scope of Services.

1.2 CONTRACT PERIOD

The contract period is for six (6) years, which includes Design, Development, and Implementation (DDI) and initial base operations, beginning with the Contract effective date and ending 72 months following the contract effective date. The parties may mutually agree to a renewal of this contract in one (1) year intervals, or any interval that is advantageous to the State. This contract, including any renewals, may not exceed a total of ten (10) years from the contract effective date, at the State's option.

1.3 SINGLE POINT OF CONTACT

From the date this Request for Proposal (RFP) is issued until an Offeror is selected and announced by the procurement officer, Offerors shall not communicate with any state staff regarding this procurement, except at the direction of the procurement officer in charge of the solicitation. Any unauthorized contact may disqualify the Offeror from further consideration. Contact information for the single point of contact is:

Procurement Officer: Tia Snyder
Phone: (406) 444-3315
Fax: (406) 444-2529
E-mail: tsnyder@mt.gov

1.4 REQUIRED REVIEW

1.4.1 Review RFP

Offerors shall carefully review the entire RFP. Offerors shall promptly notify the procurement officer of any ambiguity, unduly restrictive specifications, or error that they discover. In this notice, the Offeror shall include any terms or requirements within the RFP that preclude the Offeror from responding or add unnecessary cost. Offerors shall provide an explanation with suggested modifications. The notice must be received by the deadline for questions set forth in the RFP. The State will determine any changes to the RFP.

1.5 GENERAL REQUIREMENTS

1.5.1 Acceptance of the Contract

By submitting a response to this RFP, Offeror accepts the contract included in Attachment B –Contract. Much of the language included in the contract reflects the requirements of Montana law.

Offerors requesting additions or exceptions to the Contract terms, must upload them to the eMACS Q&A Board by the closing date specified for Contract Requests using Attachment M – Contract Exception Request Template. Offerors must complete each column in Attachment M to include an explanation detailing why the exception is being sought, what specific effect it will have on the Offeror's ability to respond to the RFP or perform the Contract and include any proposed language or changes to the RFP, Attachment A – Standard Terms and Conditions, and Attachment B –Contract. The State, in its response, shall provide accepted revisions to the Standard Terms and Conditions and contract language in an addendum to this RFP. The addendum will apply to all Offerors submitting a response to this RFP.

The Department reserves the right to address nonmaterial requests for exceptions to the contract language with the highest scoring offeror during contract negotiation. Material requests for exceptions to the Contract language may become Negotiation Items if they meet the following criteria:

1. Contract modification requests **must be submitted to the Q&A Board** in eMACS **using Attachment M – Contract Exception Request Template** by the **Closing Date for Receipt of Contract Requests** found in the Schedule of Events; and
2. Attachment M – Contract Exception Request Template must detail specific requests. Requests must include an explanation detailing why the exception is being sought, what specific effect it will have on the Offeror's ability to respond to the RFP or perform the Contract and include any proposed language or changes to the RFP; and
3. For each specific topic, the Offeror must completely and accurately fill out Attachment M – Contract Exception Request Template; incomplete requests shall not be considered; and
4. The Department agrees, in whole or in part, to negotiate the specific topic presented by an Offeror; or
5. The Department, at its sole discretion, identifies topics that will be included in Contract negotiations.

All Contract modification requests that qualify as a Negotiation Item, based on the criteria listed above, can be negotiated by any qualifying Offeror, regardless of who submitted the request. Contract negotiation will begin with the announcement of the highest scoring Offeror.

Please note that the Offeror's proposed total firm fixed price must be based on the Offeror's submitted Attachment G – Pricing Schedules and the rest of the RFP, not the Offerors requested exceptions.

1.5.2 Acceptance/Rejection of Proposal

The State reserves the right to accept or reject any or all proposals, wholly or in part, and to make awards in any manner deemed in the best interest of the State.

1.5.3 Alteration of Solicitation Document

In the event of inconsistencies or contradictions between language contained in the State's solicitation document and a vendor's response, the language contained in the State's original solicitation document will prevail. Intentional manipulation and/or alteration of solicitation document language will result in the vendor's disqualification and possible debarment.

1.5.4 Resulting Contract.

This RFP and any addenda, the Offeror's RFP response, including any amendments, a best and final offer (if any), and any clarification question responses shall be incorporated by reference in any resulting contract.

1.5.5 Mandatory Requirements

To be eligible for consideration, an Offeror ***must*** meet all pass/fail criteria as listed in Attachment I – Evaluation and Scoring. The State will determine whether an Offeror's proposal complies with the criteria. Proposals that fail to meet any pass/fail criteria listed in Attachment I – Evaluation and Scoring will be deemed nonresponsive.

1.5.6 Understanding of Specifications and Requirements

By submitting a response to this RFP, Offeror acknowledges it understands and shall comply with the RFP specifications and requirements.

1.5.7 Offer in Effect for 270 Calendar Days

Offeror agrees that it may not modify, withdraw, or cancel its proposal for a 270-day period following the RFP closing date or receipt of best and final offer, if required.

1.5.8 Offeror Competition

The State encourages free and open competition to obtain quality, cost-effective services and supplies. The State designs specifications, proposal requests, and conditions to accomplish this objective.

1.5.9 Offeror's Representations – Signatory Authority and No Collusion.

Offeror represents that the person submitting the response to this RFP is authorized to legally bind the offeror to the proposal. The offeror may not withdraw the proposal for lack of authority. Offeror shall provide proof of authority of the person signing the RFP to bind the Offeror upon State's request. The Offeror further represents that the proposal has been made without collusion.

1.6 SUBMITTING A PROPOSAL

1.6.1 Organization of Proposal

Offerors shall organize their proposal as follows. Proposal pages must be consecutively numbered.

- Introductory or cover letter stating the company name and address and identifying the contact person by name, phone number, and email address.
- Executive Summary stating the Offeror's understanding of the project. Include a list of anticipated risks and proposed mitigation strategies.
- Address each Buyer Attachment as appropriate. See Attachment C – RFP Instructions for additional detail.
- Offerors ***must*** use the RFP Price Schedules provided in Attachment G – Pricing Schedules. The price schedules serve as the primary representation of Offeror's cost/price. Offeror should include additional information as necessary to explain the Offeror's cost/price.
- Answer all Questions.
- Provide cost proposal for all Items listed in the RFP.

Unless specifically requested in the RFP, an Offeror making the statement "Refer to our literature…" or "Please see www…….com" may be deemed nonresponsive or receive point deductions. If referring to materials located in another section of the proposal, specific page numbers and sections must be noted. **The Evaluator/Evaluation Committee is not required to search through the proposal or literature to find a response.**

Submitting a Proposal. All proposals must be submitted using the Montana Acquisition & Contracting System (eMACS). For eMACS resource information, please visit http://vendorresources.mt.gov/.
NOTE: eMACS requires files loaded in Suppliers Attachments to be saved in two different pop-up windows. If the second save is not done, the file will not load correctly. Single file size is limited to 50MB.

1.6.2 Failure to Comply with Instructions

Offerors failing to comply with these instructions for submitting a proposal in prerequisites may be subject to point deductions. Further, the State may deem a proposal nonresponsive or disqualify it from further consideration if it does not follow the response format, is difficult to read or understand, or is missing requested information.

1.6.3 Debarment

Contractor certifies, by submitting this proposal, that neither it nor its principals are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction (contract) by any governmental department or agency. If Contractor cannot certify this statement, attach a written explanation for review by the State.

1.6.4 Failure to Honor Proposal

If an Offeror to whom a contract is awarded refuses to accept the award (PO/contract) or fails to deliver in accordance with the contract terms and conditions, the department may, in its discretion, suspend the Offeror for a period of time from entering into any contracts with the State of Montana.

1.6.5 Multiple Proposals

Offerors may, at their option, submit multiple proposals. All sections must clearly identify which proposal they belong to. The secondary proposals must be uploaded in Suppliers Attachments. Each proposal shall be evaluated separately.

1.6.6 Price Schedule

Offerors ***must*** use the RFP Price Schedules found in Attachment G – Pricing Schedules. These price schedules serve as the primary representation of the Offeror's cost/price. Offeror should include additional information as necessary to explain the Offeror's cost/price.

1.6.7 Copies Required and Deadline for Receipt of Proposals

Offerors must submit **one original proposal** to the State Procurement Bureau via eMACS.

1.6.8 Late Proposals

Regardless of cause, the State may not accept late proposals. Such proposals will automatically be disqualified from consideration. The eMACS system will not allow Offerors to submit proposals after the specified times listed in the solicitation.

1.6.9 Email Responses

Responses submitted via email are not allowed and shall not be considered by the State.

1.6.10 Question and Answer Board

Offerors having questions or requiring clarification or interpretation of any section within this RFP must address these issues in writing to the procurement officer listed in this event by the deadline stated. Offerors shall submit questions on the Q & A Board. Questions received after the deadline may not be considered.

The State will provide a written response to all questions received by close of business on the date stated in the Schedule of Events included with this RFP.

1.7 COSTS/OWNERSHIP OF MATERIALS

1.7.1 State Not Responsible for Preparation Costs

Offeror is solely responsible for all costs it incurs prior to contract execution.

1.7.2 Ownership of Timely Submitted Materials.

The State shall own all materials submitted in response to this RFP.

SECTION 2: RFP STANDARD INFORMATION

2.1 AUTHORITY

The RFP is issued under 18-4-304, Montana Code Annotated (MCA) and ARM 2.5.602. The RFP process is a procurement option allowing the award to be based on stated evaluation criteria. The RFP states the relative importance of all evaluation criteria. The State shall use only the evaluation criteria outlined in this RFP.

2.2 OFFEROR COMPETITION

The State encourages free and open competition to obtain quality, cost-effective services and supplies. The State designs specifications, proposal requests, and conditions to accomplish this objective.

2.3 RECEIPT OF PROPOSALS AND PUBLIC INSPECTION

2.3.1 Public Information

Subject to exceptions provided by Montana law, all information received in response to this RFP, including copyrighted material, is public information. Proposals will be made available for public viewing and copying shortly after the proposal due date and time. The exceptions to this requirement are: (1) bona fide trade secrets meeting the requirements of the Uniform Trade Secrets Act, Title 30, chapter 14, part 4, MCA, that have been properly marked, separated, and documented; (2) matters involving individual safety as determined by the State; and (3) other constitutional protections. See 18-4-304, MCA.

2.3.2 Procurement Officer Review of Proposals

Upon opening the proposals in response to this RFP, the procurement officer will review the proposals for information that meets the exceptions in Section 2.3.1, providing the following conditions have been met:

- Confidential information (including any provided in electronic media) is clearly marked and separated from the rest of the proposal.
- The proposal does not contain confidential material in the cost or price section.
- An affidavit from the Offeror's legal counsel attesting to and explaining the validity of the trade secret claim as set out in Title 30, chapter 14, part 4, MCA, is attached to each proposal containing trade secrets. Counsel must use the State of Montana "Affidavit for Trade Secret Confidentiality" form in requesting the trade secret claim. This affidavit form is available on SFSD website at: http://vendorresources.mt.gov/VendorForms or by calling (406) 444-2575.

Information separated out under this process will be available for review only by the procurement officer, the evaluator/evaluation committee members, and limited other designees. Offerors shall pay all of its legal costs and related fees and expenses associated with defending a claim for confidentiality should another party submit a "right to know" (open records) request.

2.3.3 Reciprocal Preference

The State of Montana applies a reciprocal preference against a vendor submitting a bid from a state or country that grants a residency preference to its resident businesses. A reciprocal preference is only applied to an invitation for bid for supplies or an invitation for bid for nonconstruction services for public works as defined in section 18-2-401(9), MCA, and then only if federal funds are not involved. For a list of states that grant resident preference, see http://sfsd.mt.gov/SPB/Preferences.

2.4 CLASSIFICATION AND EVALUATION OF PROPOSALS

2.4.1 Initial Classification of Proposals as Responsive or Nonresponsive

The State shall initially classify all proposals as either "responsive" or "nonresponsive" (ARM 2.5.602). The State may deem a proposal nonresponsive if: (1) any of the required information is not provided; (2) the submitted price is found to be excessive or inadequate as measured by the RFP criteria; or (3) the proposal does not meet RFP requirements and specifications. The State may find any proposal to be nonresponsive at any time during the procurement process. If the State deems a proposal nonresponsive, it will not be considered further.

2.4.2 Determination of Responsibility

The procurement officer will determine whether an Offeror has met the standards of responsibility consistent with ARM 2.5.407. An Offeror may be determined nonresponsive at any time during the procurement process if information surfaces that supports a nonresponsive determination. If an Offeror is found nonresponsive, the procurement officer will notify the Offeror by mail. The determination will be included within the procurement file.

2.4.3 Evaluation of Proposals

An evaluator/evaluation committee will evaluate all responsive proposals based on stated criteria in Attachment I – Evaluation and Scoring and recommend an award to the highest scoring Offeror. The evaluator/evaluation committee may initiate discussion, negotiation, or a best and final offer. In scoring against stated criteria, the evaluator/evaluation committee may consider such factors as accepted industry standards and a comparative evaluation of other proposals in terms of differing price and quality. These scores will be used to determine the most advantageous offering to the State. If an evaluation committee meets to deliberate and evaluate the proposals, the public may attend and observe the evaluation committee deliberations.

2.4.4 Completeness of Proposals

Selection and award will be based on the Offeror's proposal and other items outlined in this RFP. Proposals may not include references to information such as Internet websites, unless specifically requested. Information or materials presented by Offerors outside the formal response or subsequent discussion, negotiation, or best and final offer, if requested, will not be considered, will have no bearing on any award, and may result in the Offeror being disqualified from further consideration.

2.4.5 Best and Final Offer

Under Montana law, the procurement officer may request a best and final offer if additional information is required to make a final decision. The State reserves the right to request a best and final offer based on price/cost alone. Please note that the State rarely requests a best and final offer on cost alone.

2.4.6 Evaluator/Evaluation Committee Recommendation for Contract Award

The evaluator/evaluation committee will provide a written recommendation for contract award to the procurement officer that contains the scores, justification, and rationale for the decision. The procurement officer will review the recommendation to ensure its compliance with the RFP process and criteria before concurring with the evaluator's/evaluation committee's recommendation.

2.4.7 Request for Documents Notice

Upon concurrence with the evaluator's/evaluation committee's recommendation, the Montana procurement officer will request the required documents and information, such as insurance documents, contract performance security, an electronic copy of any requested material (e.g., proposal, response to clarification questions, and/or best and final offer), and any other necessary documents from the highest scoring Offeror. Receipt of this request does not constitute a contract and **no work may begin until a contract signed by all parties is in place**.

2.4.8 Contract Execution

Upon receipt of all required materials, the Contract (Attachment B) incorporating the Standard Terms and Conditions (Attachment A), as well as the highest scoring Offeror's proposal, will be provided to the highest scoring Offeror. See the process outlined in Section 2.5.2 for Pre-Award Negotiations. The highest scoring Offeror will be expected to accept and agree to all material requirements contained in Attachment A – Standard Terms and Conditions and Attachment B – Contract of this RFP. If the highest scoring Offeror does not accept all material requirements, the State may move to the next highest scoring Offeror, or cancel the RFP. Work under the Contract may begin when the Contract is signed by all parties.

2.5 STATE'S RIGHTS RESERVED

While the State has every intention to award a contract resulting from this RFP, issuance of the RFP in no way constitutes a commitment by the State to award and execute a contract. Upon a determination, such actions would be in its best interest, the State, in its sole discretion, reserves the right to:

- Cancel or terminate this RFP (18-4-307, MCA);
- Reject any or all proposals received in response to this RFP (ARM 2.5.602);
- Waive any undesirable, inconsequential, or inconsistent provisions of this RFP that would not have significant impact on any proposal (ARM 2.5.505);
- Not award a contract, if it is in the State's best interest not to proceed with contract execution (ARM 2.5.602); or
- If awarded, terminate any contract if the State determines adequate state funds are not available (18-4-313, MCA).

2.5.1 Contract Exceptions

A proposed Contract is included as Attachment B – MPATH Contract Template in eMACS – Buyers Attachments and is also found in the procurement Prerequisites in eMACS. The selected Offeror will be expected to enter into a Contract that is substantially the same as Attachment B –Contract. In no event is an Offeror to submit its own standard contract terms and conditions as a response to this RFP.

Offerors requesting additions or exceptions to the Contract terms, shall upload them to the eMACS Q&A Board by the closing date specified for Contract Requests using Attachment M – Contract Exception Request Template. Offerors must complete each column in Attachment M – Contract Exception Request Template to include an explanation detailing why the exception is being sought, what specific effect it will have on the Offeror's ability to respond to the RFP or perform the Contract and include any proposed language or changes to the RFP, Attachment A – Standard Terms and Conditions, and Attachment B – Contract. The State, in its response, shall provide accepted revisions to the Standard Terms and Conditions and contract language in an addendum to this RFP. The addendum will apply to all Offerors submitting a response to this RFP.

The Department reserves the right to address nonmaterial requests for exceptions to the contract language with the highest scoring offeror during contract negotiation. Material requests for exceptions to the Contract language may become Negotiation Items if they meet the following criteria:

1. Contract modification requests **must be submitted to the Q&A Board** in eMACS **using Attachment M – Contract Exception Request Template** by the **Closing Date for Receipt of Contract Requests** found in the Schedule of Events; and
2. Attachment M – Contract Exception Request Template must detail specific requests. Requests must include an explanation detailing why the exception is being sought, what specific effect it will have on the Offeror's ability to respond to the RFP or perform the Contract and include any proposed language or changes to the RFP; and

3. For each specific topic, the Offeror must completely and accurately fill out Attachment M – Contract Exception Request Template; and
4. The Department agrees, in whole or in part, to negotiate the specific topic presented by an Offeror; or
5. The Department, at its sole discretion, identifies topics that will be included in Contract negotiations.

All Contract modification requests that qualify as a Negotiation Item, based on the criteria listed above, can be negotiated by any qualifying Offeror, regardless of who submitted the request. Contract negotiation will begin with the announcement of the highest scoring Offeror.

Please note also that the Offeror's proposed total firm fixed price must be based on the Offeror's submitted Attachment G – Pricing Schedules and the rest of the RFP, not the Offerors requested exceptions.

In addition to submitting Attachment M – Contract Exception Request Template, the Department prefers that the Contractor provide a track changes version of the MPATH Contract Template with the Contractor's proposed Contract changes. Providing the optional track changes version of the MPATH Contract Template will expedite the Department's review and timely response to the Offeror's Contract questions.

2.5.2 Failed Pre-Award Negotiations

The State intends to conduct Pre-Award Negotiations of the Contract over a four-week period with the highest scoring Offeror, consistent with the evaluation criteria, detailed in Section 6 Evaluation Criteria. If the State and the highest scoring Offeror are not able to reach agreement on the Contract terms and conditions within four weeks from the start of negotiations, the State may terminate further negotiations if in the best interests of the State and may begin negotiations with the next highest scoring Offeror or cancel the procurement.

2.6 DEPARTMENT OF ADMINISTRATION POWERS AND DUTIES

The Department of Administration is responsible for carrying out the planning and program responsibilities for information technology (IT) for state government. (Section 2-17-512, MCA) The Chief Information Officer is the person appointed to carry out the duties and responsibilities of the Department of Administration relating to information technology.
The Department of Administration shall:
● Review the use of information technology resources for all state agencies;
● Review and approve state agency specifications and procurement methods for the acquisition of information technology resources; and
● Review, approve, and sign all state agencies IT contracts and shall review and approve other formal agreements for information technology resources provided by the private sector and other government entities.

2.6.1 Compliance with State of Montana IT Policies and Standards

The offeror is expected to be familiar with the State of Montana IT environment. All services and products provided as a result of this RFP shall comply with all applicable State of Montana IT policies and standards in effect at the time the RFP is issued. If offeror cannot comply with any *applicable* Policy or Standard, it must request an exception by posting the requested changes to the Q&A Board by the deadline set for question submittal. It will be the responsibility of the State to deny the exception request or to seek a policy or standards exception through the State CIO.

The links below provide information on State of Montana IT strategic plans, current environment, policies, and standards.

State of Montana Information Technology Strategic Plan
http://sitsd.mt.gov/Governance/IT-Plans

State of Montana Information Technology Environment
http://sitsd.mt.gov/Services-Support/Enterprise-Architecture

State of Montana IT Policies
https://montana.policytech.com/?public=true&siteid=1

State of Montana Approved Enterprise Software List
If an Offeror proposes to use third party software, the proposed software must meet the requirements of the List. The List will be made available to Offeror upon request to the Procurement Officer. Offeror's failure to request the List does not release it from complying with all the requirements of the List.

SCHEDULE OF EVENTS

EVENT	DATE
Opening Date for Receipt of Written Questions	10/15/2019
Pre-proposal Conference Call	10/23/2019
Pricing Conference Call	11/6/2019
Closing Date for Receipt of Contract Exception Requests	11/22/2019
Closing Date for Receipt of Written RFP Questions	12/03/2019
Deadline for Posting State's Written Responses to all Questions	12/13/2019
Proposal Submission Due Date	01/20/2020
Technical Proposal Scoring Meetings	*03/16/2020 through 03/27/2020
Invitation to Product Demonstrations/Interview	*03/27/2020
Offeror Product Demonstrations/Interviews and Scoring	*04/13/2020 through 04/24/2020
Reviewing and Scoring Cost	*04/24/2020
Intended Date for Contract Award(s)	*05/01/2020
Contract Negotiations	*05/18/2020 through 05/22/2020
Montana Project Kickoff	*07/22/2020

*The dates above identified by an asterisk are included for planning purposes. These dates are subject to change.

SECTION 3: SCOPE OF SERVICES

To enable the State to determine the capabilities of a Contractor to provide Claims Processing and Management Services for the Department of Public Health and Human Services (DPHHS), the Offeror shall respond to the following regarding its ability to meet the State's requirements.

All subsections of Section 3 require a written response. Sections 3.1-3.8 shall include a narrative description of how the Offeror's proposed solution and services align with the Department's standards and objectives. The Offeror must restate and include the subsection number and its corresponding text immediately prior to your written response for all subsections of Sections 3. For Sections 3.9 and 3.10, the Offeror shall include a detailed written response.

NOTE: Each item must be thoroughly addressed. Offerors taking exception to any requirements listed in this section may be found nonresponsive or be subject to point deductions.

3.1 PURPOSE AND INTENT

The Montana Department of Public Health and Human Services (DPHHS) in releasing this RFP to procure a Claims Processing and Management Services Contractor to support Montana's Medicaid modernization effort, referred to as Montana's Program for Automating and Transforming Healthcare (MPATH). The Claims Processing and Management Services is a component of the Claims Processing and Management Services module which is a part of the overall MPATH program to replace aging legacy components of the Montana Healthcare Programs enterprise.

The intent for this RFP is for DPHHS to obtain a discrete module that aligns with the Final Rule for Mechanized Claims Processing and Information Retrieval Systems as described in 42 CFR 433.111. This module will support specific business objectives within the Montana Healthcare Programs enterprise that are detailed in Sections 3.9 High Level Scope of Work and 3.10 Detailed Scope of Work in this RFP and will be required to have interoperability with other MPATH modules. Consistent with recent definitions in the Final Rule for Mechanized Claims Processing and Information Retrieval Systems, DPHHS defines a module as a group of business processes that can be implemented through software, data and interoperable interfaces that are enabled through design principles in which functions of a complex system are partitioned into discrete, scalable, reusable components.

Each procured module must meet all the automation and interfacing requirements included in this RFP. In addition, DPHHS expects Offerors to present solutions that can be easily configured to achieve the outcomes described in this RFP and that will be flexible and adaptable enough to support Montana Healthcare Programs well into the future.

Regulations at 42 CFR § 433.112(c)(2) provide that COTS-related development costs at the enhanced match rate may only include the initial licensing fee and the minimum necessary to install, configure, and customize the COTS software and ensure that other state systems coordinate with the COTS software solution. When responding to a request for the 90 percent FFP rate for a COTS product, CMS will consider whether the configuration and customization of the product would be kept to minimal levels to achieve full functionality in the most cost-effective manner.

A condition for enhanced funding of COTS software is that customization of the product is minimal. Examples of minimal customization include modification of database interactions to include additional

required data elements, processing of state specific but necessary business rules, and modification of interfaces to allow interoperability with existing components or modules. If a COTS product is heavily customized, then the solution may become so unique to that state that other states are unable to reuse it, or that newer releases of that software cannot be easily integrated into the state's system, resulting in a solution that no longer meets the Standards and Conditions criteria outlined in the most current version of MECT.

3.2 STATE VISION, GUIDING PRINCIPLES AND OBJECTIVES

3.2.1 State Vision

The DPHHS management team envisions the new Montana Healthcare Programs enterprise to be a means to improve access to healthcare and treatment outcomes for Montanans.

3.2.2 Modularity Business Objectives

The MPATH Program objectives include:

- An enterprise system that is flexible to quickly adapt to the dynamic, evolving needs of existing programs and support new regulations, policies and innovations
- An enterprise system founded on business-driven technical solutions
- An enterprise system where business processes are automated wherever possible
- An enterprise system that provides centralized access to data
- An enterprise system that includes data analytics tools to support the use of clinical data to measure treatment outcomes and the changing health status of members.
- An enterprise system that includes standardized and automated electronic communication and data exchange capabilities
- An enterprise system that includes a Master Client Index (MCI)
- An enterprise system that integrates data from disparate systems to enable enterprise wide-program management

3.2.3 Guiding Principles

The MPATH Program team, leadership and program stakeholders have established guiding principles to be considered in all decisions throughout the overall program and module specific project phases to ensure that risks are mitigated appropriately, the procurements are successful, and member and provider communities and other stakeholders encounter minimal negative impacts. Table 3.2.3 illustrates the guiding principles established to guide the program administration.

Table 3.2.3 MPATH Guiding Principles

Guiding Principles	
Flexible Enterprise Technology Platform	Implement flexible, rule-based, configurable components and services to enhance decision-making, increase management efficiency and promotes agile adaptability for new and evolving regulations, programs and initiatives.
Centralized Data Repository	Implement a centralized data warehouse and associated data analytics tools to enable real-time or near-time access to data including clinical data and enhanced reporting that meets changing business and management needs.
Business-driven Enterprise transformation	Business functions must drive technical solutions and the modular MMIS capability must be flexible to meet future needs including new regulations, legislation, and innovations.

Guiding Principles	
Process Automation	Automate manual processes and eliminate human intervention wherever possible and utilize workflow tools to standardize business processes that guide internal and external users through process steps, activities, and tasks.
Data Integration and Interoperability	Promote reusable components by using open architecture and adopting industry and national standards for interoperability, integration, and data exchange.
Data Consistency Across the Enterprise	Utilize a comprehensive data governance process to ensure consistent data management processes and policies across the Montana Healthcare Programs enterprise. Provide data that is timely, accurate, usable, and easily accessible to support analysis and decision making for health care management and program administration.
Progressive Technology	Implement services that will allow the State to take advantage of progressive technology (access via mobile devices, mobile apps, instant messenger, etc.) to improve how it interacts and communicates with recipients, providers, and contractors.
Member and Provider Centric Focus	Implement solutions that provides easy to access and comprehensive portal for providers, members and other stakeholders that promotes self-service functionality. For example, claims status and member eligibility inquiries. The solution would leverage role-based security to make sure stakeholders have access to only the information required for their needs.
Cost Efficiency and Effectiveness	Implement a solution that supports future State strategies of paying providers based on the quality of services rather than quantity of services, focus on the member outcomes, and efficiently processing fee-for-service claims.

3.3 MODULARITY APPROACH AND BLUEPRINT

3.3.1 Modularity Approach

DPHHS has adopted a modularity component/services blend approach to procuring new systems and services to support the Medicaid modernization effort. This approach will result in multiple, strategically timed procurements and implementations. A modular component/services blend approach allows the state to focus on best of breed functionality versus best of suite to meet the “to be” business objectives defined in the Montana MITA 3.0 State Self-Assessment. Montana believes that this approach expands the universe of available Contractors as opposed to the traditional monolithic Medicaid Management Information Systems (MMIS) replacement approach. The modularity component/services blend approach is also aligned with the principles behind the Standards and Conditions for Medicaid outlined in the most current version of MECT and further clarified in SMD #16-010. The very nature of this approach promotes modularity, interoperability, aligns with MITA 3.0 Business Results conditions as well as optimizing the state’s ability to meet the Industry Standards Condition.

3.3.2 Modularity Blueprint

The State developed the MPATH Modularity blueprint through a number of modularity planning and decision meetings with stakeholders, guidance received from CMS, discussions with industry contractors, and through collaboration with other States’ Medicaid Programs. In addition to this RFP, there are a number of other procurements planned as illustrated in Figure 3.3.2.1 to replace the Montana Healthcare Programs enterprise. Figure 3.3.2.2 represents the timeline of the overall Medicaid modernization effort.

Figure 3.3.2.1 MPATH Modularity Groups

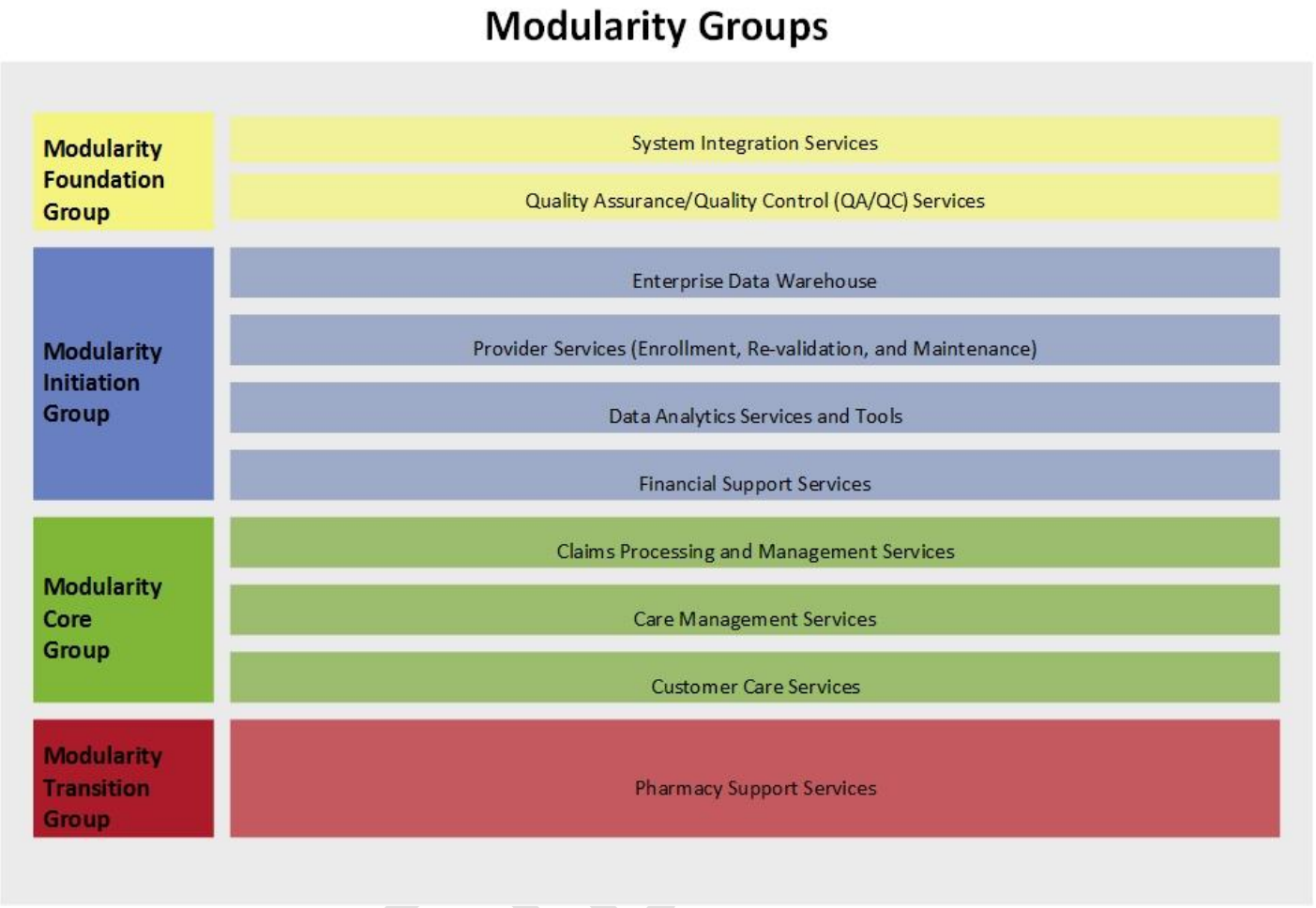
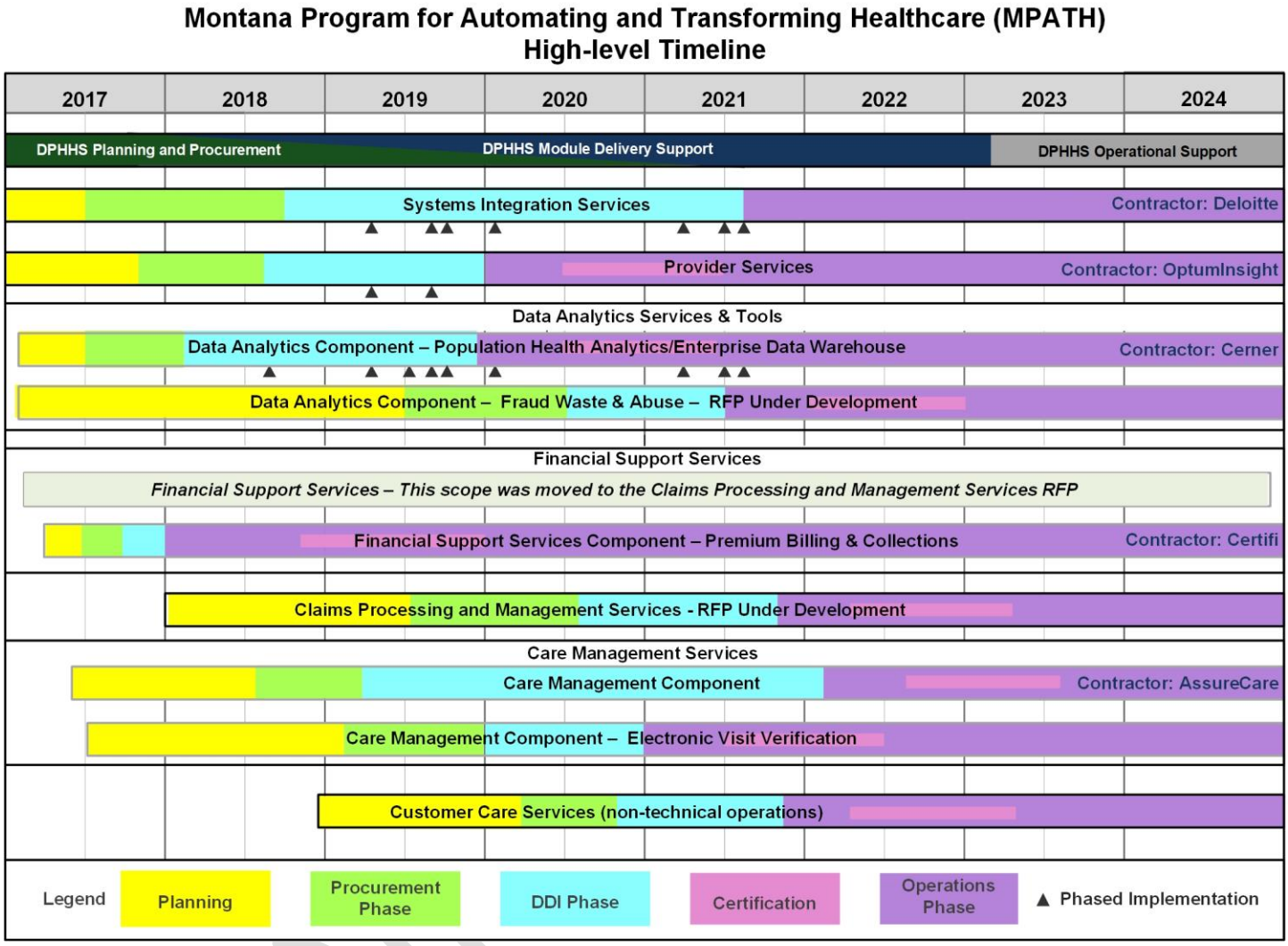


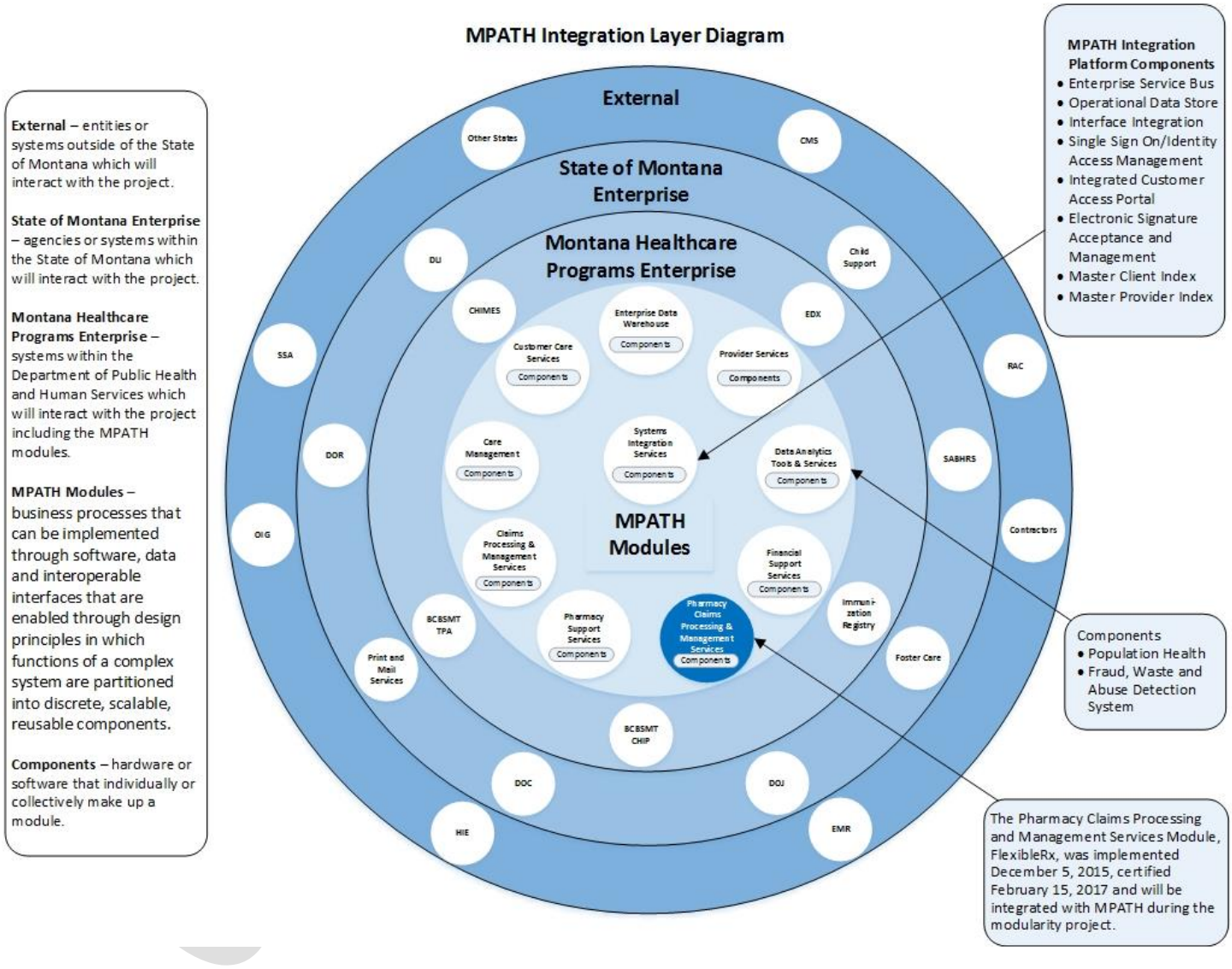
Figure 3.3.2.2 Montana Program for Automating and Transforming Healthcare (MPATH) Modularity High Level Timeline



3.3.3 MPATH Modules

The MPATH modules and components will be integrated with the overall Montana Healthcare Programs enterprise, the State of Montana enterprise, and other External stakeholders and entities to create standardized, automated electronic data exchanges to enable enterprise wide program management and maximize interoperability through integration. The MPATH Integration Layer graphic in Figure 3.3.3, illustrates the integration/transactional relationships between the MPATH components and modules and the various entities that are related by shared business processes.

Figure 3.3.3 MPATH Integration Layer



Systems Integration Services (SI)

The Systems Integrator project with Deloitte started in October 2018. The MPATH Integration Platform went live in July 2019, and includes enterprise integration capabilities, an operational data store, and Master Client Index and Master Provider Index. The Systems Integration Services Contractor will establish the MPATH Integration Platform to be the integration framework based on the standards identified by the DPHHS Enterprise Architecture Committee. The integration framework will enable the seamless integration of various modularity components including Commercial off the Shelf (COTS) software, Software as a Services (SaaS) solutions, and other modules. The integration framework will include the configuration, support and maintenance of an enterprise service bus (ESB), transformational services, and protocol

services. The Systems Integration Services Contractor will assist with the development of standards for architecture, interfaces, and data for each modularity project, including the data coming in through the ESB into the operational data store and eventually transformed into the Enterprise Data Warehouse and other Modules. The Department will begin integrating the first MPATH modules with the MPATH Integration platform beginning in July 2019 throughout the remainder of 2019 into 2020.

Provider Services (PS)

On March 19, 2018 the State of Montana awarded six of the eight vendors who responded to the multi-state procurement, Master Agreements. CMS approved a Master Agreement with OptumInsight on May 21, 2018. Montana and OptumInsight agreed to scope that includes the core provider services functionality (enrollment, screening, monitoring, revalidation and maintenance) and Option A Self-Service Portal via a Participating Addendum. The Participating Addendum was approved by CMS in June 2018 and the Provider Services project kicked-off July 9, 2018.

The Provider Services solution will provide a configurable, web based, self-service solution that allows healthcare providers to enroll electronically with Montana Healthcare Programs and provide an option for provider self-service updates. The web-based application(s) will adhere to NIST security standards and all federal and state requirements and all laws, rules, and regulations such as HIPAA and ACA.

The Provider Services module will support provider enrollment activities, including an automated tool for provider screening and monitoring that must be completed in accordance with State and federal statutes and policies.. The web-based application will collect required information to support decisions regarding approval or denial of a provider's enrollment request. The online application will accept the electronic attachment of supporting documentation, collect electronic signatures to enable provider enrollment eligibility. The solution will leverage an automated workflow tool so that data and documentation are routed to appropriate units responsible for decisions on provider enrollment applications. The Provider Services module will also support online provider re-validation, and maintenance activities. Providers will have the ability to submit updates to their information and complete periodic revalidations of their enrollment information via the Self-Service portal.

Enterprise Data Warehouse (EDW)

The Department will receive subsequent Enterprise Data Warehouse Services as a part of the Population Health Data Analytics contract. Figure 2.2.6 represents the Enterprise Data Warehouse implementations in relation to the Population Health Data Analytics releases as defined in the Population Health Data Analytics Contract. EDW services implemented in parallel with the Population Health Data Analytics Releases will utilize the data load processes and reporting completed in EDW Phase 1a to validate the successful transition of data into the new Enterprise Data Warehouse as well as validation of reporting to support population health data analytics and other Montana Healthcare Programs data analytics. EDW Phase 1a began in September 2017 and will be complete December 31, 2018. The Population Health Data Analytic Services and Tools contract project began March 5, 2018. The Population Health Data Analytics Services and Tools contract will deliver the remaining EDW requirements which include establishing the Montana Healthcare Programs centralized Enterprise Data Warehouse (EDW), the Intake Services Platform to process data received from all Data Providing Entity Interfaces as well as all State and Federal reporting.

Data Analytics Services and Tools (DA)

The Department released an RFP in August of 2017 to obtain Population Health Data Analytics Services and Tools for predictive modeling and to identify member risk for care management related activities. The Population Health Data Analytics Services and Tools is one of multiple COTS solutions planned to satisfy the multi-dimensional data analytics necessary to modernize data analysis and reporting of Montana Healthcare Programs data. These data analysis solutions will enable the creation of comprehensive statistical profiling of healthcare delivery and utilization for both providers and members for population health management.

Additionally, these tools and services will provide comprehensive analytical reporting, budgeting, forecasting, and daily program monitoring.

The Population Health Data Analytics Services and Tools procurement was awarded to Cerner in December 21, 2017. The initiation of the Population Health Data Analytics Services and Tools project began March 5, 2018.

The state intends to release an additional RFP under the Data Analytics module for Fraud, Waste, and Abuse Services. The Fraud, Waste and Abuse Services will be procured separately from the Population Health Data Analytics solution but the data will be fully integrated into the Montana Healthcare Programs central data repository.

Financial Support Services (FSS)
The Department plans to procure a Third-Party Liability (TPL) recoveries solution under the Financial Support Services module. This solution will handle all TPL recovery business processes for the Department including carrier billing, estate, tort, and lien recoveries. The solution will track the recoveries through the full life cycle. The Department expects to release this RFP in March 2020. In addition, the state will obtain a Financial Support Services module for financial services functionality not procured as a part of the Claims Processing and Management Services solution.

In addition, the Financial Support Services module includes a component for member premium processing. The Department signed an agreement with Certifi Inc. in September 2017 to obtain services to support Premium Billing and Collection Services. The Premium Billing and Collections component facilitates the billing and collection of premiums for the Montana Health and Economic Livelihood Partnership (HELP) participants within the Medicaid program. This solution has been live since January 2018 and the Department will be requesting CMS certification in late 2019.

Claims Processing and Management Services (Claims)

The Claims Processing and Management Services module will adjudicate, edit, price, and determine reimbursement amounts for healthcare claims. During claims adjudication this module will also process service authorizations, third party insurance liability, and calculate member liabilities including cost share. Montana is seeking a solution that is highly automated, configurable, modular, and processes claims real-time.
Claims will be adjudicated “real-time” and process payments and remittance advice daily (or at an interval determined by the state). The claims RFP is a multi-state procurement, led by Montana, in conjunction with NASPO ValuePoint.

Care Management Services (CM)
The Department released an RFP in July of 2018 to procure a Care Management Services module. This module will support activities to improve member healthcare outcomes and reduce healthcare costs for Montana Healthcare Programs by helping members and caregivers more effectively manage health conditions. The care management module will utilize defined criteria to identify members for specific programs, coordinate care for members enrolled in individual or multiple care management programs and collect and report on treatment outcomes. The solution will need to support member outreach, configurable development of assessments, capturing and monitoring assessments and screenings, treatment plans, authorize services, and incident management and reporting. It will provide comprehensive case management and workflow to track a member’s care from inception to conclusion with the tracking of key events being triggered based on the member’s condition or type of services required. The Department awarded this RFP to AssureCare in December 2018, and the project kicked-off in April 2019.

The Department plans to procure an electronic visit verification services component separately from the overall care management solution to support personal care services, home health care services as well as

other home and community-based services determined to benefit from the mandates of Section 12006 of the 21st Century CURES Act.

Customer Care Services (CCS)

Operations management encompasses all aspects of the customer care experience for providers and members during and after enrollment in Montana Healthcare Programs. This module will meet Montana's need to provide customer and member interaction and support, and to provide self-service access to the data and information needed to successfully navigate Montana Healthcare Programs. The contractor is expected to provide a comprehensive suite of services, tools, and systems necessary to promote a positive customer care interaction experience. Provider and member self-service options supplemented by call center support are key components to a successful and positive customer experience. Provider and member data will be available through a variety of sources such as website, mobile aps, and social media. Data can be accessed using various devices such as computers, tablets, and smartphones. Provider and member self-service options will be available across all platforms in order to provide a positive, comprehensive and seamless experience for all users.

Pharmacy Claims Processing and Management Services (PBMS)
FlexibleRx, the Pharmacy Claims Processing and Management Services module is an on-line, real time pharmacy claims adjudication system. FlexibleRx was implemented December 2015 as the first legacy replacement module within the Montana Healthcare Programs enterprise. FlexibleRx was certified by the Centers for Medicare and Medicaid Services (CMS) on February 15, 2017. FlexibleRx receives member eligibility and provider information from the legacy MMIS. Claims adjudicated in FlexibleRx are sent to the MMIS for payment generation to providers.

Pharmacy Support Services (PSS)
The Pharmacy Support Services module (PSS) encompasses two objectives. DPHHS will procure new components to replace the legacy Drug Rebate Analysis and Management System (DRAMS) and Retrospective Drug Utilization Review (RetroDUR) systems. Additionally, in order to reduce the dependency of FlexibleRx, the pharmacy claims processing and management system on the existing legacy MMIS, the current pharmacy claims processing and management services contractor, Conduent will complete enhancements to integrate multiple services including member eligibility, provider, financial transaction processing, and centralized data storage and reporting into the MPATH Integration Platform.

3.3.4 Exclusions

The Montana Department of Public Health and Human Services (DPHHS) will release a number of RFPs for software, components and services to replace legacy Montana Healthcare Programs services and components. Contractors awarded the Systems Integration Services and Independent Verification and Validation Services contracts are precluded from bidding on any other module within the MPATH Program scope.

DPHHS developed prime contractor and subcontractor exclusions based on the August 16, 2016 State Medicaid Director letter (SMD # 16-010 CMS, RE-2392-F Mechanized Claims Processing and Information Retrieval Systems – Modularity). SMD letter #16-010 directs states to use an acquisition strategy that limits the potential for conflicts of interest Systems Integration Services Contractors may encounter based on their specific scope of services by precluding them from bidding on other functional modules. Additionally, DPHHS identified exclusions for the Independent Verification and Validation Services contractor to ensure independence from any and all module prime or subcontractors.

DPHHS used the following key principles to make exclusionary decisions:

- Eliminate potential conflicts of interest based on contractor roles.
- Minimize the dependence of DPHHS on individual contractors.
- Focus on a best of breed replacement strategy rather than a best of suite approach.

Table 3.3.4 details the mapping of module procurement contractor exclusions for the MPATH Program. The exclusions identified in Table 3.3.4 apply equally to both prime contractors and subcontractors (e.g., if a company is part of the team that is awarded the Systems Integration Services Contract, they are precluded from being able to participate as a prime contractor or as a subcontractor on the Provider Services module or any other MPATH module).

In the event that the Systems Integration Services are re-procured after the award of other MPATH module(s), any successful module(s) prime contractor and their subcontractors will be precluded from a contract award as a prime contractor or subcontractor for the Systems Integration Services re-procurement.

Table 3.3.4 MPATH Contractor Procurement Exclusions

Module Name	SI	PS	DA	FSS	Claims	CM	CCS	PSS	EDW
Systems Integrator (SI)	Open	Excluded	Excluded	Excluded	Excluded	Excluded	Excluded	Excluded	N/A
Provider Services (PS)	Excluded	Open	Open	Open	Open	Open	Open	Open	N/A
Data Analytics, Tools and Services (DA)	Excluded	Open	Open	Open	Open	Open	Open	Open	N/A
Financial Support Services (FSS)	Excluded	Open	Open	Open	Open	Open	Open	Open	N/A
Claims Processing and Management (Claims)	Excluded	Open	Open	Open	Open	Open	Open	Open	N/A
Care Management Services (CM)	Excluded	Open	Open	Open	Open	Open	Open	Open	N/A
Customer Care Services (CCS)	Excluded	Open	Open	Open	Open	Open	Open	Open	N/A
Pharmacy Support Services (PSS)	Excluded	Open	Open	Open	Open	Open	Open	Open	N/A
Enterprise Data Warehouse (EDW)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Legend
Excluded: Awarded vendor(s) are excluded from bidding on subsequent modules within the overall program.
Open: Awarded vendor(s) are not excluded from bidding on subsequent modules within the overall program.
N/A: Not applicable. Service will be provided by the State of Montana Information Technology Services Division.

3.4 TECHNOLOGY STANDARDS

The overall goal of the MPATH Program is to implement components and services that improve access to healthcare and treatment outcomes for Montanans. Montana's modularity blueprint is founded on a strategy that utilizes a flexible enterprise technology platform which leverages solutions and services that provide the State of Montana the ability to more effectively meet current business objectives and provide a platform to support the evolving complexities of individuals served by Montana Healthcare Programs. The state intends to utilize Commercial Off The Shelf (COTS) products and software as a service (SaaS) where possible, to enable an enterprise-wide program management system that utilizes claims and clinical data to measure treatment outcomes, improve the health status of Montanans and reduce healthcare costs. DPHHS will collaborate with multiple Contractors to implement streamlined business rules and flexible solutions to meet State and Federal laws, rules and regulations.

DPHHS high level requirements for the MPATH Program are reflected in Table 3.4.

Table 3.4 High Level Requirements for the MPATH Program

Requirements	Requirement Definition
Alignment with the Standards and Conditions	Comply with the Standards and Conditions, set forth by CMS, in order to receive enhanced FFP.
Flexible Enterprise Technology Platform	Utilize enterprise architecture governance process that incorporates MITA standards to accommodate future programs and initiatives.
Automated Workflow Management	Provide centralized, configurable workflow solution that allows for workflow creation, execution and automation.
Enhance Program Reporting and Data Analytics	Implementation of Data Analytic tools and services to enable accurate, real-time data and reporting that will meet changing business and management needs. The solution should be enterprise centric, which would enable other health care and program data typically not found in an MMIS to support enterprise decision-making.
Centralized Access to Data	Provide real-time and centralized access to members, providers, benefit plan(s), claims, and case management data for the Department's programs including Medicaid, Healthy Montana Kids Plus (HMK Plus), Healthy Montana Kids (HMK) (the state's Children's Health Insurance Program CHIP)), Montana Health and Economic Livelihood Partnership Plan (HELP), Passport to Health, Patient Centered Medical Home (PCMH) and waiver services. Provide the ability to enhance decision-making and increase management efficiencies.
Data Integration and Interoperability	Provide interfaces and components that are reusable and follow industry and national standards for data exchange. Procured solutions will include exposed APIs for easy integration with other enterprise solutions.
Standard Communication Protocols	Standardized protocols for electronic communication will allow DPHHS to move to electronic options for communications using modern services such as Simple Object Access Protocol (SOAP) and Representational State Transfer (REST) including a Web Portal. In addition, standardization will support the ability to provide messaging in Multilanguage and multi-literate formats.
Progressive Technology	Provide progressive technology, e.g., mobile apps, text messaging, etc., that increase communication venues and encourages member and provider interaction with Montana Healthcare Programs.
Automate Manual Processes	Automate a majority of manual processes to replace human interactions with automated configurable business rules.
Administrative Simplification	Adhere to the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II).
Mechanized Claims Processing and Information Retrieval Systems Final Rule	Meet requirements specified in the Mechanized Claims Processing and Information Retrieval Systems (90/10) Final Rule (42 CFR 433), specifically related to configuration and customization of COTS software.

Requirements	Requirement Definition
Standards and Implementation Specifications for Health Information Technology Final Rule	Modularity approach is aligned with industry standards adopted by the Office of the National Coordinator for Health IT described in Final Rule (45 CFR part 170, subpart B).
HIPAA and HITECH	All solutions and services shall be fully compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Public Law 104-1919) and Administrative Simplification (Subset of Title II) requirements in effect as of the date of release for the RFP and with any changes that subsequently occur, unless otherwise noted. The Contractor shall sign a Business Associate Agreement, included in the contract, which is subject to HIPAA and HITECH regulations CFR 45 parts 160 and 164.

3.5 MONTANA HEALTHCARE PROGRAMS OVERVIEW

Montana Healthcare Programs is a group of programs funded by a combination of federal and state funds that provide health and long-term care coverage to Montanans who meet specified income guidelines, and/or are elderly and/or have certain healthcare conditions, disabilities or illnesses. The term “Montana Healthcare Programs” collectively refers to all healthcare benefit programs administered by the State of Montana in partnership with the federal Centers for Medicare and Medicaid Services (CMS). Montana Healthcare Programs operates under Title XIX of the Social Security Act, Title XXI State Healthy Montana Kids (HMK), State funded Mental Health Services Plan (MHSP), and the Montana Health and Economic Livelihood Partnership (HELP) Act. Montana Healthcare Programs is the state’s largest public/private healthcare coverage program and now touches the lives of approximately 20% Montanans.

Table 3.5 represents the groups of individuals who may receive healthcare coverage through Montana Healthcare Programs.

Table 3.5 Montana Healthcare Programs Member Groups

Healthy Montana Kids (HMK) coverage may be provided to children who are in the following groups:	
HMK Plus	Medicaid coverage provided to children up to the age of 19 in families with countable income equal to or less than 143% of the Federal Poverty Level (FPL)
HMK	The Children’s Health Insurance Program (CHIP), referred to as Healthy Montana Kids (HMK) in Montana, is currently administered by a third-party administrator and provides healthcare coverage to children up to the age of 19 in families with countable income above 143% through 261% of the FPL.
Standard Medicaid benefits may be provided to individuals who are in the following groups:	
Pregnant Women	Standard Medicaid benefits may be provided to eligible pregnant women with countable income equal to or less than 157% FPL.
Families with Dependent Children	Standard Medicaid benefits may be provided to parents or related caretakers (grandparents, aunts/uncles, etc.) whose countable income is below the Family Medicaid income level (approximately 24% FPL).

Subsidized Adoption, Subsidized Guardianship and Foster Care	Children eligible for an adoption or guardianship subsidy through the department are automatically eligible for Medicaid coverage through the month of the child's 21st birthday. Children, placed into licensed foster care homes by the Child and Family Services Division are also Medicaid eligible.
Former Foster Care Children	Standard Medicaid benefits may be provided to young adults between the ages of 18-26 that were in Foster Care and receiving Medicaid at the age of 18, may be eligible for the Former Foster Care Medicaid program.
Aged, Blind or Disabled Individuals Who Receive Supplemental Security Income (SSI)	Standard Medicaid benefits are available for any individual determined eligible for SSI.
Aged	Individuals, age 65 or older, may be eligible for Medicaid if their countable income is within allowable guidelines and their resources do not exceed $2000 for an individual or $3000 for a couple.
Blind/Disabled	Individuals may be eligible for Medicaid if determined blind or disabled using Social Security criteria, and if their income is within allowable limits and their resources do not exceed $2000 for an individual or $3000 for a couple.
Breast and Cervical Cancer Treatment	This program is for an individual diagnosed with certain breast or cervical cancer or pre-cancerous conditions of the breast or cervix. An eligible individual must be under 65 years old, not have insurance considered to be 'creditable coverage,' meet citizenship or qualified alien requirements, be a Montana resident, and have been screened through the Montana Breast and Cervical Health Program. Countable income cannot exceed 250% of the FPL
Medically Needy	Certain individuals or families whose income exceeds the Categorically Needy income standards, but who have a significant medical need may be eligible for Standard Medicaid benefits. The individual or family is obligated to incur medical expenses or make a cash payment (spenddown) for the difference between their countable income and the Medically Needy Income Level each month. The resource limit is $2000 for an individual, and $3000 for a couple or family.
Autism Services	This program provides intensive treatment services for Medicaid members up to age 21 with a diagnosis of autism spectrum disorder or related condition.
Montana Medicaid for Workers with Disabilities (MWD)	MWD allows certain individuals who meet Social Security's disability criteria to receive Medicaid benefits through a cost share. The cost share is based on a sliding scale according to an individual's income. MWD resource and income standards are significantly higher than many other Medicaid programs: $15,000 for an individual and $30,000 for a couple; while the countable income limit is 250% of the FPL.
Additional healthcare services	

Medicaid Expansion	On January 1, 2016, Montana expanded healthcare coverage to thousands of state residents through the Montana Health and Economic Livelihood Partnership (HELP) Act. Individuals who receive healthcare coverage through the HELP Act are eligible for Standard Medicaid benefits. Section 9 of the HELP Act includes provisions to provide health care services for individuals who are in the custody of the Department of Corrections or who are residents by commitment or otherwise residents of the following facilities. • Montana State Hospital • Montana Mental Health Nursing Care Center • Montana Chemical Dependency Center • Montana Developmental Center
Mental Health Services Plan (MHSP)	This program provides state funded benefits for individuals who have severe and disabling mental illness and meet income limits establish by the state but do not qualify for Standard Medicaid.
Emergency Alien Medical Coverage	This program provides limited benefits for emergency services such as labor and delivery. Other emergency services may be covered from the time treatment is first given for a condition until that same condition is no longer considered an emergency. These services must be determined an emergency by Medicaid department staff.
Medicare Savings Program (MSP)	MSP benefits may be provided to individuals who are low income Medicare beneficiaries. • Qualified Medicare Beneficiary (QMB) –Medicare premiums, co-payments and deductibles are covered for individuals who have QMB eligibility. • Specified Low-Income Medicare Beneficiary (SLMB) – Medicare premiums are covered for individuals who have SLMB eligibility. • Qualified Individuals (QI) – Part B premium payments are covered for individuals who have QI eligibility.
Montana Waiver Programs	Montana has many waiver programs that provide services to supplement existing Standard Medicaid benefits that include the following waivers: • Section 1115 waivers ▪ 1115 Plan First ▪ 1115 Health and Economic Livelihood Partnership (HELP) Demonstration ▪ 1115 Basic Waiver for Additional Services and Populations • Section 1915 (b) waivers ▪ 1915(b) Passport to Health ▪ 1915(b)(4) Montana Big Sky Waiver Case Management ▪ 1915(b)(4) Montana Autism Evaluation Services • Section 1915 (c) waivers ▪ 0208 HCBS Comprehensive Services Waiver for Individuals with Developmental Disabilities ▪ 1915(c) Montana Big Sky ▪ 1915(c) HCBS Severe Disabling Mental Illness (SDMI) • Section 1915 (k) waiver ▪ 1915(k) Community First Choice (CFC)

3.5.1 Montana Healthcare Programs Benefits

Montana Healthcare Programs Standard Medicaid benefit plan meets federal guidelines for mandatory benefits. In addition, Montana has chosen to cover a number of other cost-effective optional services.

Table 3.5.1 represents some of the services covered by Standard Medicaid (services covered for other programs under the Montana Healthcare Programs umbrella may vary).

Table 3.5.1 Example of Standard Medicaid Covered Services

Standard Medicaid Covered Services	
Inpatient hospital services (excluding inpatient services in institutions for mental disease)	Durable medical equipment, prosthetics and supplies
Outpatient hospital services	Optometric, optician and eyeglasses
Laboratory and X-ray services	Transportation and per diem
Nursing facility	Ambulance
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	Specialized non-emergency transportation
Physician & Nurse Practitioner services	Family Planning
Podiatry services	Home and community services
Physical therapy	Mid-level practitioner
Speech therapy	Hospice
Occupational therapy	Licensed psychologist
Audiology and hearing aids	Licensed clinical social worker
Personal care services	Licensed professional counselor
Home dialysis	Inpatient psychiatric
Federally Qualified Health Centers	Mental health center
Rural Health Clinics	Outpatient Drugs
Dental and denturist services	Case management
Pharmacy	Institutions for mental diseases for persons age 65 and older
Home Health	Indian Health Service (IHS)

The services are paid by a number of payment methodologies: fee for service, percent-of-charges, Resource-Based Relative Value Scale (RBRVS), All Patient Related Diagnosis Related Groups (APR-DRG), Ambulatory Payment Classification (APC), Prospective Payment System (PPS), Relative Value for Dentists (RVD) and negotiated rates.

For additional information regarding Montana Healthcare Programs, please refer to the Montana Department of Public Health and Human Services Report to the 2017 Legislature available in the procurement library.

3.6 MONTANA HEALTHCARE PROGRAMS ENTERPRISE

The Montana Healthcare Programs enterprise is comprised of multiple components and services that support activities related to provider enrollment and maintenance, population health management, care management, benefit management, claims adjudication, payments, reporting and other business processes necessary to administer Montana Healthcare Programs.

3.6.1 Current MMIS Environment

The current Montana Healthcare Programs enterprise is comprised of a newly implemented pharmacy claims processing system, FlexibleRx, and a compilation of 48 other legacy systems and services.

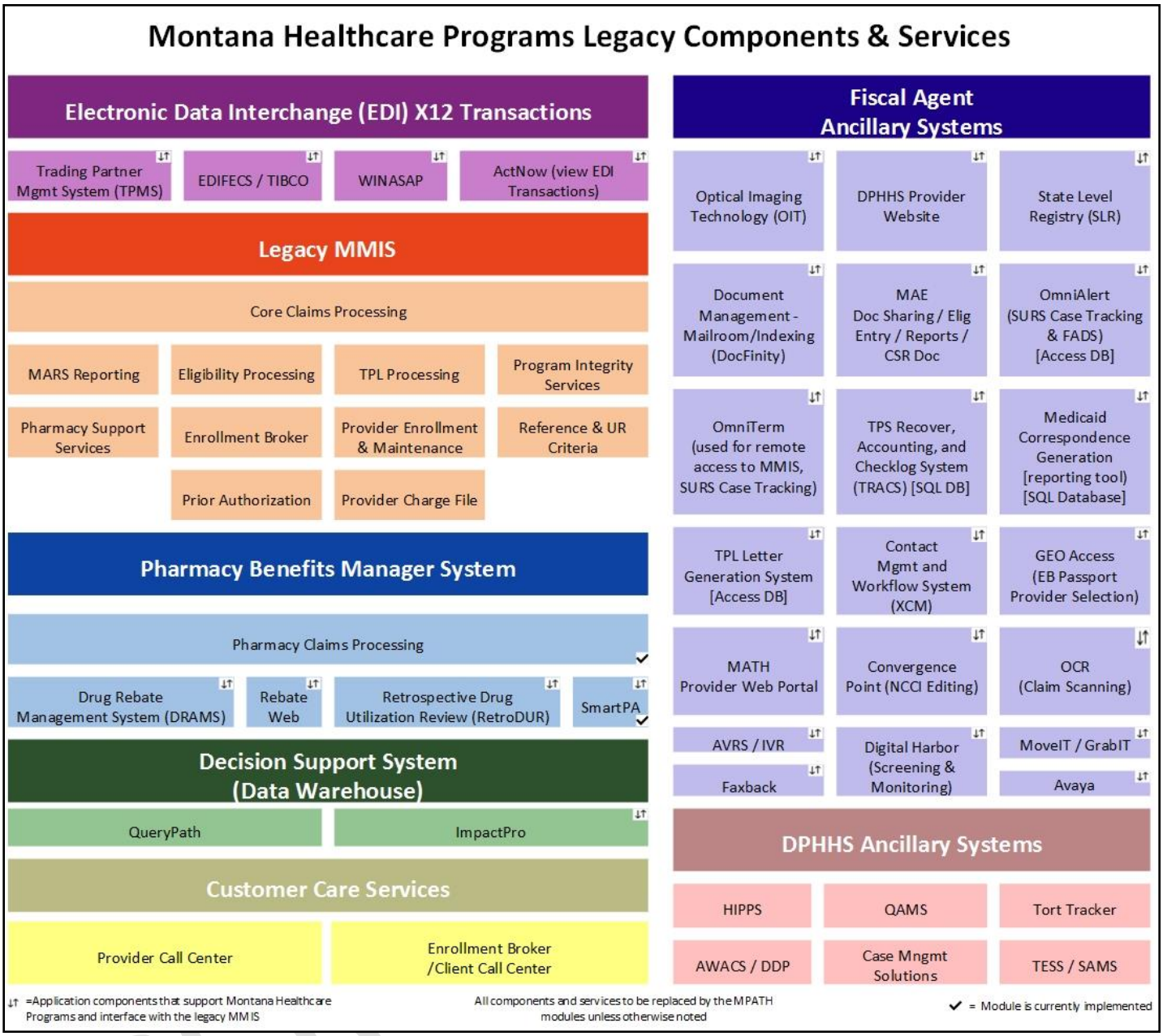
Montana's core MMIS system is a mainframe Custom Information Control System/Virtual Storage Access Method (CICS v3 r1.0/VSAM v4.2) and utilizes Common Business-Oriented Language (COBOL v4.2) legacy language that has been in operation since 1985. The MMIS was updated in 1997 and certified by CMS in 1998. Conduent is contracted with the State to provide fiscal agent operation services. The State has found it necessary to replace the current MMIS with more modern solutions and services due to the old technology and data integrity of the remaining legacy components. Ongoing system maintenance and enhancements are extensively delayed due to the dated technology and are further impeded by the limited number of knowledgeable resources familiar with the COBOL language.

In addition to the core MMIS, a number of other components are necessary to support Montana Healthcare Programs business objectives.

Figure 3.6.1 represents the current Montana Healthcare Programs environment.

Figure 3.6.1 Montana Healthcare Programs Legacy Components and Services

Montana Healthcare Programs Legacy Components & Services



3.6.2 Legacy Components and Services

Table 3.6.2 represents the approximate number of Montana Healthcare Programs Legacy Systems Users.

Table 3.6.2 Montana Healthcare Programs Legacy Systems Approximate Users Count by Component Group

Component	Users
Legacy MMIS	425
Pharmacy Claims Processing and Management	120
Legacy DSS	225
DPHHS Ancillary Legacy Systems	1855
Fiscal Agent Ancillary Legacy Systems	550

3.6.2.1 Electronic Data Interchange (EDI) X12 Transaction Components/Services

Trading Partner Management System

The Trading Partner Management System (TPMS) is the system that is used to create and manage the types of EDI transactions that trading partners have enrolled to submit and receive.

EDIFECS/TIBCO

EDIFECS/TIBCO is the software used to verify the information contained in EDI transactions meet the necessary requirements.

WINASAP

WINASAP5010 is free billing software offered to providers enrolled with Montana Healthcare Programs to create, and submit X12 compliant EDI claims transactions.

ACTNow

ActNow is software used by the customer care center to view and research EDI transactions.

3.6.2.2 Pharmacy Benefits Management System Components/Services

FlexibleRx

FlexibleRx, the Pharmacy Claims Processing and Management module is an on-line, real time pharmacy claims adjudication system. Today, FlexibleRx receives member eligibility and provider information from the legacy MMIS. Adjudicated claims are sent to the MMIS for payment generation to providers. FlexibleRx was implemented December 2015 as the first legacy replacement module within the Montana Healthcare Programs enterprise and was certified by the Centers for Medicare and Medicaid Services (CMS) on February 15, 2017.

Drug Rebate Analysis and Management System (DRAMS)

The Drug Rebate Analysis and Management System (DRAMS) is an application which calculates, invoices, and maintains records of rebate amounts paid for pharmacy claims and physician-injectable drugs to provide the necessary data for CMS for reporting on drug rebates

Rebate Web

Rebate Web is a web-based application where drug rebate invoices and associated standard file formats are uploaded for manufacturer drug rebate management.

Retrospective Drug Utilization Review

Retrospective Drug Utilization Review (RetroDUR) uses a member's drug utilization history to create a usage profile which is then used to help prevent instances of drug abuse, misuse, or fraud. This service is currently contracted to Mountain Pacific Quality Health.

Smart PA

SmartPA is a web based service that interfaces with the pharmacy claims processing system (FlexibleRx) and provides prior authorization validation services during adjudication for pharmacy claims.

3.6.2.3 Decision Support System Components/Services

Query Path

QueryPath is a secure web-based application used for ad hoc reporting and analysis of Montana Healthcare Programs data stored in the legacy data warehouse.

3.6.2.4 Customer Care Services

Provider Call Center

The provider call center are fiscal agent services contracted by DPHHS to assist providers with inquires related to enrollment, billing, member eligibility, claims and benefit limits.

Enrollment Broker/Member Call Center

The enrollment broker/member call center facilitates member enrollment into care management programs, assignment of a primary care provider/medical home, conducts outreach, and provides information and education to eligible Montana Healthcare Programs members. Additionally, this service performs provider enrollment outreach and education of the care management programs.

3.6.2.5 Fiscal Agent Ancillary Systems

Montana Access to Health Web Portal

Montana Access to Health (MATH) Web portal is a web based tool for providers to enroll with Montana Healthcare Programs, submit electronic claims, view remittance advices, check member eligibility, view claims based medical history, as well as other provider self-service activities.

Automated Voice Response/Integrated Voice Response System

The Automated Voice Response /Integrated Voice Response system (AVR/IVR) is a provider self-service tool used to verbally supply member eligibility information, provider payment and claims status.

FaxBack

Faxback is another provider self-service tool used to supply member eligibility information or claims status to providers via fax machine.

Avaya

Avaya is used by the current fiscal agent for automated call distribution and supports customer relationship management.

Digital Harbor

Digital Harbor is a tool used by the current fiscal agent to complete automated provider screening and monitoring activities required by the Affordable Care Act (ACA) for new provider enrollments, revalidating providers and monthly monitoring of all actively enrolled providers.

Optical Imaging Technology

Optical Imaging Technology (OIT) is used by the current fiscal agent to capture, store, and retrieve imaged documentation in electronic form that are stored in a document repository.

Optical Character Recognition

Optical Character Recognition (OCR) software is a tool used by fiscal agent resources to scan claims for automated input into the MMIS.

DPHHS Provider Website

The DPHHS Provider Website is a provider resource, administered by the current fiscal agent that houses provider manuals, fee schedules and notices. Additional resources include; claims and electronic billing

instructions, provider FAQs, training, program information, provider newsletter (Claim Jumper) as well as links to the MATH Web Portal and other helpful provider resource information.

DocFinity
DocFinity is used by the fiscal agent for document management which includes document scanning, indexing, searching and viewing.

Montana ACS Extranet
Montana ACS Extranet (MAE) is a secured website, hosted by the fiscal agent that provides a venue for DPHHS and the fiscal agent to view, exchange and store information including reports, reference documentation, formal correspondence and provider communication logs. MAE also serves as an eligibility entry portal for certain Montana Healthcare Programs. Customer service requests (CSRs) and file update requests (FURS) are also managed and stored in MAE.

OmniAlert
OmniAlert provides statistical peer group comparison as a tool to analyze behavior patterns of healthcare providers and members to investigate possible fraud, waste and abuse.

OmniTerm
OmniTerm is a terminal server used to obtain remote access to fiscal agent applications including SURS case tracking, MAE and the MMIS.

Third Party Recovery and Checklog System
The Third-Party Recovery and Checklog System (TRACS) is an SQL database used by the fiscal agent to manage recovery activities such as carrier billing, provider credit balances, member TPL verification work items and trauma letters.

Medicaid Correspondence Generation Tool
The Medicaid Correspondence Generation Tool is a SQL database used by the fiscal agent used to generate Montana Healthcare Programs correspondence to providers and members.

Third Party Liability Letter Generation Tool
The Third-Party Liability (TPL) Letter Generation System is an access database used to generate letters specifically for recovery activities, i.e., credit balance, trauma letters)

State Level Registry
State Level Registry (SLR) is an application used to administer the Electronic Health Record (EHR) provider incentive program.

Conduent Case Management
Conduent Case Management (CCM) is a cloud based workflow automation tool which is also used for contact management.

GEO Access
GEO Access is used by the MMIS Managed Care subsystem to geographically map providers who are near to a member's physical address.

MoveIT/GrabIT
MoveIT/Grab IT is used to provide secure file processing, storage and transfer.

Convergence Point
Convergence Point is the tool used for claim NCCI editing as a part of the claims adjudication process.

3.6.2.6 DPHHS Ancillary Systems

Health Insurance Premium Payment System
The Health Insurance Premium Payments System (HIPPS) is a tool used by DPHHS staff for evaluating and tracking health insurance premium payment activities.

Quality Assurance Management System (QAMS)
QAMS is used to track trends, medication errors, and reporting critical incidents.

Tort Tracker
The Tort Tracker is database utilized by DPHHS staff for third party liability recovery activities.

Agency Wide Accounting Client System (Developmental Disabilities Services)
The Agency Wide Accounting Client System (AWACS) is the system used by the waiver program for case management, budgeting, creating and maintaining member plans of care, invoicing, and early intervention services.

Case Management Solutions
DPHHS has a number of disparate case management solutions to support current waiver and member care management services.

Shortgrass – This system is used for overall case management, developing and maintaining plans of care, cost plans and waitlists for two waiver programs.
Therap – This system is used for incident reporting.

The Eligibility Screening System
The Eligibility Screening System (TESS) is used to perform eligibility entry for individuals covered under the Mental Health Services Plan state funded eligibility and Mental Health Services Crisis Stabilization Program.

Substance Abuse Management System
The Substance Abuse Management System (SAMS) is used to track substance abuse treatments and outcomes for Federal Reporting and provider payment.

Web Infrastructure for Treatment Services
Web Infrastructure for Treatment Services (WITS) is a web-based application used to collect reporting requirements and manage primary prevention programs for substance abuse prevention and treatment

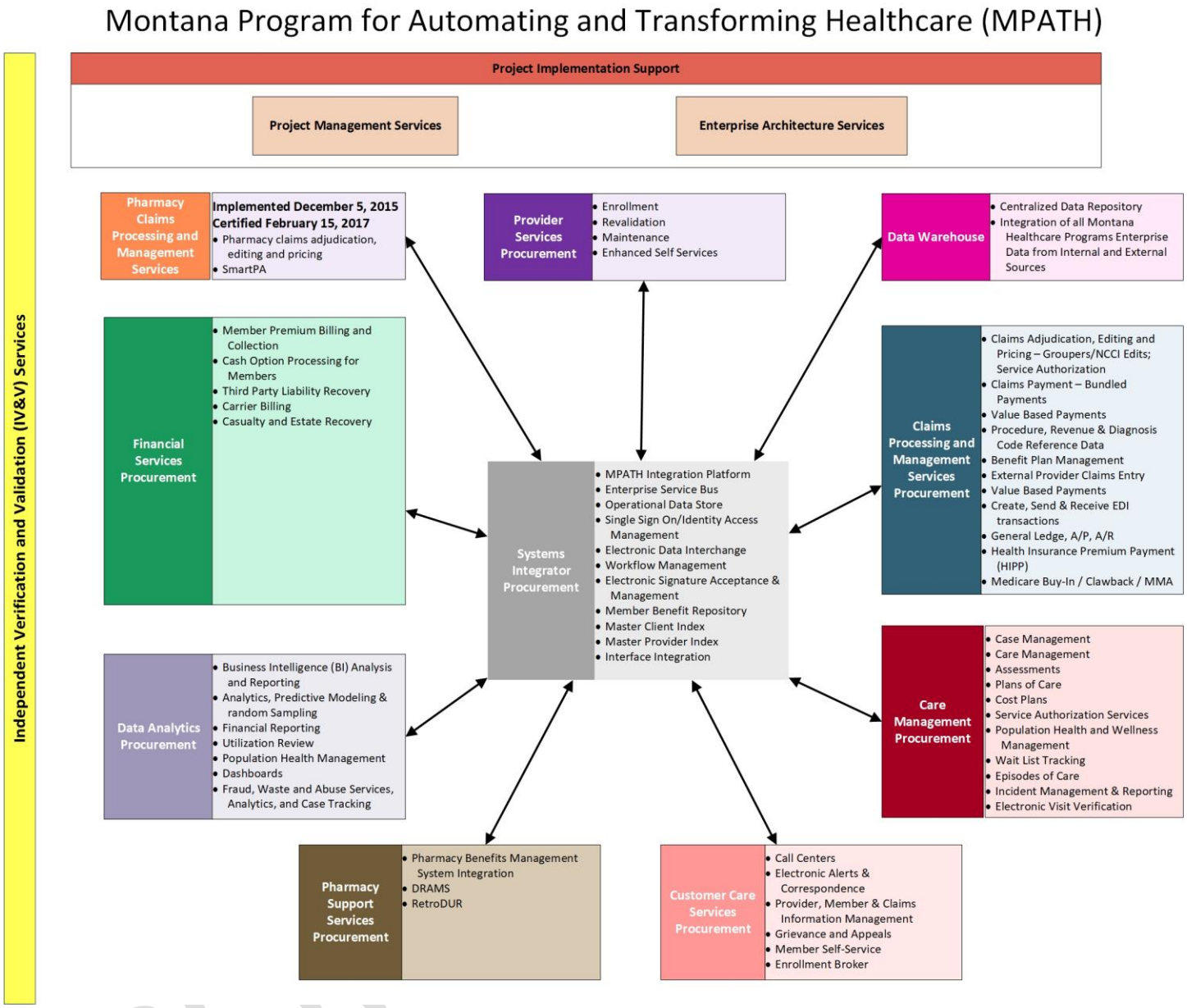
3.7 FUTURE MPATH ENVIRONMENT

The future MPATH environment will be an enterprise framework of integrated systems and services enabled by an enterprise services bus (ESB). The exact composition of the enterprise framework will evolve over time as existing legacy solutions are replaced with more modern, flexible solutions that better meet DPHHS' current and future business needs.

DPHHS will contract with multiple Contractors who will each provide a discrete set of components and/or services to support the MPATH modules and components. Each contractor will be responsible to operate and maintain its provided solution and will work with the Systems Integration Services Contractor to integrate the solution with rest of the MPATH Integration Platform.

Figure 3.7 below illustrates a high-level view of the to-be future MPATH Modularity Blueprint Environment.

Figure 3.7 Future MPATH Modularity Blueprint



3.8 STAKEHOLDERS AND GOVERNANCE

3.8.1 Governing Stakeholders

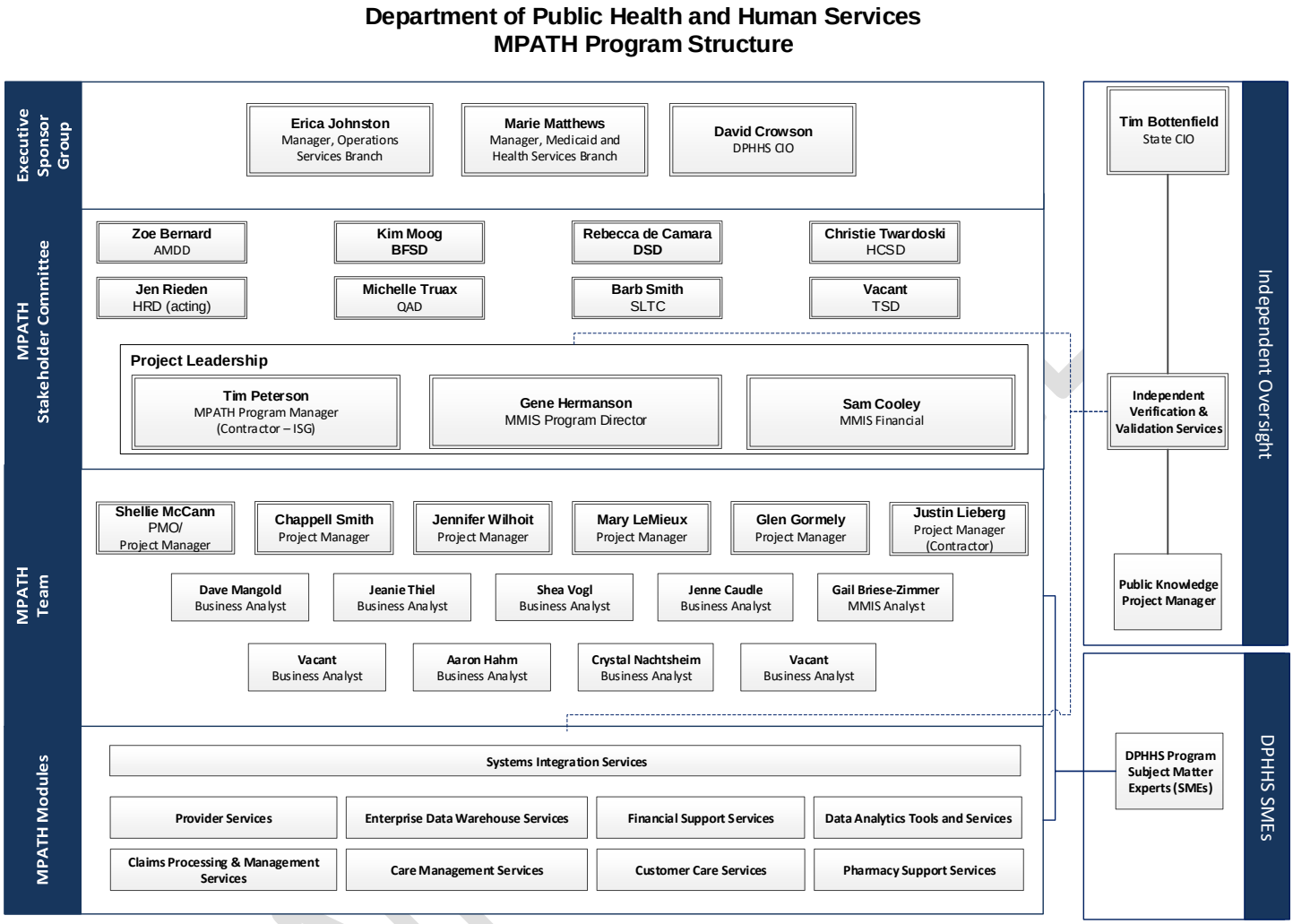
The following stakeholders will contribute to decisions guiding and impacting the MPATH Program:

Center for Medicare and Medicaid Services (CMS): CMS is the government entity responsible for authorizing enhanced federal funding for the design, development and installation or enhancement of a state's MMIS. The Mechanized Claims Processing and Information Retrieval Systems (90/10) Final Rule, effective January 1, 2016, expanded the definition of mechanized claims processing and information retrieval systems to include a "System of Systems". This "System of Systems" allows enhanced federal funding for installation or enhancement of open source software, proprietary software, services, shared services, module, COTS software, and Software as a Service (SaaS) that comprise a State's MMIS enterprise. The Contractor and DPHHS will work with CMS and comply with all regulations to ensure the combination of solutions are certified and meet all federal reporting requirements necessary to ensure CMS authorization of enhanced federal funding.

Department of Public Health and Human Services (DPHHS): DPHHS is responsible for the administration of Montana Healthcare Programs and for the administration and oversight of the MPATH modules and components. The following Divisions are directly involved in the MPATH Program.

- The Medicaid and Health Services Branch of DPHHS is responsible for contractual administration and Fiscal Agent management responsibilities.
- The Human and Community Services Division (HCSD) is responsible for Member eligibility determinations.
- The Business and Financial Services Division (BFSD) is responsible for the accounting and financial functions of Montana Healthcare Programs.
- The Health Resources Division (HRD) is responsible for overseeing and managing the Acute, Physician and Hospital programs. The care management, Healthy Montana Kids (HMK) and Montana Health and Economic Livelihood Partnership (HELP) programs are also located in this Division.
- The Senior and Long-Term Care Division (SLTC) is responsible for overseeing and managing the Nursing Facility Services and Home and Community Based Services programs.
- The Addictive and Mental Disorders Division (AMDD) is responsible for overseeing and managing the adult mental health, behavioral health, home and community services, and chemical dependency programs. The State funded MHSP is also located in this Division.
- The Quality Assurance Division (QAD) is responsible for all activities related to Program Integrity and third-party liability programs.
- The Disability Services Division (DSD) began reimbursing providers through the MMIS system for Waiver services in August 2019. DSD will be utilizing the new systems and services procured via the MMIS Replacement Program. This division is responsible for overseeing the Developmental Disability, HCBS waiver and the Children's Mental Health program.
- For additional information on the State programs and a DPHHS organization chart, please refer to the DPHHS website at https://dphhs.mt.gov/Portals/85/Documents/dphhsorganizationalchart.pdf

Table 3.8.1 MPATH Program Structure



Independent Oversight Stakeholder Group: The Independent Oversight group consists of the State CIO and their designee(s). This group administers the MPATH IV&V Contract to ensure that the IV&V service provider can deliver findings and recommendations to state and federal executive leadership and management without restriction, fear of retaliation, or coercion (e.g., reports being subject to prior review or approval from the development group before release to outside entities, such as the federal government).

Executive Sponsor Committee: The Executive Sponsor committee members include Marie Matthews, Manager of the Medicaid and Health Services Branch, David Crowson, DPHHS Chief Information Officer, and Erica Johnston, Operations Services Branch Manager. The committee's role is to make enterprise wide decisions regarding the modularity project, set priorities, provide recommendations and guidance, and monitor modularity project status and issues. The committee has been involved from project inception and planning phases and will continue to be involved through the final module implementation and the certification phase.

MPATH Stakeholder Committee: The MPATH Stakeholder Committee is made up of the division administrators from each DPHHS division and the MPATH Program leadership. The division administrators advise the MPATH Program Leadership on business requirements, program rules and policies. The Division administrators also ensure subject matter experts are available to MPATH DDI Team as necessary to provide detailed insight into specific processes or procedures.

MMIS Program Director: The MMIS Program Director, Gene Hermanson, administers the Medicaid modularity modernization effort, and will be a primary point of contact for contractual matters, in conjunction with the MPATH Program Manager. The MMIS Program Director provides program updates to the MPATH Stakeholder Committee members and supervises the program personnel in addition to the oversight and administration of the MMIS legacy contracts.

MPATH Program Manager: The MPATH Program Manager, Tim Peterson, coordinates each module project across the Montana Healthcare Programs Modularity Program. The MPATH Program manager monitors scope, schedule, issues, risks, issues and quality for all module specific projects. The MPATH Program Manager is responsible for reporting project status to the MMIS Program Director, the MPATH Stakeholder Committee and the Executive Sponsor Committee. The MPATH Program Manager will also oversee the Contract and will be a primary point of contact for contractual matters, in conjunction with the Medicaid Systems Operations Manager.

MPATH Program Management Office: The MPATH Program Management Office is comprised of the MMIS Program Director, MPATH Program Manager, the MPATH PMO Manager and the MPATH module Project Managers. The Program Management Office will meet regularly to review Program status, scope, schedule, issues, risks, and quality and will make recommendations to the DPHHS Stakeholder Committee and the Executive Sponsor Committee.

Project Governance Team: For each MPATH module there will be a project governance team comprised of the MMIS Program Director, the MPATH Program Manager, the MPATH PMO and the module specific Project Manager. The project governance team will meet regularly with the Contractor to review project status, scope, schedule, issues, risks, and quality and will make recommendations to the DPHHS Stakeholder Committee and the Executive Sponsor Committee. The project governance team will also be responsible for approving project deliverables and change requests.

MPATH Project Manager: For each MPATH module, a MPATH Project Manager will be designated by the MMIS Program Director to work with the module Contractor's project manager to coordinate DPHHS activities related to the project. The MPATH Project Manager will be responsible for day-to-day contract administration and ensuring compliance with the contract, monitoring scope, schedules, issues, risks and quality.

Lead Business Analyst: For each MPATH module, a lead business analyst will be designated by the Medicaid Systems Operations Manager and Program Manager to work with the Contractors to participate in requirements validation, solution review sessions and other project meetings. The Lead Business Analyst will be responsible for research and provide timely responses to Contractor inquiries and requests, completing deliverable reviews and conducting parallel and user acceptance testing.

Independent Validation and Verification (IV&V) Contractor: The State's IV&V Contractor, Public Knowledge LLC., is responsible for assessing project management methodologies and project execution and validates conformance of the product and project to RFP requirements and to the contract. The IV&V Contractor further assists the MPATH Program Management Office in monitoring project schedule, scope, quality, risk and completing MECT milestone reviews and Certification activities for each project.

3.8.2 Impacted Stakeholders

The following stakeholders will be directly impacted by the Montana Healthcare Programs Modularity Program:

Members: The MPATH Program will provide stakeholder-centric solutions that improve outcomes for Montana Healthcare Program members and provide timely and accurate communications to members.

Providers: The MPATH Program will provide stakeholder-centric solutions that enable providers to enroll in Montana Healthcare Programs, revalidate, and maintain their enrollment information, to submit claims, to

receive timely and accurate reimbursements, and to resolve inquiries through self-service tools where possible.

3.9 HIGH LEVEL SCOPE OF WORK

The Claims Processing and Management Services solution will replace and modernize Montana Healthcare Programs' claims processing functionality provided by the legacy MMIS. The solution will meet Montana's "to be" vision for flexible and configurable claims processing as well as other applicable MITA business areas, detailed in the MITA 3.0 State Self-Assessment found in the Procurement Library.

The solution will manage the receipt, adjudication, editing, pricing, payment, and reporting of claims, including but not limited to: physician, hospital, outpatient, nursing home, dental, vision, transportation, disability services, behavioral health (adult and children), and waiver services. Claims will be adjudicated in real-time and produce remittance advices. The solution must support a diverse set of reimbursement methodologies for fee-for-service and managed care organizations and apply those reimbursements appropriately based on simple and complex criteria. In addition, the solution will have the capability to track, display and report on all claims processing activity throughout the adjudication process, including reimbursement. The solution will be configurable and flexible to support claims processing to ensure accurate and timely processing and adjudication determinations based on benefit criteria and associated reference data defined within each plan.

The solution must be flexible, adaptable, and configurable to support enhancements, updates, and changes of increasing complexity required by Federal and State regulations and policy including, continuous improvement in business operations with transparency and accountability to ensure the system meets the system requirements and performance standards. In addition the solution must support all current and future HIPAA transactions and communication to providers.

The Claims Processing and Management Services solution procurement is a multi-state cooperative procurement initiative through NASPO ValuePoint. NASPO ValuePoint® is a cooperative purchasing program among states. This solicitation is managed by a multi-state Sourcing Team, led by Montana. Other sourcing team states include Georgia and Missouri. There is functionality within the Claims Processing and Management Services solution scope that is not required by every participating state. Therefore, Optional Services have been included to be priced separately which will allow each state to determine if the optional functionality and/or services should be included in their specific scope of work. If the Optional Services cannot be implemented with the Core Services without affecting the Core Services timeline, the State may consider adding an additional implementation phase to the Claims Processing and Management Services solution schedule. Below is a list of the Optional Services detailed further in Section 3.10. Requirements for the base Claims Processing and Management Services solution and Optional Services are also included in Attachment F – Requirements Response Matrix.

Option A: Financial:

- Fiscal Management
- Financial Reporting

Option B: Call Center

- Member and provider call center

Option C: Federal Reporting

- Federal Reporting

3.10 DETAILED SCOPE OF WORK

The Department of Public Health and Human Services (DPHHS) defined the scope of work stated in the Requirements Response Matrix which is included as Attachment F of this RFP. Attachment F requirements are Mandatory requirements and may only be changed through written approval of DPHHS and the Contractor. The requirements in section 3.10, unless otherwise noted, shall apply throughout the life of the Contract. Additionally, the Contractor's scope of work must be performed within the Offeror's proposed cost

for each project phase as defined in Attachment G – Pricing Schedules, Schedule B – DDI Payment Milestones.

3.10.1 Technical and Information Architecture Requirements

The Systems Integration Services Contractor, will establish the MPATH Integration Platform, and provide an inventory of Application Programming Interfaces (APIs) in addition to performing other systems integration services to fulfill the Technical and Informational Architecture requirements. Module Contractor(s) must work with the Systems Integration Services Contractor to integrate with the MPATH Integration Platform. The "to-be" technical architecture and supporting technology requirements for the MPATH modules and components are defined in Attachment F – Requirements Response Matrix.

3.10.1.1 Compliance

This section addresses compliance with state and federal statutes, policy, mandates as well as industry standards required for the Contractor's Scope of work. Offerors must describe how their solution, services and operational approach meet each of the Compliance requirements detailed in Attachment F – Requirements Response Matrix. In addition, the Contractor is required to demonstrate that their hosting solution is Statement on Standards for Attestation Engagements (SSAE-18) SOC 2 Type II compliant. The Offeror simply repeating the RFP requirements does not qualify as a good response as defined in Section 6.1.1 of this RFP.

3.10.1.2 Security

This section addresses security requirements for the Contractor's solution(s) and operations. Due to the nature of the information managed by the State, any event resulting in a potential loss of confidentiality, integrity and/or availability of government data is unacceptable. This section includes security requirements needed for applications used on mobile devices for online and offline functionality. Offerors must describe their approach to security and describe how proposed solution(s) meet each of the Security requirements detailed in Attachment F – Requirements Response Matrix. The Offeror simply repeating the RFP requirements does not qualify as a good response as defined in Section 6.1.1 of this RFP.

3.10.1.3 Hosting and Environments

This section addresses hosting and environment requirements. The Department expects the delivery of the solution/services to be seamless with the hosting environment providing the flexibility to integrate other solutions for security and regulatory purposes in the future, and be cost-effective and scalable. The Contractor is expected to provide a hosting environment for all solution components that has a Federal Risk and Authorization Management Program (FedRAMP) Certification, FedRAMP Risk Assessment that indicates compliance, or has a documented NIST 800-53 rev 4 at a "moderate" system risk assessment designation. In addition, the Contractor is required to demonstrate that their hosting solution is Statement on Standards for Attestation Engagements (SSAE-18) SOC 2 Type II compliant.

In their response, the Offeror must describe their approach to solutions and services that meets State and federal regulations and hosting requirements detailed in Attachment F – Requirements Response Matrix. The Offeror simply repeating the RFP requirements does not qualify as a good response as defined in Section 6.1.1 of this RFP.

3.10.1.4 Integration

This section addresses integration requirements. The Claims Processing and Management Services solution will be required to integrate with the MPATH Integration Platform and third-party care management solutions. The MPATH Integration Platform, administered by the Systems Integration Services Contractor, will enable interactions between MPATH modules via an Enterprise Services Bus (ESB), bidirectional interfaces, data imports and data exports. The Claims Processing and Management Services Solution Contractor must ensure all service endpoints/APIs are clearly defined, exposed to the ESB and be able to receive and submit messages through the ESB to facilitate standardized data exchanges throughout the MPATH Integration Platform. The Offeror must describe their approach to meet each of the integration

requirements detailed in Attachment F – Requirements Response Matrix. The Offeror simply repeating the RFP requirements does not qualify as a good response as defined in Section 6.1.1 of this RFP.

3.10.1.4.1 Integration Service Type Definition

These definitions are critical in defining the various types of integrations that the Claims Processing and Management Services Contractor will be required to perform throughout the life of the MPATH project. These type definitions will also serve as the bases for the fixed hour amounts that the Department will require each Offeror to provide for each Integration Service Type definition (see Attachment G – Pricing Schedules – Schedule J – Integration Service Types).

The Department has outlined five discrete Integration Service Types below, to describe the distinct types/levels of integration services required to support module integration. The Contractor will use the Integration Services Type definitions below to provide a fixed number of hours (i.e. level of effort) for each Integration Services Type. For each unique Service Integration required to support MPATH integration needs (e.g., the integration of a module, Montana Healthcare Enterprise component, or outside entities) the Department and the Contractor will mutually agree on the appropriate Integration Service Type for each unique integration service request. The Department will require the Contractor to identify the hour breakdown for each Integration Services Type by resource type necessary to implement services.

The following sections outline scope of services for each integration service type.

3.10.1.4.1.1 Major Integration Service

A major service involves some combination of significant adaptor data transformation/translation development, complex orchestration, frequent communications, high number of business process steps, significant performance requirements, multiple shared data stores, technical conformance requirements, or significant failure handling requirements.

3.10.1.4.1.2 Complex Integration Service

A complex service involves some combination of simple adaptor data transformation/translation development or difficult transformations, detailed orchestration, frequent communications, a moderately high number of business process steps, significant performance requirements, multiple shared data stores, technical conformance requirements, or significant failure handling requirements.

3.10.1.4.1.3 Standard Integration Service

A standard service involves some combination of moderate transformation development, simple orchestration, regular interval communications, a moderate number of business process steps, straight forward performance requirements, several shared data stores, well defined and supported technical conformance requirements, or limited failure handling requirements.

3.10.1.4.1.4 Simple Integration Service

A simple service involves some combination of simple transformation development, simple orchestration, infrequent communications, a small number of business process steps, straight forward performance requirements, few shared data stores, well defined and supported technical conformance requirements, or limited failure handling requirements.

3.10.1.4.1.5 Onboarding Integration Service

Onboarding is the effort to configure a pre-built integration service for use with no modifications to service components. The Onboarding Integration service includes tasks from inception through implementation, (e.g., access configuration, testing, implementation and documentation).

3.10.1.4.1.2 DDI Requisitioned Integration Services Pool

The DDI Requisitioned Integration Services Pool is a bucket of hours to be used during the DDI phase to provide integration services to support the exchange of information between modules. The Offeror will be required to propose a fixed dollar estimate for the hours in the DDI Requisitioned Integration Services Pool.

The DDI Requisitioned Integration Services Pool will provide the Department the hour equivalent of XX Major Services, 25 Complex Services, 10 Standard Services, 5 Simple Services, 25 Onboarding Services. The actual number of integration services to be provided by the DDI Requisitioned Integration Services Pool will be dependent on the composition of integration services and the mutually agreed upon category designation (defined in Sections 3.10.1.4.1.1 through 3.10.1.4.1.5), for each required service integration. The actual composition of services required from the DDI Requisitioned Integration Services Pool will be based on what is required to integrate the actual modules and will likely differ from the predefined Integration Services Type quantities used to establish the pool (e.g., based on the total hours available in the pool, the eventual composition of integrated services may be 30 Complex Services, 5 Standard Services, 6 Simple Services and 18 Onboarding Services).

The DDI Requisitioned Integration Service Pool will be used to develop new Integration Services for the Claims Processing and Management Services module with outside entities or to onboard new components using an existing Integration Services.

The Claims Processing and Management Services Contractor will develop an interface control document (ICD). The Department and the Contractor mutually agree upon Integration Services Type. Construction work can begin following the Department's approval of the ICD. Each integration service, once approved by the Department, will be a deliverable during the DDI phase. Upon delivery and Department acceptance of each unique integration service, the Contractor will be reimbursed the Integration Service hours for the service at the DDI Requisitioned Integration Services Pool Average Hourly Rate defined in Attachment G – Pricing Schedules, Schedule K – DDI Requisitioned Integration Services Pool Hours and Cost.

The Contractor will not be guaranteed to be paid the DDI Requisitioned Integration Services Pool cost. The Contractor will only be paid for the hours the Department approves to be used from this pool. If upon completion of the DDI phase, DDI Requisitioned Integration Services Pool hours remain, at the Department's discretion, all unused DDI Requisitioned Integration Services Pool hours and cost for DDI will:

a) be rolled over to the System Enhancement Pool for Operations; or
b) be reduced from the Contract along with the unused dollars.

Section 5 Cost Proposal, details how the Integration Service Types will be used to develop Attachment G – Pricing Schedules, Schedule K – DDI Requisitioned Integration Services Pool Hours and Cost.

3.10.1.5 Data Management

Data management within the Offeror's proposed solution and operational data management policies must at a minimum meet HIPAA, HITECH, ARRA and other federal and state privacy and security requirements as they exist on the release date of this RFP and be configurable to assist in meeting future requirements. The Offeror must describe their approach to meeting each of the Data Management and Data Services requirements detailed in Attachment F – Requirements Response Matrix. The Offeror simply repeating the RFP requirements does not qualify as a good response as defined in Section 6.1.1 of this RFP.

3.10.1.6 Interfaces

This section addresses interface requirements. The Contractor's Application Program Interfaces (APIs) and components must comply with industry standards (e.g., National Information Exchange Model (NIEM), National Institute of Standards and Technology (NIST) and HIPAA compliance standards). In their response, the Offeror must describe current methods of electronic data exchange, detail the industry standard formats currently used and describe any proprietary formats used. The Claims Processing and Management solution will be required to receive, process, and store data from provider's third-party case management solutions using a standard format provided by the Claims Processing and Management contractor and approved by the Department. The Offeror must also describe their approach to meet each of the interface requirements detailed in Attachment F – Requirements Response Matrix and in Attachment XX. The Offeror

simply repeating the RFP requirements does not qualify as a good response as defined in Section 6.1.1 of this RFP.

3.10.1.7 Business Rules
This section addresses Business Rule requirements for the Contractor's solution(s) and operations. The Contractor shall describe the proposed solution's capacity to configure, support and maintain business rules (i.e., add, modify, or remove/retire rules) and the type of resource and necessary skill set(s) required for business rule configuration. Describe the change management processes associated with business rule configuration. In addition, the Offeror must describe their approach to meet each of the Business Rules requirements detailed in Attachment F – Requirements Response Matrix. The Offeror simply repeating the RFP requirements does not qualify as a good response as defined in Section 6.1.1 of this RFP.

3.10.1.8 Correspondence Management
This section addresses Correspondence Management requirements for the Contractor's solution(s) and operations. The Contractor's correspondence engine shall be configured to generate enterprise correspondence and coordinate the print and distribution through a State approved print and mail service. The Contractor's solution will need to be able to generate approval and denial notices for service authorizations. The Contractor must describe the proposed solution's capacity to configure, support and maintain correspondence management functionality (i.e., add, modify, or remove correspondence) and the type of resource and necessary skill set(s) required for correspondence management functions. Describe the change management processes associated with correspondence management. In addition, the Offeror must describe their approach to meet each of the Correspondence Management requirements detailed in Attachment F – Requirements Response Matrix.

3.10.1.9 Enterprise Content Management
This section addresses Enterprise Content Management requirements for the Contractor's solution(s) and operations. The MPATH Integration Platform will include a centralized enterprise content management solution. The Contractor's solution will be required to send all documentation to the MPATH Integration Platform for storage in the centralized enterprise content management solution. The Contractor shall describe the proposed solution's capacity to configure, support and maintain an enterprise content management solution and the type of resource and necessary skill set(s) required for enterprise content management and configuration. Describe the change management processes associated with enterprise content management. In addition, the Offeror must describe their approach to meet each of the Enterprise Content Management requirements detailed in Attachment F, Requirements Matrix.

3.10.1.10 Workflow
This section addresses Workflow requirements for the Contractor's solution(s) and operations. The MPATH Integration Platform will exchange data with all MPATH components to support enterprise wide automated business process orchestration. The Contractor's solution shall include a configurable workflow solution for process definition, execution, monitoring, and management. The Contractor shall describe the proposed solution's capacity to configure, support and maintain a workflow solution (i.e., add, modify, or remove/retire existing workflow configurations) and the type of resource and necessary skill set(s) required for workflow management. Describe the change management processes associated with workflow management. In addition, the Offeror must describe their approach to meet each of the Workflow requirements detailed in Attachment F, Requirements Matrix.

3.10.2 Project Management and System Development Requirements

The Contractor will be expected to apply proven project management and system development methodologies to the initial implementation of the proposed solution and to each subsequent enhancement or iteration of the solution.

DPHHS does not require a particular project management or system development methodology. The Offeror must propose an approach that will satisfy the scope of work and incorporate all activities required,

or their conceptual equivalent. The Contractor will be expected to adjust the project management approach or project schedules, as necessary, to collaborate with the Systems Integration Services Contractor and other contractors in order to incrementally build the MPATH modules and components. In addition, DPHHS will require the coordination of efforts among its staff and all contractors, as no single contractor can perform its required responsibilities without coordination and cooperation with the other contractors. The selected contractors shall maintain communication with other contractors and DPHHS management and staff as necessary to meet its responsibilities that pertain to this RFP's scope of work.

3.10.2.1 Project Management
The Contractor shall submit in their response, a high-level project schedule that represents the overall implementation timeline of their proposed solution. The high-level schedule must include key dependencies and all phases of the project from project initiation and kick-off through certification of the system (approximately one year following the implementation of all DDI Contract requirements). The Contractor must adhere to the Project Management Institute (PMI) or similar industry-standard project management standards and approach throughout the Contract term and will be required to deliver a Project Management Plan and Project Work Plan in addition to other project planning deliverables. The offer must describe their approach to meet each of the Project Management requirements defined in Attachment F – Requirements Response Matrix. The Offeror simply repeating the RFP requirements does not qualify as a good response as defined in Section 6.1.1 of this RFP.

3.10.2.2 System Development Methodology
The Contractor will be expected to follow an industry-standard systems development methodology for the initial implementation of the proposed solution and throughout the Contract term. The project management deliverables, activities, and nonfunctional requirements are required regardless of the Contractor proposed system development methodology, unless agreed upon and managed through the change management process. The Offeror must propose a System Development Methodology approach that achieves the expected outcomes of the SDLC-based activities stated below.

3.10.2.3 Requirements Management
The Contractor must work with the DPHHS MPATH Team and other DPHHS business owners to confirm the Contractor's understanding of the RFP requirements and to reconcile the RFP requirements for the scope of work against the proposed solution. The Offeror must describe their approach to meet each of the Requirements Management requirements detailed in Attachment F – Requirements Response Matrix. The Offeror simply repeating the RFP requirements does not qualify as a good response as defined in Section 6.1.1 of this RFP.

3.10.2.4 Data Conversion, Cleansing and Migration
Data conversion, cleansing, and migration activities required to support the scope of work contained in this RFP include planning, identifying and analyzing conversion specifications, testing, execution and coordination of all data and file conversion, migration and data cleansing processes. Data conversion often encounters risks and issues related to the complexities in defining the relationship between source and target data structures, differences in the data required for processing between legacy and new systems and the historical changes to processing requirements and valid codes that may result in data inconsistencies and missing data conditions.

Active and historical data will need to be converted from several source systems, (e.g., MMIS, SAMS, Mediregs). The Offeror must describe their approach to meet each of the detailed data conversion, cleansing and migration requirements defined in Attachment F – Requirements Response Matrix. The Offeror simply repeating the RFP requirements does not qualify as a good response as defined in Section 6.1.1 of this RFP.

3.10.2.5 Design, Configuration, and Build
The Contractor shall undertake activities to resolve gaps between the RFP requirements and the proposed solution. Once designs have been approved by DPHHS, the Contractor shall configure and/or customize the

solution based on the desired business outcomes. The Offeror must describe their approach to meet each of the Design, Configuration, and Build requirements defined in Attachment F – Requirements Response Matrix. The Offeror simply repeating the RFP requirements does not qualify as a good response as defined in Section 6.1.1 of this RFP.

3.10.2.6 Testing

Testing is a critical component for successful implementation of any system configuration/development effort, therefore, in depth, process driven, fully documented testing processes are required for all implementations and configuration changes within the Montana Healthcare Programs enterprise. The testing activities shall include planning, managing and executing a comprehensive testing effort to include unit, system, regression, parallel, integration and UAT.

Prior to implementing a new release, the Contractor is responsible for ensuring that all required tests are performed and evidence that each component meets or exceeds all relevant functional, technical, security, and performance requirements is provided. The Offeror must describe their approach to meet each of the detailed testing requirements defined in Attachment F – Requirements Response Matrix. The Offeror simply repeating the RFP requirements does not qualify as a good response as defined in Section 6.1.1 of this RFP.

3.10.2.7 Training

The Contractor shall provide training staff to develop, organize, lead, and conduct training and education activities (e.g., provider and Agency staff training) as defined by the Agency. The Contractor must provide training to achieve an understanding of the new system, services, or release. Additionally, the Contractor must provide initial and ongoing training on the Claims Processing and Management solution. The training should be configurable for diverse groups of users based on their role (e.g., administration, State staff, providers). Users must become proficient in using and viewing information in the Contractor's solution in order to ensure effective and efficient business operations and service delivery. The Offeror must describe their approach to meet each of the detailed training requirements defined in Attachment F – Requirements Response Matrix. The Offeror simply repeating the RFP requirements does not qualify as a good response as defined in Section 6.1.1 of this RFP.

3.10.2.8 Implementation and Acceptance

Prior to implementation, the Contractor must demonstrate readiness to implement the solution and to provide operational support and maintenance of the proposed solution(s) for the remainder of the Contract term. The Contractor is responsible for managing the end-to-end implementation of the proposed solution. DPHHS expects the Contractor to help formulate strategies for a successful transition.

DPHHS must formally approve the implementation of the solution based on pre-defined acceptance criteria. DPHHS's acceptance of the solution will initiate the Operations, Maintenance and Configuration phase of the contract. The Offeror must describe their approach to meet each of the implementation and acceptance requirements defined in Attachment F – Requirements Response Matrix. The Offeror simply repeating the RFP requirements does not qualify as a good response as defined in Section 6.1.1 of this RFP.

3.10.3 Certification

The Contractor must work with DPHHS and other contractors as necessary to ensure that all solutions provided by the Contractor meet requirements specified in the Mechanized Claims Processing and Information Retrieval Systems (90/10) Final Rule (CMS 2392-F) and relevant federal certification requirements as described in the most current version of the MECT Toolkit available at https://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/mect.html.

The Contractor will be responsible for providing and maintaining a solution that meets all applicable checklist items in the most current version of the Medicaid Enterprise Certification Toolkit (MECT), and supporting the review and validation of those items by the Department, IV&V Contractor, and CMS. The Contractor must become knowledgeable of all MECT-related items associated with the solution offered. The

MECT Mapping document, found as Attachment D, contains the MECT 2.3 checklist items applicable to the Contractor's scope of work, mapped to the associated business requirements. The Department is using the MECT Module checklists.

The Contractor must provide staff and other resources to support and to participate in MECT milestone reviews and other Certification activities that occur before, during and after implementation of the proposed solution(s). The Offeror must describe their approach to meet each of the Certification requirements defined in Attachment F – Requirements Response Matrix. The Offeror simply repeating the RFP requirements does not qualify as a good response as defined in Section 6.1.1 of this RFP.

3.10.4 Operations, Maintenance, and Configuration

The Contractor shall provide Operations support, Maintenance, and ongoing Configuration of the provided Solution(s) throughout the life of the Contract. This includes providing Operations support as described in the scope of work as well as providing Maintenance and Enhancements to the provided Solution(s). The Contractor will follow project management and system development processes throughout the life of the Contract. The Offeror must describe their approach to meet each of the Operations, Maintenance, and Configuration requirements defined in Attachment F – Requirements Response Matrix. The Offeror simply repeating the RFP requirements does not qualify as a good response as defined in Section 6.1.1 of this RFP.

3.10.4.1 Maintenance and System Enhancements

Throughout the life of the contract there are two distinct classifications of work that all MPATH Module Contractors will perform maintenance and system enhancements.

3.10.4.1.1 Maintenance

DPHHS defines maintenance for each MPATH module as follows:

1. Making configuration updates as requested by DPHHS. Configuration includes changes to table values, parameters, codes, and business logic, including hardcoded business logic.
2. Correcting deficiencies (defects) found in the solution(s) based on detailed requirements described in the scope of work and published design specifications.
3. Correcting deficiencies (defects) found in the solution(s) based on a failure to meet the detailed requirements in completed enhancement, configuration or maintenance requests.
4. Conducting research requested by DPHHS or required to support the Department. For example:
    a. System behavior and results
    b. New healthcare initiatives
    c. Best practices research across states and industry
    d. Impacts of new State and federal legislation
5. Performing mass adjustments or mass changes as requested by DPHHS or required to support Montana Healthcare Programs (for example, errors in pricing, eligibility, cost share, and financial code assignments, TPL discovery, and provider reimbursement changes).
6. Performing regular maintenance as needed by DPHHS required to support Montana Healthcare Programs. Examples of maintenance include but are not limited to:
    a. Performance optimization
    b. Database management
    c. Software, hardware, and tools (e.g., patches, upgrades, and replacement).
    d. Interface, report, and correspondence changes.
    e. Making corrections or changes to maintain the integrity of the system or the data within it (e.g., backing out changes, correcting duplicate records, cleansing corrupt data, adding security measures, adding redundancy).
7. Using appropriate testing, configuration, and change control procedures.
8. Updating system, user, and training documentation and online help to reflect changes that have been made to the solution.

9. Performing the activities above to maintain customizations implemented as part of an approved enhancement.

If incremental integration can be handled using configuration, the integration will fall under the definition of maintenance, if the incremental integration requires system development and testing efforts the integration will fall under the definition of enhancement.

All maintenance activities will be performed at no additional cost to the State in the Contractor's response. The Contractor will be required, at no additional cost, to add resources necessary to complete all activities by the required due date. Maintenance activities and any associated hours will not be applied to the system enhancement hourly pool.

3.10.4.1.2 System Enhancements

DPHHS defines systems enhancements as follows:

1. System enhancements exclude any activities defined in "Maintenance" above.
2. New features or functionality that fall outside the scope of all RFP requirements, Offeror's RFP response, the contract, or agreements of any supplemental negotiations.

The State must approve both the design and level of effort prior to the start of development or configuration for system enhancements. DPHHS must approve any changes to the design or level of effort that occur after the original approval. The level of effort billed cannot exceed the level of effort approved by DPHHS. During DDI, any approved system enhancements will be priced based at the rates defined in Attachment G – Pricing Schedules, Schedule E – Resource Hourly Rates.

The Contractor must provide an estimate of any impact to annual operations cost, for the enhancement during the operations phase of the Contract if applicable. Reimbursements for any additional operations costs must be addressed in a contract amendment.

3.10.4.1.2.1 System Enhancement Pool

DPHHS recognizes that enhancements to the solution may be required periodically throughout the life of the contract to meet mandated Federal or State rules or regulations or to provide increased efficiency in operations or promote cost savings. The Contractor will add resources as necessary to complete enhancements by the required due date.

3.10.4.1.2.2 System Enhancement Pool for DDI Base Scope of Work

The Contractor will provide 7,500 system enhancement pool hours for the duration of the DDI phase of the contract. The cost of these 7,500 system enhancement pool hours are included in the offeror's fixed price and included in Attachment G – Pricing Schedules and Schedule D – Enhancement Pool Hours. The System Enhancement Pool for DDI includes personnel cost for all resources supporting the system enhancement effort.

The unused system enhancement pool hours for DDI will be rolled over to the system enhancement pool for Operations or the number or system enhancement pool hours may be adjusted downward, at the discretion of the State. Any reduction in the number of system enhancement pool hours for DDI will require one month notification by the State, and the cost of the contract will be reduced proportional to the cost of the reduction in system enhancement pool hours eliminated using the rates provided in Attachment G – Pricing Schedules and Schedule D –Enhancement Pool Hours.

3.10.4.1.2.3 System Enhancement Pool for DDI Option A Scope of Work

The Contractor will provide 3,000 system enhancement pool hours for the duration of the DDI phase of the contract for the Option A Scope of Work. The cost of these 3,000 system enhancement pool hours are included in the offeror's fixed price and included in Schedule D-Enhancement Pool Hours. The System Enhancement Pool for DDI includes personnel cost for all resources supporting the system enhancement effort.

The unused system enhancement pool hours for DDI will be rolled over to the system enhancement pool for Operations or the number or system enhancement pool hours may be adjusted downward, at the discretion of the State. Any reduction in the number of system enhancement pool hours for DDI will require one-month notification by the State, and the cost of the contract will be reduced proportional to the cost of the reduction in system enhancement pool hours eliminated using the rates provided in Attachment G, Provider Pricing Schedules, Schedule D-Enhancement Pool Hours.

3.10.4.1.2.4 System Enhancement Pool for DDI Option B Scope of Work
The Contractor will provide 3,000 system enhancement pool hours for the duration of the DDI phase of the contract for the Option B Scope of Work. The cost of these 3,000 system enhancement pool hours are included in the offeror's fixed price and included in Schedule D-Enhancement Pool Hours. The System Enhancement Pool for DDI includes personnel cost for all resources supporting the system enhancement effort.

The unused system enhancement pool hours for DDI will be rolled over to the system enhancement pool for Operations or the number or system enhancement pool hours may be adjusted downward, at the discretion of the State. Any reduction in the number of system enhancement pool hours for DDI will require one-month notification by the State, and the cost of the contract will be reduced proportional to the cost of the reduction in system enhancement pool hours eliminated using the rates provided in Attachment G, Provider Pricing Schedules, Schedule D-Enhancement Pool Hours.

3.10.4.1.2.5 System Enhancement Pool for DDI Option C Scope of Work
The Contractor will provide 3,000 system enhancement pool hours for the duration of the DDI phase of the contract for the Option B Scope of Work. The cost of these 3,000 system enhancement pool hours are included in the offeror's fixed price and included in Schedule D-Enhancement Pool Hours. The System Enhancement Pool for DDI includes personnel cost for all resources supporting the system enhancement effort.

The unused system enhancement pool hours for DDI will be rolled over to the system enhancement pool for Operations or the number or system enhancement pool hours may be adjusted downward, at the discretion of the State. Any reduction in the number of system enhancement pool hours for DDI will require one-month notification by the State, and the cost of the contract will be reduced proportional to the cost of the reduction in system enhancement pool hours eliminated using the rates provided in Attachment G, Provider Pricing Schedules, Schedule D-Enhancement Pool Hours.

3.10.4.1.2.6 System Enhancement Pool for Operations Core Scope of Work
The Contractor will provide 4,000 system enhancement pool hours during the Operations phase per operations year. The cost of these annual 4,000 system enhancement pool hours are included in the Offeror's fixed price and included in Schedule D – Enhancement Pool Hours. The System Enhancement Pool includes personnel cost for all staff supporting the system enhancement effort.

The level of effort incurred to complete an enhancement will be applied to the System Enhancement Pool once the enhancement is implemented and approved by the Department. If the level of effort exceeds the System Enhancement Pool hours remaining, the Department may choose to utilize hours from the next Contract operations year or have the Contractor invoice the Department for the balance at the rates defined in Attachment G – Pricing Schedules, Schedule E – Resource Hourly Rates.

Unused system enhancement pool hours for each year of operations may be rolled forward to the next operations year or the number of system enhancement pool hours may be adjusted downward, at the discretion of the State. Any reduction in the number of system enhancement pool hours for operations will require a one month notification by the State, and the cost of the contract will be reduced proportional to the cost of the reduction in system enhancement pool hours eliminated using the rates provided in Attachment G, Pricing Schedule D – Enhancement Pool Hours. The cost of the Contract will

be reduced proportional to the cost of the unused hours using the rates provided in Pricing Schedule D – Enhancement Pool Hours.

3.10.4.1.2.7 System Enhancement Pool for Operations Option A Scope of Work
The Contractor will provide 2,000 system enhancement pool hours during the Operations phase per operations year for the Option A Scope of Work. The cost of these annual 2,000 system enhancement pool hours are included in the Offeror's fixed price and included in Schedule D-Enhancement Pool Hours. The System Enhancement Pool includes personnel cost for all staff supporting the system enhancement effort.

Unused system enhancement pool hours for each year of operations may be rolled forward to the next operations year or the number of system enhancement pool hours may be adjusted downward, at the discretion of the State. Any reduction in the number of system enhancement pool hours for operations will require a one month notification by the State, and the cost of the contract will be reduced proportional to the cost of the reduction in system enhancement pool hours eliminated using the rates provided in Attachment G, Provider Pricing Schedules, Schedule D – Enhancement Pool Hours. The cost of the contract will be reduced proportional to the cost of the unused hours using the rates provided in Attachment G, Provider Pricing, Schedule D – Enhancement Pool Hours.

3.10.4.1.2.8 System Enhancement Pool for Operations Option B Scope of Work
The Contractor will provide 2,000 system enhancement pool hours during the Operations phase per operations year for the Option B Scope of Work. The cost of these annual 2,000 system enhancement pool hours are included in the Offeror's fixed price and included in Schedule D-Enhancement Pool Hours. The System Enhancement Pool includes personnel cost for all staff supporting the system enhancement effort.

Unused system enhancement pool hours for each year of operations may be rolled forward to the next operations year or the number of system enhancement pool hours may be adjusted downward, at the discretion of the State. Any reduction in the number of system enhancement pool hours for operations will require a one month notification by the State, and the cost of the contract will be reduced proportional to the cost of the reduction in system enhancement pool hours eliminated using the rates provided in Attachment G, Provider Pricing Schedules, Schedule D – Enhancement Pool Hours. The cost of the contract will be reduced proportional to the cost of the unused hours using the rates provided in Attachment G, Provider Pricing, Schedule D – Enhancement Pool Hours.

3.10.4.1.2.9 System Enhancement Pool for Operations Option C Scope of Work
The Contractor will provide 2,000 system enhancement pool hours during the Operations phase per operations year for the Option B Scope of Work. The cost of these annual 2,000 system enhancement pool hours are included in the Offeror's fixed price and included in Schedule D-Enhancement Pool Hours. The System Enhancement Pool includes personnel cost for all staff supporting the system enhancement effort.

Unused system enhancement pool hours for each year of operations may be rolled forward to the next operations year or the number of system enhancement pool hours may be adjusted downward, at the discretion of the State. Any reduction in the number of system enhancement pool hours for operations will require a one month notification by the State, and the cost of the contract will be reduced proportional to the cost of the reduction in system enhancement pool hours eliminated using the rates provided in Attachment G, Provider Pricing Schedules, Schedule D – Enhancement Pool Hours. The cost of the contract will be reduced proportional to the cost of the unused hours using the rates provided in Attachment G, Provider Pricing, Schedule D – Enhancement Pool Hours.

3.10.5 Key Personnel and Resources

The Offeror must provide key personnel to be assigned to the DDI and Certification phases of the project. At a minimum, key personnel shall include a Project Manager, Systems Manager, Contract Manager, Claims Manager, Testing Lead, Integration Lead and a Certification Lead. DPHHS will review and approve all key personnel.

The Contractor shall provide the defined key personnel of Project Manager, Operations Manager, Systems Manager, Claims Manager, Technical Manager, and a Contract Manager for the Operations, Maintenance and Configuration phase of the project. The Contractor must identify other key personnel for the Operations, Maintenance and Configuration phase of the project. The Department will review and approve all key personnel.

For all phases of the Project, the Offeror's Project Manager will be required to perform work at the Primary Project location (local Agency) unless approved by DPHHS to work remotely. Other Offeror staff working remotely, must be available to work in Helena, Montana at the Department's request for functions necessary to support the scope of work (e.g., risk review meetings, root cause analysis sessions, integration planning, release planning, operational readiness reviews, UAT, implementation, and production deployment). For any work performed at a location other than the Helena, Montana, the Offeror must identify the specific location (city, state, country), describe the type of work to be performed, and the percent of the total hours for that type of work at that location.

The Offeror must propose a staffing approach to meet each of the requirements detailed in Attachment F – Requirements Response Matrix. The Offeror simply repeating the RFP requirements does not qualify as a good response as defined in Section 6.1.1 of this RFP.

3.10.5.1 Resource Allocation Schedules

Offerors must complete the Resource Allocation Schedules provided in Attachment H – Resource Allocation Schedules. These schedules serve as the representation of Offeror's plan for staffing the project by resource type. Offeror should include additional information as necessary to explain the Offeror's resource allocation. If the Offeror has one or more subcontractors, the Offeror must submit a Schedule A and Schedule B with a comprehensive total for all FTE and hours representing the effort of the prime contractor and all subcontractor work in total. In addition, a separate Schedule A and Schedule B for each contractor (prime contractor and subcontractor) must be submitted.

Table 3.10.5.1 Resource Allocation Schedules (These schedules are provided in Attachment H – Resource Allocation Schedules).

List of Resource Allocation Schedules	
Schedule	**Title**
Schedule A - Core	Number of Full Time Equivalent
Schedule B - Core	Number of Hours
Schedule A Option A	Number of Full Time Equivalent
Schedule B Option A	Number of Hours
Schedule A Option B	Number of Full Time Equivalent
Schedule B Option B	Number of Hours
Schedule A Option C	Number of Full Time Equivalent
Schedule B Option C	Number of Hours

All schedules must be completed in full at the time of submittal. The resource types listed in the schedule are not exhaustive, nor should the Contractor assume that DPHHS is requesting resources from each category. Use any resource type listed above and/or add resource types necessary to successfully deliver the scope of work.

Schedule A: This schedule details the number of full time equivalents the Offeror plans to allocate to the project by phase and by resource type.

Schedule B: This schedule details the number of resource hours the Offeror plans to allocate to the project by phase and by resource type.

3.10.6 Project Closeout and Turnover

At least twelve months prior to the end of the contract, the Contractor will provide an initial turnover plan to detail how the Contractor will manage the completion and closure of all work for the Contract and deliver project artifacts, including deliverables, data, and anything needed to operate and maintain the integrity of the Montana Healthcare Programs and systems.

Transition activities will be dependent upon the nature of the solution or services, which may include but is not limited to:

- State Owned and Contractor hosted
- State Leased software hosted by a third party
- Software as a Services (SaaS)

The Contractor must demonstrate that all contractual requirements have been met, transition operational tasks to a new Contractor and/or DPHHS completed, and provide lessons learned from the project prior to the end of the contract term. The Offeror must describe their approach to meet each of the Project Closeout and Turnover requirements defined in Attachment F – Requirements Response Matrix. The Offeror simply repeating the RFP requirements does not qualify as a good response as defined in Section 6.1.1 of this RFP.

3.10.7 Project Deliverables and Documentation

The documentation deliverables outlined in Table 3.10.7 have been identified for this scope of work. If the successful offeror provides a Commercial Off The Shelf(COTS)/Software-as-a-Service (SaaS) solution, DPHHS will review the list of required deliverables and may remove or modify the deliverable requirements to reflect a COTS or SaaS implementation approach. COTS or SaaS contractors will still be required to provide all documentation required for MECT certification. COTS or SaaS contractors will still be required to provide all documentation required for MECT certification. For each documentation deliverable, the Contractor shall follow the guidelines outlined in the Documentation Standards document in the Procurement Library in eMACS. The Contractor will submit documents that meet the specific deliverable acceptance criteria as outlined in the Deliverable Expectation Document for the specific deliverable. All deliverables must be approved by DPHHS. Project artifacts and information will be shared on the CMS Reuse Repository. The Offeror must describe their approach to meet each of the Documentation requirements defined in Attachment F – Requirements Response Matrix. The Offeror simply repeating the RFP requirements does not qualify as a good response as defined in Section 6.1.1 of this RFP.

Table 3.10.7 Documentation Deliverables

Deliverable	Delivery and Update Frequency	Requirement Number	Deliverables Expectations Document Required?
Business Rules Catalog	Project initiation, procurement of each MPATH module and updates as necessary	BR03	Yes
Certification Crosswalk	As scheduled in approved PWP, updates as necessary	CERT01	Yes

Deliverable	Delivery and Update Frequency	Requirement Number	Deliverables Expectations Document Required?
Data Dictionary	As scheduled in approved PWP, updates as necessary	DM11	Yes
Conceptual Data Model	As scheduled in approved PWP, updates as necessary	DM55	Yes
System Security Plan	As scheduled in approved PWP, updates as necessary	DOC01	Yes
Certification Plan	As scheduled in approved PWP, updates as necessary	DOC02	Yes
Data Management, Conversion, and Migration Plan	As scheduled in approved PWP, updates as necessary	DOC03	Yes
Application, Configuration, and Maintenance Plan	As scheduled in approved PWP, updates as necessary	DOC04	Yes
User Documentation	Project initiation, updates as necessary	DOC07	Yes
Business Continuity and Disaster Recovery Plan	As scheduled in approved PWP, annually	DOC08, DOC09, DOC10	Yes
Operations, Maintenance and Configuration Plan	As scheduled in approved PWP, updates as necessary	DOC12	Yes
Module Implementation Plan	As scheduled in approved PWP, updates as necessary	DOC13	Yes
System Design Documentation	As scheduled in approved PWP, updates as necessary	DOC14	Yes
Communication Plan	As scheduled in approved PWP, updates as necessary	DOC15	Yes
Quality Management Plan	As scheduled in approved PWP, updates as necessary	DOC16	Yes
Change Management Plan	As scheduled in approved PWP, updates as necessary	DOC18	Yes
Technical Documentation	Project initiation, updates as necessary	DOC19	Yes
Solution Architecture Document	As scheduled in approved PWP, updates as necessary	DOC21	Yes
Defect Management Plan	As scheduled in approved PWP, updates as necessary	DOC22	Yes

Deliverable	Delivery and Update Frequency	Requirement Number	Deliverables Expectations Document Required?
Staffing Plan	As scheduled in approved PWP, updates as necessary	DOC24	Yes
Master Test Plan	As scheduled in approved PWP, updates as necessary	DOC26	Yes
Training Plan	As scheduled in approved PWP, updates as necessary	DOC27	Yes
System Test Plan	As scheduled in approved PWP, updates as necessary	DOC28	Yes
System Documentation	Project initiation, updates as necessary	DOC29	Yes
Turnover Plan	12 months prior to final Contract year	DOC37	Yes
Risk Management Plan	As scheduled in approved PWP, updates as necessary	DOC38	Yes
Issue Management Plan	As scheduled in approved PWP, updates as necessary	DOC40	Yes
Operations Procedure Manual	As scheduled in approved PWP, updates as necessary	DOC42	Yes
Attachment L – Technology Matrix	Upon initial proposal, annually	DOC44	No
User Interface Style Guide	As scheduled in approved PWP, updates as necessary	DOC46	Yes
Implementation Letter	As scheduled in approved PWP	IA01	No
Operational Readiness Test Results	As scheduled in approved PWP date	IA04	Yes
Operational Readiness Review Checklist	As scheduled in approved PWP date	IA06	Yes
Interface Control Documents (ICD)	As scheduled in approved PWP, updates as necessary	INR07	Yes
Personnel Background Check Attestation	As necessary	KR19	No
Disaster Recovery/Business Continuity Test Report	Annual	OMC03	Yes

Deliverable	Delivery and Update Frequency	Requirement Number	Deliverables Expectations Document Required?
Deliverable Review and Acceptance Process	Project initiation, updates as necessary	PMT15	Yes
Monthly Status Report	Monthly	PMT17	No
Project Management Plan	As scheduled in approved PWP, updates as necessary	PMT18	Yes
System Enhancement Pool Report	Monthly	PMT29	Yes
Project Work Plan	Project initiation, updates as approved.	PMT36	No
Updated Turnover Plan	6 months prior to final Contract year	PTO02	No
Monthly Turnover Report	Monthly, during Turnover Period	PTO03	Yes
Turnover Results Report	Upon completion of turnover activities	PTO07	Yes
Requirements Traceability Matrix (RTM)	As scheduled in approved PWP, updates as necessary	RQM06	Yes
Risk Assessments	Annually and As Needed	SEC11	Yes
Penetration Test Report	Annual and 6 months prior to implementation	SEC15	Yes
Security Audit Report	Annually on September 30	SEC22	No
CMS Information Security Program Plan of Action and Milestones (POA&MS)	Conditional upon security risk assessment findings	SEC55	No
Privacy Impact Analysis	As scheduled in the approved PWP, updated annually	SEC68	No
Service Organizational Control (SOC) 1 Type II Reports	Annually	SEC73	No
Subcontractor Usage Report	Annual	SUB05	Yes
Integration Test Results	As scheduled in approved PWP, updates as necessary	TEST04	Yes
Parallel Test Results	As scheduled in approved PWP, updates as necessary	TEST04	Yes

Deliverable	Delivery and Update Frequency	Requirement Number	Deliverables Expectations Document Required?
Performance Test Results	As scheduled in approved PWP, updates as necessary	TEST04	Yes
Regression Test Results	As scheduled in approved PWP, updates as necessary	TEST04	Yes
System Test Results	As scheduled in approved PWP, updates as necessary	TEST04	Yes

3.10.8 Performance Standards

Performance requirements are defined in Attachment F – Requirements Response Matrix. Performance standards (Service Level Agreements), including associated liquidated damages for unmet standards are defined in Attachment J – Service Level Agreements. The Department will defer the enforcement of Operational Performance Standards until the first full month that begins 60 calendar days following the System Acceptance by the Department of the production implementation of the Claims Processing and Management solution. This one-time deferral does not apply to software deployments or releases that follow the initial production implementation (e.g., major/minor implementations, patches, fixes, or maintenance releases). In their response, the Offeror must describe their approach to meet the Performance requirements defined in Attachment F – Requirements Response Matrix and Performance Standards (Service Level Agreements) in Attachment J – Service Level Agreements. The Offeror simply repeating the RFP requirements does not qualify as a good response as defined in Section 6.1.1 of this RFP.

3.10.9 Subcontractors

The highest scoring Offeror will be the Prime Contractor if a contract is awarded and shall be responsible, in total, including for all work of any subcontractors. Nothing contained within this document or any contract documents created as a result of any contract awards derived from this RFP shall create any contractual relationships between any subcontractor and the State. The Offeror must describe their approach to meet the Subcontractor requirements defined in Attachment F – Requirements Response Matrix. The Offeror simply repeating the RFP requirements does not qualify as a good response as defined in Section 6.1.1 of this RFP.

3.10.10 Edits, Processing, and Adjustments

This section addresses claims editing, processing, and adjustment requirements. The solution will adjudicate all claims transactions and apply edits based on configurable business rules (e.g., duplicate, history, bundling, procedure, service limit(s), accumulators such as dollar and units limits reached monthly, annual, and lifetime, diagnosis codes, procedure code relationships, service authorizations, age, gender, eligibility, provider type, specialty, and category of service, and NCCI editing). The solution will have configurable claim transaction adjustment processes with automated and ad-hoc functions to support retroactive rate changes, procedure or diagnosis code revisions, benefit plan updates, and audit activities. The Offeror must describe their approach to meet each of the Edits, Processing, and Adjustments requirements defined in Attachment F – Requirements Response Matrix. The Offeror simply repeating the RFP requirements does not qualify as a good response as defined in Section 6.1.1 of this RFP.

3.10.11 Pricing and Payment

This section addresses claims pricing and payment requirements. The solution will accurately calculate and price using applicable reimbursement methodologies for services, including but not limited to, fee for service, percent-of-charges, Resource-Based Relative Value Scale (RBRVS), Diagnosis Related Groups (DRG), Ambulatory Payment Classification (APC), Prospective Payment System (PPS), Relative Value for Dentists (RVD), laboratory and x-ray services, and negotiated rates including encounter and capitation fees.

The solution must also be flexible to meet future needs, new regulations, and innovations with the ability to model proposed changes to identify impact and risk. The Offeror must describe their approach to meet each of the Pricing and Payment requirements defined in Attachment F – Requirements Response Matrix. The Offeror simply repeating the RFP requirements does not qualify as a good response as defined in Section 6.1.1 of this RFP.

3.10.12 Benefit and Reference Data Management

This section addresses requirements related to benefit and reference data management. The solution will have the capability to store and manage benefit plans and support a variety of pricing methodologies, and provider contracts with the flexibility to support multiple payers and financial management processes. In support of claims adjudication, this solution will also process against service authorizations, third party insurance liability, and calculate member liabilities including cost share and cost share coordination between multiple payers. The solution will provide and maintain configurable reference data to support complex business rules utilized for claim adjudication. The Offeror must describe their approach to meet each of the Benefit and Reference Data Management requirements defined in Attachment F – Requirements Response Matrix. The Offeror simply repeating the RFP requirements does not qualify as a good response as defined in Section 6.1.1 of this RFP.

3.10.13 Claims Data and Reporting

This section addresses requirements related to reporting claims data. The solution will include sophisticated configurable automated and ad-hoc reporting functionality based on current and historical medical and non-medical transaction data including claims (paid, pending, and denied), rate updates, and provider payment. These reports and analyses will be used to inform State and Federal reporting and support the information requirements necessary for the evaluation, comparison, and management of claims. The Offeror must describe their approach to meet each of the Claims Data and Reporting requirements defined in Attachment F – Requirements Response Matrix. The Offeror simply repeating the RFP requirements does not qualify as a good response as defined in Section 6.1.1 of this RFP.

3.10.14 System Administration and Operations

This section addresses requirements related to the overall operations of the claims solution. The solution will act as the Electronic Data Interchange (EDI) gateway to process all inbound and outbound HIPAA mandated X12 compliant transactions and Trading Partner management.

In addition, the solution must provide a self-service portal with enhanced web-based capabilities to support the following:

- on-line real-time transactions processing and direct data entry for claims
- claim status inquiry
- batch upload, download, view and print HIPAA transactions
- submission and retrieval of documents
- secure messaging
- help-desk functions.

The System Administration and Operations section also includes requirements for change management including the creation of tickets and tracking of requests through implementation. The offeror must describe how the solution will be continuously maintained, enhanced, and modified to ensure compliance with new Federal and state regulations and mandates, healthcare delivery models, and to support interoperability with all other data sharing entities. The Offeror must describe their approach to meet each of the System Administration and Operations requirements defined in Attachment F – Requirements Response Matrix. The Offeror simply repeating the RFP requirements does not qualify as a good response as defined in Section 6.1.1 of this RFP.

3.10.15 Service Authorizations

This section addresses authorization requirements. The Claims Processing and Management Services solution needs to include functionality for both service authorizations and referrals. This functionality will be used by state staff, case managers, providers, and contractors. This functionality must be configurable to meet the needs of diverse programs (e.g., physical and behavioral health). Service authorizations are used to allow for specific services, track utilization, and monitor outcomes. The Claims Processing and Management solution will also create, update, and send referrals from primary care providers to other providers (e.g., specialty providers), as well as, from state staff to contractors. The Offeror must describe in their response their approach to meet each of the Authorization requirements defined in Attachment F – Requirements Response Matrix. The Offeror simply repeating the RFP requirements does not qualify as a good response as defined in Section 6.1.1 of this RFP.

3.10.16 Option A: Financial

Option A: Financial includes requirements to support Agency-wide integrated financial management to support accounts payable, accounts receivable, and general ledger functions that is compliant with Generally Accepted Accounting Principles (GAAP) and facilitates Federal and State financial reporting.

3.10.16.1 Fiscal Management

This section also outlines the requirements necessary to meet overall fiscal management business processes. The solution will allow data required for financial business processes to be entered manually, received from other sources, or automatically generated based on a configurable business rules engine. Data received from other systems will be translated into consistent financial account coding to report back to the state's financial system. The transactions are translated into summary level data and detailed data. Financial information (e.g., FMAP, fund code) is assigned to each healthcare claim and financial transaction at the line and header level. Accounts payable and receivable will be associated with an entity with flexibility in payment schedules. Adjustments will be generated to change financial information assigned to a healthcare or financial claim as appropriate. These adjustments generate corrected financial information without requiring the claims be re-adjudicated.

3.10.16.2 Financial Reporting

This section outlines the requirements necessary to meet financial reporting requirements. The solution must have the capability for a user to view all financial transactions related to one payee, drill down to the details (e.g., remittance advice, accounts receivable, recoupments, recoveries, etc.), and create configurable reports. Information will be captured and shared for required state and federal processes. The Offeror must describe their approach to meet each of the Option A Financial requirements defined in Attachment F, Requirements Matrix. The Offeror simply repeating the RFP requirements does not qualify as a good response as defined in Section 6.1.1 of this RFP.

3.10.17 Option B. Call Center

Option B includes requirements that detail how the solution will provide Call Center management functionality to field provider and member inquiries through telephone, secure email, and text chat and perform a wide range of activities to support efficient access to services for a diverse population. The solution will provide sophisticated automated workflow processes and integrated interactive voice response capabilities.

3.10.17.1 Member and Provider Call Center

This section outlines the requirements necessary to meet call center functionality for providers and members. The call center solution must assist providers and billing agents with general billing questions, research and provide resolution advice for claims transactions, and verify member eligibility and benefit verification including service limits, service authorization, third party liability, and cost-share. Additionally, the solution shall support quality improvement activities including administering provider satisfaction surveys or collecting data necessary for performance measurement of Call Center staff.

This section also outlines the requirements necessary to meet call center functionality for members. The call center solution must assist members with claims-related inquiries including claims adjudication and payment status. The Offeror must describe their approach to meet each of the Member Call Center requirements defined in Attachment F, Requirements Matrix. If the Contractor chooses to include these services in their proposal the Contractor must describe in their response, their approach to meet the Option B requirements detailed in Attachment F, Requirements Matrix. The Offeror simply repeating the RFP requirements does not qualify as a good response as defined in Section 6.1.1 of this RFP.

3.10.18 Option C. Federal Reporting

The solution will provide comprehensive Federal Reporting functionality, including receiving and storing data and generating reports, to satisfy a state's reporting Federal requirements.

3.10.18.1 Federal Reporting

This section outlines the requirements necessary to meet Federal reporting in compliance with applicable guidelines. The solution must collect, group, and analyze data to generate all applicable federal reports and processes (e.g., CMS64, CMS21, CMS416, CMS 372, TMSIS, PERM). The Offeror must describe their approach to meet each of the Federal Reporting requirements defined in Attachment F, Requirements Response Matrix. The Offeror simply repeating the RFP requirements does not qualify as a good response as defined in Section 6.1.1 of this RFP.

SECTION 4: OFFEROR QUALIFICATIONS

All subsections of Section 4 require a response. The Offeror must indicate certification of understanding for Sections and the offeror must restate the subsection number and the text immediately prior to your written response.

4.1 STATE'S RIGHT TO INVESTIGATE AND REJECT

The State may make such investigations as deemed necessary to determine the Offeror's ability to provide the supplies and or perform the services specified. The State reserves the right to reject a proposal if the information submitted by, or investigation of, the Offeror fails to satisfy the State's determination that the Offeror is properly qualified to perform the obligations of the contract. *This includes the State's ability to reject the proposal based on negative references.*

4.2 OFFEROR QUALIFICATIONS

To enable the State to determine the capabilities of an Offeror to provide the services specified in the RFP, the Offeror shall respond to the following regarding its ability to meet the State's requirements. **THE RESPONSE, "(OFFEROR'S NAME) UNDERSTANDS AND WILL COMPLY," IS NOT APPROPRIATE FOR THIS SECTION.**

NOTE: Each item must be thoroughly addressed. Offerors taking exception to any requirements listed in this section may be found nonresponsive or be subject to point deductions.

For the purposes of Offeror Qualifications, the Offeror must include company information, references, financial information, and other qualification information and materials for the entity that will be the actual Contracting Entity. For example: if corporation XYZ chooses to bid, and it plans to have its wholly owned affiliate ABC sign the contract, the proposal must include references, qualifications, financial and other reference information for the ABC affiliate. XYZ can also submit qualification material from XYZ Corporation but it won't be considered in evaluating the actual Contracting Entity.

4.2.1 References

Offeror shall provide a minimum of 3 (three) references that are currently using or have previously used products and/or services of the type proposed in this RFP. The references may include state governments, universities, or comparable private sector projects for whom the Offeror, within the last 5 (five) years, has successfully implemented scope similar in nature to the MPATH Claims Processing and Management Services scope of work. At a minimum, the Offeror shall provide the company name, location where the products and/or services were provided, contact person(s), contact telephone number, e-mail address, and a complete description of the products and/or services provided, and dates of service. These references will be contacted to verify Offeror's ability to perform the contract. The State reserves the right to use any information or additional references deemed necessary to establish the ability of the Offeror to perform the contract. Negative references or the inability to contact the reference may be grounds for proposal disqualification. Provide the information above for each proposed subcontractor.

4.2.2 Company Profile and Experience

Offeror shall provide documentation establishing the individual or company submitting the proposal has the qualifications and experience to provide the supplies and/or services specified in this RFP, including, at a minimum:

- a detailed description of any similar past projects, including the product/service type and dates the products and/or services were provided;
- the client for whom the services were provided; and

- a general description of the company including its primary source of business, organizational structure and size, number of employees, years of experience performing services similar to those described within this RFP;
- Provide the information above for each proposed subcontractor.

4.2.3 Resumes

A resume or summary of qualifications, work experience, education, and skills must be provided for all key personnel, including any subcontractors, who will be performing any aspects of the contract. Include years of experience providing services similar to those required; education; and certifications where applicable. Identify what role each person would fulfill in performing work identified in this RFP.

4.2.4 Offeror Financial Stability

Offerors shall demonstrate their financial stability to supply, install, and/or support the services specified by: (1) providing annual financial statements, preferably audited (for publicly traded companies), audited financial statements (for privately held companies), or unaudited financial statements and tax returns (for privately held companies for which audited statements are not available), for the three consecutive years immediately preceding the issuance of this RFP. If an Offeror does not have three (3) years of such documentation, it shall submit the documentation that it does have going back no more than three Offeror fiscal years; and (2) providing copies of any quarterly financial statements that have been prepared since the end of the period reported by its most recent annual report. If financial statements aren't publicly available, Offeror must meet the requirements of Sections 2.3.1 and 2.3.2 to have the information kept confidential.

4.2.5 Oral Presentation/Product Demonstration/Interview

Offerors selected to participate in product demonstrations/interviews will be notified by the State in advance. For planning purposes, the State will submit an agenda and specific guidance as deemed appropriate to promote productive and efficient product demonstrations. The Offeror is expected to demonstrate and answer questions on the products and/or services outlined in the Offeror's proposal to meet the requirements of this RFP. It is required that the Contractor have a demonstration environment that is comprised of the proposed solution components that are currently operating in a production environment. Product Demonstrations/Interviews will be scheduled for all Offerors who received an 80% or higher score on the technical proposal.

Offerors will be required to bring certain key personnel to the product demonstrations/interviews. At a minimum, the following key staff are expected to be present. Offerors are welcome to bring additional staff at their discretion.

1. Project Manager
2. Operations Manager
3. Claims Manager
4. Systems Manager
5. Contract Manager
6. Testing Lead
7. Integration Lead
8. Certification Lead

4.2.6 Equal Pay for Montana Women

Executive Order No. 12-2016 promoting equal pay for Montana women directs the Department of Administration to include incentives in the RFP process for contractors who engage in best practices to promote wage transparency. These best practices include the following:

(a) posting salary ranges in employment listings;
(b) certifying that the contractor will not ask about wage history in employee interviews; and
(c) certifying that the contractor will not retaliate or discriminate against employees who discuss or disclose their wages in the workplace.

☐ No, I do not agree.

Company Name (Clearly Printed): _____
Authorized Signature: _____
Date: _____

Statement of Compliance with Equal Pay for Montana Women. Offeror indicating it will comply with Executive Order No. 12-2016 will receive 5% of the total points available. Offerors who do not comply will not receive the available points. Offerors are required to sign and upload a PDF copy of this certification with their proposal to certify compliance.

☐ Yes, I agree and will comply with the best practices to promote wage transparency outlined in Executive Order No. 12-2016.

Company Name (Clearly Printed): _____
Authorized Signature: _____
Date: _____

4.2.7 Disclosure of Dark Money Spending

By Executive Order entities seeking to do business with the State of Montana must disclose contributions or expenditures they have made in Montana elections. A copy of the Executive Order can be found at http://sfsd.mt.gov/Portals/24/SPB/Dark%20Money/EO-15-2018_Disclosure%20Requirement.pdf?ver=2019-04-25-124741-437.

All vendors must complete the declaration form in eMACShttp://sfsd.mt.gov/Portals/24/SPB/Dark%20Money/EO_DECLARATION%20FORM_04102019.pdf?ver=2019-04-25-124741-453

Those vendors who mark “yes” on the declaration form, will be required to submit a disclosure form. http://sfsd.mt.gov/Portals/24/SPB/Dark%20Money/dark_Money_Disclosure_Template.xlsm

SECTION 5: COST PROPOSAL

All subsections of Section 5 require a response. The Offeror must indicate certification of understanding for the Section and the Offeror must restate the subsection number and the text immediately prior to the written response.

5.1 ESTIMATED BUDGET

DPHHS has established the following estimated budget amount for the Claims Processing and Management Services module. This estimate is based on the amounts approved in the DPHHS modularity I-APD but the estimated budget does not represent a budgeted amount for Option A, Option B or Option C Services or a maximum budget for Claims Processing and Management Services. Table 5.1 outlines the Claims Processing and Management Services module estimated budget:

Table 5.1 Estimated Claims Services Module Budget by Phase and Duration

Phase	Duration in Months	Total Amount
DDI, Integration, Implementation, and Certification	28	$20,275,225
Operations and Maintenance (Base Years)	44	$44,000,000
Operations and Maintenance (Optional Years)	48	$50,400,000
System Enhancement Hours (7,500 DDI Hours)		$937,500
System Enhancement Hours (4,000 *8 Operations years)		$4,000,000
Total Estimated Budget		$119,612,725

5.2 PRICE SCHEDULES

In order to give Offerors more flexibility in their pricing, the overall cost proposal was constructed using a two-variable approach:

A) Fee for Service Annual Spend per State: A five (5) tier scale based using ten years of historical Fee for Service annual spending for every State. Attachment N offers a detailed table of the range of every Tier (See Table 5.2.1 below). States will select their appropriate Tier using the XXXX totals from the CMS-64 and the XXXX totals from the CMS-21 for the previously completed Federal Reporting prior to the date of the Participating Addendum.

Table 5.2.1 Claims Processing and Management Services Fee for Service Spend Tiers (2018)

Claims Pricing Tiers			
Claims Pricing Tier	**Lower Limit**	**Higher Limit**	**Range Spend**
Tier 1	$ 0	$ 1,499,999,999	$ 1,499,999,999
Tier 2	$ 1,500,000,000	$ 3,499,999,999	$ 2,000,000,000
Tier 3	$ 3,500,000,000	$ 6,499,999,999	$ 3,000,000,000
Tier 4	$ 6,500,000,000	$ 13,999,999,999	$ 7,500,000,000
Tier 5	$ 14,000,000,000	+	infinite

Total Number of Members per State: a seven (7) group scale based on the number of active de-duplicated Members served by each State across healthcare programs was created within each one of the five Fee for service tiers. To further expand the difference between how a Offeror will use the Tier/Group, please observe the table 5.2.2 below:

Table 5.2.2 Groups (Member Range)

Groups (Member Range)							
	0-249,999	250K – 399,999	400K – 899,999	900K – 1,349,000	1.35M – 1,799,999	1.8M – 3,999,999	4M +
Tier 1	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	Group 7
Tier 2	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	Group 7
Tier 3	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	Group 7
Tier 4	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	Group 7
Tier 5	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	Group 7

The combination of “Tier” based on the Fee for Service annual spend and “Group” number of Members being served by each State provides the Contractor additional flexibility to tailor the cost to the size and scale of the states in their cost proposal.

The Table 5.2.3 below presents a count of how many States are in each Tier and Group based on 2018 figures.

Table 5.2.3 Count of States per Tier/Group

Count of State/ Territory	**Groups**							
Tiers	**Group 1**	**Group 2**	**Group 3**	**Group 4**	**Group 5**	**Group 6**	**Group 7**	**Grand Total**
Tier 1	6	5	1					**12**
Tier 2	2	3	3	2	2			**12**
Tier 3			3	5	3	2		**13**
Tier 4			2	2	2	4	1	**11**
Tier 5							3	**3**
Grand Total	**8**	**8**	**9**	**9**	**7**	**6**	**4**	**51**

Attachment G – Pricing Schedules is comprised of five 5 workbooks, one for each Tier. Each workbook represents a tier derived from the Total Fee for Services Spend per State. Offerors must complete all the Price Schedules for each of the five tier workbooks provided in Attachment G. Offerors shall propose a firm fixed price for each of the fields contained on the pricing schedules. These schedules serve as the representation of Offeror's price. Offeror should include additional information, if requested, to explain the Offeror's price. No cost information shall be included in the technical proposal. All schedules must be completed in full at the time of submittal. The Offeror’s complete cost proposal shall be represented in

Attachment G –Pricing Schedules and includes the costs for the items included in Attachment L - Technology Matrix.

The requirements and schedules are detailed in Table 5.2.4 Pricing Schedule List:

Table 5.2.4 Pricing Schedule List (These schedules are provided in Attachment G, Pricing Schedules).

List of Schedules	
Schedule	**Title**
Schedule A	Cost Summary
Schedule B** • Schedule B-1 • Schedule B-2 • Schedule B-3 • Schedule B-4 • Schedule B-5	DDI Payment Milestone by Phase • Claims Services Core Scope of Work Claims Solution Installation for Agency • Claims Services Core Scope of Work Design Development & Implementation (DDI) Payment Milestones By Phase • Claims Services Option A Scope of Work Design, Development and Implementation (DDI) Payment Milestones By Phase • Claims Services Option B Scope of Work Design, Development and Implementation (DDI) Payment Milestones By Phase • Claims Services Option C Scope of Work Design, Development and Implementation (DDI) Payment Milestones By Phase
Schedule C**	Cost of Operations
Schedule D**	Enhancement Pool Hours
Schedule E	Resource Hourly Rates
Schedule F • Schedule F-1 • Schedule F-2 • Schedule F-3 • Schedule F-4	Claims Services Core Scope of Work Cost • Claims Services DDI Cost • Claims Services Operations Cost • Claims Services DDI Enhancement Pool Hour Cost • Claims Services Operations Enhancement Pool Hour Cost
Schedule G (optional*) • Schedule G-1 • Schedule G-2 • Schedule G-3 • Schedule G-4	Claims Services Option A Scope of Work Cost • Claims Services DDI Cost • Claims Services Operations Cost • Claims Services DDI Enhancement Pool Hour Cost • Claims Services Operations Enhancement Pool Hour Cost
Schedule H (optional*) • Schedule H-1 • Schedule H-2 • Schedule H-3 • Schedule H-4	Claims Services Option B Scope of Work Cost • Claims Services DDI Cost • Claims Services Operations Cost • Claims Services DDI Enhancement Pool Hour Cost • Claims Services Operations Enhancement Pool Hour Cost
Schedule I (optional*) • Schedule I-1 • Schedule I-2 • Schedule I-3 • Schedule I-4	Claims Services Option C Scope of Work Cost • Claims Services DDI Cost • Claims Services Operations Cost • Claims Services DDI Enhancement Pool Hour Cost • Claims Services Operations Enhancement Pool Hour Cost
Schedule J	Claims Services Integration Service Types
Schedule K	DDI Requisitioned Integration Services Pool Hours and Cost
Schedule L	Claims Services Data Conversion Optional Years of Data Costs
Schedule M (optional**)	Claims Services Option D Scope of Work Cost

• Schedule M-1 • Schedule M-2 • Schedule M-3 • Schedule M-4	• Claims Services DDI Cost • Claims Services Operations Cost • Claims Services DDI Enhancement Pool Hour Cost • Claims Services Operations Enhancement Pool Hour Cost

*These schedules are optional.
** These schedules are only completed as part of the Participating Addendum.

All non-optional schedules in each of the Tier workbooks must be completed in full at the time of submittal. **Montana state law dictates a contract limit of 10 years**. The Contract term will include DDI and operations years for the Claims Processing and Management Services Module.

The preferred technical standards for the State of Montana Department of Public Health and Human Services (Department) have been provided in the procurement library. The Department does not have excess licenses for these components. Therefore, if the Contractor chooses to include any of these components in their solution, the Contractor shall include the costs of these components in their proposal.

Schedule A: This is a summary of the all-inclusive cost of the proposal. These totals will be automatically taken from Schedules F (tabs F-1 thru F-4). Cost summary for Option A services will be automatically taken from Schedule G (tabs G-1 thru G-4). Cost summary for Option B services will be automatically taken from Schedule H (tabs H-1 thru H4). Offerors are only required to complete Schedules G-1 thru G-4 and/or H-1 thru H-4 if choosing to bid on services outlined in Option A and/or Option B.

Schedule B: This schedule represents the percentage of the total cost for Design, Development and Implementation and will be completed in the Participating Addendum process. Do not include operations costs in this schedule. This schedule reflects payment milestones for each phase of the project. *Schedule B does not need to be completed as a part of the Offeror's proposal submission. This schedule will be completed as part of the Participating Addendum process.* As part of the Participating Addendum process, the offeror must complete matrices B-1 & B-2 and if applicable matrices B-3, B-4, and B-5 by inserting a dollar amount for each payment milestone/phase* such that the total percentages by phase are within the minimum and max percentage for each phase. The total amount of each matrix should match the totals found in Schedules F-1, G-1, H-1, and I-1. If the Offeror is bidding on services outlined in Options A, B, or C, the Offeror is required to complete the corresponding Schedules B-2, B-3, B-4.

NOTE: In accordance with CMS guidance, Certification may not be requested by the Participating State until 6 months after implementation of the complete solution. The Certification process is complete once the presentation to CMS is completed, all open issues are resolved, and the Agency receives a letter from CMS certifying the solution.

Schedule C: This schedule represents the total cost of operations including four base years and optional years, excluding the DDI period which may be one year or greater. This will be completed as an attachment to a Participating Addendum. *Schedule C does not need to be completed as a part of the Offeror's proposal submission. This schedule will be completed as part of the Participating Addendum process.* Operations year one begins the first day of the month following the implementation of the Claims Processing and Management Services (CPMS) Module.

Schedule D: This schedule represents the cost for enhancement pool hours for both the DDI and Operations phases of the proposal. This will be completed as an attachment to a Participating Addendum. *Schedule D does not need to be completed as a part of the Offeror's proposal submission. This schedule will be completed as part of the Participating Addendum process.* Operations year one begins the first day of the month following the implementation of the Claims Processing and Management Services module.

Schedule E: This schedule represents the hourly rates for Offeror resources. These rates are only to be used if a Participating State requests an estimate for work that is not initially contemplated in the original Scope of Work of the Claims Processing and Management Services module.

NOTES:

1. Offerors are only required to complete Schedules G-1 thru G-4, H-1 thru H-4 or I-1 thru I-4 if choosing to bid on services outlined in Option A, Option B or Option C. Schedules F, G, H, I and M can be completed partially automated or manually. If Offeror decides to use the partially automated option for the generation of these schedules they must be aware that the formulas in the spreadsheet will use three distinct metrics to generate the final values, so they must have at hand the following:
   A) Current Cost-of-Living-Adjustment (COLA) percentage (this metric will be year to year multiplier that will increase/decrease the price of Service Operation Costs and Pool hours),
   B) Year 1 Hourly Rate for every type of schedule,
   C) Their Variable Rate Factor for each Group Member Range (1-7).

2. Offerors completing Schedules F-I manually must enter values in each field highlighted in green and orange.
3. Offerors completing Schedules F-I using the automated formulas must enter values in each field highlighted in green and blue. All other fields are protected and cannot be changed.
4. Color code: Cells highlighted in Green, Orange, and Blue are the only cells designated for Offerors to use. Cells highlighted in Cyan are only for Participating States to use. All other cells are protected and cannot be changed.
5. Claims transactions include fee for service and encounter claims.
6. Schedules E, F, G, H, I, K, L, & M will be updated by the Consumer Price Index Urban (CPI-U) once the Participating State Tab is completed by the Agency.

Schedule F (includes tabs F-1 thru F-4): This schedule represents the Claims Services Core Scope of Work Cost by Members. The Offeror must complete Schedule F based on the number of Members for each tab (F-1 thru F-4) of Schedule F. Schedule F will only be considered complete and valid if all the green and all the orange highlighted cells have a value in F-1 thru F-4. The base and variable costs identified in tabs F-1 thru F-4 must include the costs necessary to support **all Core contract requirements** including the technology detailed in Attachment L - Technology Matrix. *For step by step instructions of how to fill this Schedule, review the attachment named "Partially Automated-Manual Pricing Instructions Offerors-PS".*

Schedule G (includes tabs G-1 thru G-4): This schedule represents the Claims Services Option A (Financial) Scope of Work Cost by Members. Offerors are only required to complete Schedules G-1 thru G-4 if choosing to bid on services outlined in Option A. The Offeror must complete Schedule G based on the number of Members for each tab (G-1 thru G-4) of Schedule G. Schedule G will only be considered complete and valid if all the green and all the orange highlighted cells have a value in G-1 thru G-4. The base and variable costs identified in tabs G-1 thru G-4 must include the costs necessary to support **all Option A (Financial) contract requirements** including the technology detailed in Attachment L - Technology Matrix. *For step by step instructions of how to fill this Schedule, review the attachment named "Partially Automated-Manual Pricing Instructions Offerors-PS".*

Schedule H (includes tabs H-1 thru H-4): This schedule represents the Claims Services Option B (Call Center) Scope of Work Cost by Members. Offerors are only required to complete Schedules H-1 thru H-4 if choosing to bid on services outlined in Option B. The Offeror must complete Schedule H based on the number of Members for each tab (H-1 thru H-4) of Schedule H. Schedule H will only be considered complete and valid if all the green and all the orange highlighted cells have a value in H-1 thru H-4. The base and variable costs identified in tabs H-1 thru H-4 must include the costs necessary to support **all Option B (Call Center) contract requirements** including the technology detailed in Attachment L - Technology Matrix. *For step by step instructions of how to fill this Schedule, review the attachment named "Partially Automated-Manual Pricing Instructions Offerors-PS".*

Schedule I (includes tabs I-1 thru I-4): This schedule represents the Claims Services Option C (Federal Reporting) Scope of Work Cost by Members. Offerors are only required to complete Schedules I-1 thru I-4 if

choosing to bid on services outlined in Option C. The Offeror must complete Schedule I based on the number of Members for each tab (I-1 thru I-4) of Schedule I. Schedule I will only be considered complete and valid if all the green and all the orange highlighted cells have a value in I-1 thru I-4. The base and variable costs identified in tabs I-1 thru I-4 must include the costs necessary to support **all Option C (Federal Reporting) contract requirements** including the technology detailed in Attachment L - Technology Matrix. *For step by step instructions of how to fill this Schedule, review the attachment named "Partially Automated-Manual Pricing Instructions Offerors-PS".*

Schedule J: This schedule represents the Claims Services Integration Service Types. Offerors need to determine the number of hours for every resource specified in every one of the Integration Types:

1. Major Integration Service Type Effort
2. Complex Integration Service Type Effort
3. Standard Integration Service Type Effort
4. Simple Integration Service Type Effort
5. Onboarding Integration Service Type Effort

For step by step instructions of how to fill this Schedule, review the attachment named "Partially Automated-Manual Pricing Instructions Offerors-PS".

Schedule K: This schedule represents the DDI Requisitioned Integration Services Pool Hours and Cost. Offerors need to determine the Total Cost for the DDI Requisitioned Integration Services Pool Hours. Schedule K will only be considered complete and valid when the green highlighted cell has a value. *For step by step instructions of how to fill this Schedule, review the attachment named "Partially Automated-Manual Pricing Instructions Offerors-PS".*

Schedule L: This schedule represents the Data Conversion Optional Years of Data Cost. Schedule I will only be considered complete and valid when all the green and orange highlighted cells have a value. *For step by step instructions of how to fill this Schedule, review the attachment named "Partially Automated-Manual Pricing Instructions Offerors-PS".*

Schedule M: This schedule represents the placeholder for Claims Services Option D (State Specific) Scope of Work Cost by Members. This Schedule is a placeholder for the costs associated with the State Specific requirements not currently found in the RFP but will be added on the Participating Addendum process. Offerors are only required to complete Schedules M-1 thru M-4 if the Participating States decide to have State Specific requirements that are not covered in the Core, Option A, Option B, or Option C requirements. The Offeror must complete Schedule M based on the number of Members for each tab (M-1 thru M-4) of Schedule M. Schedule M will only be considered complete and valid if all the green and all the orange highlighted cells have a value in M-1 thru M-4. The base and variable costs identified in tabs M-1 thru M-4 must include the costs necessary to support **all Option D (State Specific Requirements) contract requirements** including the technology detailed in Attachment L - Technology Matrix. *For step by step instructions of how to fill this Schedule, review the attachment named "Partially Automated-Manual Pricing Instructions Offerors-PS".*

Cost proposals will be evaluated for all offerors who passed the minimum score (80%) in Step 2 of the evaluation process for the Core Claims Services scope of work.

NOTE: The following information is provided to help the Offeror understand how a Participating Entity will use Schedules F, G, H, I, K, L, and M to determine DDI cost and annual Operations cost.

DDI Costs

The State will use the following method to compute State Specific Total DDI Costs:

1. Determine the number of total active de-duplicated members (Total Members) by computing a twenty-four (24) month average of the quarterly total active de-duplicated members (i.e. Members

with eligibility on the last day of the quarter) for the first twenty-four (24) of the last twenty seven (27) months. This will be completed as an attachment to a Participating Addendum.

2. Identify the applicable Group using the Total Members and enter the number of Total Members in row 8 for that group.
3. Calculate the total variable DDI Costs (Variable DDI Costs) by multiplying the Variable Members by the Group Variable Rate (done automatically).
4. Calculate the Total DDI Costs by adding Base DDI Cost plus Variable DDI Costs (done automatically).

Operations

Each year, the State will use the following method to compute State Specific Total Monthly Operations Costs:

1. Determine the number of total active de-duplicated members (Total Members) by computing a twenty-four (24) month average of the quarterly total active de-duplicated members (i.e. Members with eligibility on the last day of the quarter) for the first twenty four (24) of the last twenty seven (27) months. This will be completed as an attachment to a Participating Addendum.
2. Identify the applicable Group using the Total Members and enter the number of Total Members in row 9 for that group.
3. Calculate the total variable monthly operations costs (Variable Monthly Operations Costs) by multiplying the Variable Members by the Group Variable Rate (done automatically).
4. Calculate the Total State Monthly Operations by adding Base Operations Cost plus the Variable Monthly Operations Costs (done automatically).

A similar method will be used to determine the cost of System Enhancement pool hour cost for DDI and System Enhancement pool hour cost for each year of Operations.

5.2.1 Adjusting DDI and Operational Costs One or More Years After the Effective Date of the Master Agreement

For Participating Addenda signed one year or more years after the effective date of the Master Agreement, the base cost and the initial variable rate for DDI and Operations will be adjusted using the Consumer Price Index Urban (CPI-U) to account for economic changes that may impact cost.

For DDI costs outlined in Attachment G –Pricing Schedules, Schedule F-1 Claims Svcs DDI Cost, Schedule G-1 Claims Svcs DDI Cost, Schedule H-1 Claims Svcs DDI Cost, Schedule I-1 Claims Svcs DDI Cost:

For (Tab F-1 Claims Svcs DDI Cost: cells D10, F10, H10, J10, L10, N10, P10 and R10), (Tab G-1 Claims Svcs DDI Cost: cell D10, F10, H10, J10, L10, N10, P10 and R10), (Tab H-1 Claims Svcs DDI Cost: cell D10, F10, H10, J10, L10, N10, P10 and R10), (Tab I-1 Claims Svcs DDI Cost: cell D10, F10, H10, J10, L10, N10, P10 and R10) and (Tab M-1 Claims Svcs DDI Cost: cell D10, F10, H10, J10, L10, N10, P10 and R10) can be adjusted using the inflation factor derived by utilizing the CPI-U calculation noted below. If a Participating Addendum is signed one year or more following the effective date of the Master Agreement, the cells noted above will be multiplied by the CPI-U inflation factor E. The CPI-U adjustment only applies to the cells referenced and only occurs at the initiation of the Contract. The CPI-U calculation will be performed automatically using the "Participating State" tab the workbook.

For Operation costs outlined in Attachment G – Claims Pricing Schedules, Schedule F-2 Claims Svcs Ops Cost, G-2 Claims Svcs Ops Cost, H-2 Claims Svcs Ops Cost, and I-2 Claims Svcs Ops Cost:

For (Tab F-2 Claims Svcs Ops Cost: cells D11:D19, F11:F19, I11:I19, L11:L19, O11:O19, U11:U19 and X11:X19), (Tab G-2 Claims Svcs Ops Cost: D11:D19, F11:F19, I11:I19, L11:L19, O11:O19, U11:U19 and X11:X19), (Tab H-2 Claims Svcs Ops Cost: cell D11:D19, F11:F19, I11:I19, L11:L19, O11:O19, U11:U19 and X11:X19), and (Tab I-2 Claims Svcs Ops Cost: cell D11:D19, F11:F19, I11:I19, L11:L19, O11:O19, U11:U19 and X11:X19), and (Tab M-2 Claims Svcs Ops Cost: cell D11:D19, F11:F19, I11:I19, L11:L19, O11:O19, U11:U19 and X11:X19) can be adjusted using the inflation factor derived by utilizing the CPI-U calculation noted below. If the Participating addenda is signed one year or more following the effective date of the Master Agreement, the cells would be multiplied by CPI-U inflation factor E. The CPI-U adjustment only applies to the cells referenced and only occurs at the initiation of the Contract. The CPI-U calculation will be performed automatically using the "Participating State" tab the workbook.

CPI-U for United States Adjustment Factor Calculation:
CPI-U Index for the month and year of the execution of a Participating Addendum: A
Less the CPI-U Index for the month and year of the Effective Date of the Master Agreement: B
Equals Index Point Change: C
Divided by CPI-U Index B: C/B = D
Equals: D
Result multiplied by 100: D*100 = E
Equals CPI-U Inflation Percentage: E

5.3 PAYMENTS

During the DDI phase of the Contract, the Contractor will be paid for each successful payment milestone identified in Attachment G, Pricing Schedule B – DDI Payment Milestones, based on the approval and acceptance of the milestone by DPHHS. The Contractor will submit an invoice for each milestone after DPHHS acceptance. The Department shall pay such invoices within 30 calendar days following receipt of an acceptable invoice.

During operations, Contractor may submit monthly invoices equal to 1/12 of the fixed price proposed for that contract year as identified in Attachment G, Pricing Schedule C – Cost of Operations. The Contractor will submit an invoice at the beginning of the month following the month for which services were performed. The Department shall pay such invoices within 30 calendar days following receipt of an acceptable invoice.

Enhancement pool hours for both the DDI and Operations phase will be paid for each enhancement upon acceptance and approval by DPHHS. The Contractor will submit a monthly System Enhancement Pool Report itemizing the hours for accepted and approved enhancements during the previous month. The Department shall pay for associated hours in the approved System Enhancement Pool Report within 30 calendar days based on the proration of rates provided in Attachment G, Pricing Schedule D – Enhancement Pool Hours.

SECTION 6: EVALUATION PROCESS

The Scope of Services, Offeror Qualifications, and Cost Proposal will be evaluated based on the criteria set forth below.

6.1 BASIS OF EVALUATION

The evaluator/evaluation committee will review and evaluate the offers according to the following criteria based on a total number of 5,000 points.

The ability to meet the Detailed Scope of Work, Company Profile and Experience, Resumes, and Product Demonstrations/Interviews portions of the proposal will be evaluated based on Section 6.1.1 Scoring Guide below. The Offeror simply repeating requirements for any and/or all Sections of 3.10 does not qualify as a good response as defined in Section 6.1.1 of this RFP. Compliance, Performance Standards, Financial Stability, Disclosure of Dark Money Spending, Subcontractors, and References portions of the proposal will be evaluated on a pass/fail basis. Receiving a "fail" for any one of the pass/fail portions will result in the Offeror being eliminated from further consideration. Compliance with Executive Order will be assigned 5% of the available points. The basis of evaluation will be a multi-step process as outlined below:

Step 1: Technical Proposal will be evaluated first. Proposals receiving at least 80% of possible points for the technical proposal will move to Step 2. Proposals failing to obtain 80% of possible points will be eliminated from further consideration.

Step 2: Product Demonstrations/Interviews will be scheduled for all Offerors who received the minimum required score in Step 1. Product demonstrations receiving evaluation scores of 80% or better will move to Step 3. Product Demonstrations failing to meet the 80% threshold will be eliminated from further consideration.

Step 3: Compliance with Executive Order 12-2016 will be awarded 5% of the available points,and will be considered after Step 2. Those who do not comply with Executive Order 12-2016, will be awarded zero points for this criteria.

Step 4: Cost proposals will only be evaluated for those offerors who passed the minimum score in Step 2 of the evaluation process (Product Demonstrations/Interviews).

Lowest overall cost receives the maximum allotted points. All other proposals receive a percentage of the points available based on their cost relationship to the lowest.

Example: Total possible points for cost are 1000. Offeror A's cost is $20,000. Offeror B's cost is $30,000. Offeror A would receive 1000 points. Offeror B would receive 670 points (($20,000/$30,000) = 67% x 1000 points = 670).

$$\frac{\text{Lowest Responsive Offer Total Cost}}{\text{Offeror's Total Cost}} \times \text{Number of Available Points} = \text{Award Points}$$

6.1.1 Scoring Guide

In awarding points to the evaluation criteria in Steps 1-2, the evaluator/evaluation committee will consider the following guidelines:

Superior Response (95-100%): A superior response is an exceptional reply that completely and comprehensively meets all the requirements of the section. In addition, the response may cover areas not originally addressed within the RFP and/or include additional information and recommendations that would prove both valuable and beneficial to DPHHS.

Good Response (80-94%): A good response clearly meets all the requirements of the section and demonstrates in an unambiguous and concise manner a thorough knowledge and understanding of the project, with no deficiencies noted.

Fair Response (65-79%): A fair response minimally meets most requirements set forth in the section. The Offeror demonstrates some ability to comply with guidelines and requirements of the project, but knowledge of the subject matter is limited.

Failed Response (64% or less): A failed response does not meet the requirements set forth in the section. The Offeror has not demonstrated sufficient knowledge of the subject matter.

6.2 EVALUATION CRITERIA

The evaluation criteria to score and weight the total number of 5,000 points can be found below. For the detailed list of scoring items, please see Attachment I – Evaluation and Scoring.

Table 6.2 Evaluation Criteria

RFP Section	Evaluation Criteria Section	Section Weighting	Subsection Weighting
	Step 1: Technical Proposal	40% for a possible 2,000 points	
3.10.1	Technical and Information Architecture		6%
3.10.2	Project Management and System Development		3%
3.10.3	Certification		1.5%
3.10.4	Operations, Maintenance & Configuration		2%
3.10.5	Key Personnel & Staffing		1.5%
3.10.6	Project Closeout and Turnover		0.5%
3.10.7	Project Deliverables and Documentation		2%
3.10.8	Performance Standards		Pass/Fail
3.10.9	Subcontractors		Pass/Fail
3.10.10	Edits Processing & Adjustment		5.0%
3.10.11	Pricing & Payment		4.0%

3.10.12	Benefit & Reference Data Management		2.5%
3.10.13	Data & Reporting		2.5%
3.10.14	System Administration & Operations		5.0%
3.10.15	Service Authorizations		0.5%
4.2.1	References		Pass/Fail
4.2.2	Company Profile & Experience		2%
4.2.3	Resumes		2%
4.2.4	Offeror Financial Stability		Pass/Fail
	Step 2: Product Demonstration/Question & Answer	35% for a possible 1,750 points	
4.2.5	Product Demonstration/Question & Answer		35%
4.2.6	Step 3: Certification of Compliance with Executive Order No. 12-2016	5% for a possible 250 points	
	Certification of Compliance with Executive Order No. 12-2016		5%
4.2.7	Compliance with Executive Order 15-2018	Pass/Fail	Pass/Fail
	Step 4: Cost Proposal	20% for a possible 1,000 points	
5	Cost Proposal		20%
	Total	100%	

Table 6.2.1 represents the points needed to move on to each step of the evaluation process

Evaluation Step	Possible Points	Points Required to Move to Next Step in Evaluation Process
Step 1 – Technical Proposal	2,000	1,600
Step 2 – Product Demonstration/Interviews	1,750	1,400

ATTACHMENT A: STANDARD TERMS AND CONDITIONS

ACCEPTANCE/REJECTION OF BIDS, PROPOSALS, OR LIMITED SOLICITATION RESPONSES: The State reserves the right to accept or reject any or all bids, proposals, or limited solicitation responses, wholly or in part, and to make awards in any manner deemed in the best interest of the State. Bids, proposals, and limited solicitation responses will be firm for 30 days, unless stated otherwise in the text of the invitation for bid, request for proposal, or limited solicitation.

ALTERATION OF SOLICITATION DOCUMENT: In the event of inconsistencies or contradictions between language contained in the State's solicitation document and a vendor's response, the language contained in the State's original solicitation document will prevail. Intentional manipulation and/or alteration of solicitation document language will result in the vendor's disqualification and possible debarment.

DEBARMENT: Contractor certifies, by submitting this bid or proposal, that neither it nor its principals are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction (contract) by any governmental department or agency. If Contractor cannot certify this statement, attach a written explanation for review by the State.

FAILURE TO HONOR BID/PROPOSAL: If a bidder/offeror to whom a contract is awarded refuses to accept the award (PO/contract) or fails to deliver in accordance with the contract terms and conditions, the department may, in its discretion, suspend the bidder/offeror for a period of time from entering into any contracts with the State of Montana.

RECIPROCAL PREFERENCE: The State of Montana applies a reciprocal preference against a vendor submitting a bid from a state or country that grants a residency preference to its resident businesses. A reciprocal preference is only applied to an invitation for bid for supplies or an invitation for bid for nonconstruction services for public works as defined in section 18-2-401(9), MCA, and then only if federal funds are not involved. For a list of states that grant resident preference, see http://sfsd.mt.gov/SPB/Preferences.

SOLICITATION DOCUMENT EXAMINATION: Vendors shall promptly notify the State of any ambiguity, inconsistency, or error which they may discover upon examination of a solicitation document.

ATTACHMENT B: CONTRACT

Attachment B represents the Contract for the specific module procurement.

ATTACHMENT C: RFP INSTRUCTIONS

An Offeror's response must be complete at the time of submittal and contain all the reference materials necessary to provide a complete response to the RFP. Unless specifically requested in the RFP, an offeror making the statement "Refer to our literature…" or "Please see www…….com" may be deemed nonresponsive or receive point deductions. If making reference to materials located in another section of the RFP response, specific page numbers and sections must be noted. The Evaluator/Evaluation Committee is not required to search through literature or another section of the proposal to find a response.

Offerors must submit one original proposal to the State Procurement Bureau via eMACS prior to the RFP closing time.

Offeror must submit all of the following documents as part of their Proposal submission via eMACS. Figure C.1. details the documentation required with the Offeror's Response.

Figure C.1. Documents Required with Offeror's Response

Documents Required with Offeror's Response	
Document	Description
RFP Sections 3.1-3.8,	In addition to certifying understanding, the Offeror must provide an explanation of how their proposed solution can support the vision, goals and objectives of the MPATH program.
RFP Sections 3.9, 3.10, & 4	Offeror must respond in detail to the scope of work outlined in Sections 3.9 and 3.10 and all associated requirements in Attachment F – Requirements Response Matrix. The Offeror simply repeating the RFP requirements does not qualify as a good response as defined in Section 6.1.1 of this RFP. The Offeror must restate the subsection number and the text immediately prior to the written response.
RFP Sections 5 & 6	The Offeror must certify their understanding for these sections.
References	Offerors must provide a list of references. Detailed instructions can be found in Section 4.2.1.
RFP Section 4.2.2 Company Profile and Experience	Offeror shall provide documentation establishing the individual or company submitting the proposal has the qualifications and experience to provide the supplies and/or services specified in this RFP. Details regarding minimum criteria of this documentation can be found in Section 4.2.2.
RFP Section 4.2.3 Resumes	The Offeror shall provide a resume or summary of qualifications, work experience, education, and skills for all key personnel, including any subcontractors, who will be performing any aspect of the contract. Details regarding minimum criteria of this documentation can be found in Section 4.2.3.
RFP Section 4.2.4 Financial Stability	Offerors shall demonstrate their financial stability to supply, install, and/or support the services. Details regarding minimum criteria of this documentation can be found in Section 4.2.4.

Documents Required with Offeror's Response	
Document	Description
RFP Section 4.2.6 Equal Pay for Women Certificate of Compliance	Offerors must complete, sign and upload in Buyers Attachments in eMACS to receive the points.
Attachment F – Requirements Response Matrix	Attachment F contains a list of all requirements related to the module Base Scope of Work requirements in addition to Optional Member Mobile Application Services requirements. Offerors shall respond to all requirements listed for the Base Scope of Work contained in the Requirements Response Matrix. Offerors choosing to bid on Optional Member Mobile Application Services must respond to all requirements applicable to Member Mobile Application Services. Further instructions are found in the Attachment F, Legend tab.

Attachment G – Pricing Schedules	Attachment G serves as the representation of the Offeror's fixed price and must be completed in full at the time of submittal unless otherwise noted in the Attachment G – Pricing Schedules, Instructions Tab. Pricing Schedules include: • Schedule A – Cost Summary • Schedule A-1 - Claims Processing and Management Services Core Cost Summary • Schedule A-2 - Claims Processing and Management Services Option A Financial Cost Summary • Schedule A-3 - Claims Processing and Management Services Option B Call Center Cost Summary • Schedule A-4 - Claims Processing and Management Services Option C Federal Reporting Cost Summary • Schedule B - DDI Payment Milestone • Schedule B-1 - Claims Processing and Management Services Installation DDI Payment Milestone • Schedule B-2 - Claims Processing and Management Services Core DDI Payment Milestone • Schedule B-3 - Claims Processing and Management Services Option A Financial DDI Payment Milestone • Schedule B-4 - Claims Processing and Management Services Option B Call Center DDI Payment Milestone • Schedule B-5 - Claims Processing and Management Services Option C Federal Reporting Payment DDI Milestone Summary • Schedule C - Operations Costs • Schedule C-1 - Claims Processing and Management Services Core Cost of Operations • Schedule C-2 - Claims Processing and Management Services Option A Financial Cost of Operations • Schedule C-3 - Claims Processing and Management Services Option B Call Center Cost of Operations Milestone • Schedule C-4 - Claims Processing and Management Services Option C Federal Reporting Cost of Operations • Schedule D - System Enhancement Pool Hours • Schedule D-1 Claims Processing and Management Services Core System Enhancement Pool Hours • Schedule D-2 Claims Processing and Management Services Option A System Enhancement Pool Hours • Schedule D-3 Claims Processing and Management Services Option B Call Center System Enhancement Pool Hours • Schedule D-4 Claims Processing and Management Services Option C Federal Reporting System Enhancement Pool Hours • Schedule F-1 – Claims Processing and Management Services DDI Costs • Schedule F-2 – Claims Processing and Management Services Operations Costs • Schedule F-3 – Claims Processing and Management DDI Pool Costs • Schedule F-4 – Claims Services Operations Pool Costs • Schedule G-1 – Claims Processing and Management Services Option A Financial DDI Costs

Documents Required with Offeror's Response	
Document	Description
	• Schedule G-2 – Claims Processing and Management Services Option A Financial Operations Costs • Schedule G-3 – Claims Processing and Management Services Option A Financial DDI Pool Costs • Schedule G-4 – Claims Processing and Management Services Option A Financial Operations Pool Costs • Schedule H-1 – Claims Processing and Management Services Option B Call Center DDI Costs • Schedule H-2 – Claims Processing and Management Services Option B Call Center Operations Costs • Schedule H-3 – Claims Processing and Management Option B Call Center DDI Pool Costs • Schedule H-4 – Claims Processing and Management Services Option B Call Center Operations Pool Costs • Schedule I-1 – Claims Processing and Management Services Option C Federal Reporting DDI Costs • Schedule I-2 – Claims Processing and Management Services Option C Federal Reporting Operations Costs • Schedule I-3 – Claims Processing and Management Option C Federal Reporting DDI Pool Costs • Schedule I-4 – Claims Processing and Management Services Option C Federal Reporting Operations Pool Costs • Schedule J – Integration Service Types • Schedule K – DDI Requisitioned Integration Services Pool Hours and Cost • Schedule L – Data Conversion Optional Years of Data • Schedule M - Claims Services Option D Scope of Work Cost
Attachment H – Resource Allocation Schedules	Attachment H Resource Allocation Schedules is the representation of Offeror's plan for staffing the project by resource type. Resource Allocation Schedules include: • Schedule A – Number of Full Time Equivalent • Schedule B – Number of Hours Further instructions are found in the Attachment H, Instructions tab.
Attachment L – Technology Matrix	Attachment L – Technology Matrix represents the technology being proposed by Offeror including product type, operating system, licensing, number of seat(s), hosting strategy, cost information and renewal information. The Offeror must provide the detailed hardware and software information for each applicable row using the values defined in the Legend below. The Offeror must include the costs for each component including all ongoing costs and annual maintenance costs detailed in the Technology Matrix. The costs outlined in the Technology Matrix must be included the appropriate Attachment G – Pricing Schedules.

Documents Required with Offeror's Response	
Document	Description
Attachment M – Contract Exception Request Template	Attachment M – Contract Exception Request Template represents all Contract Exceptions requested by the Offeror. 1. Contract modification requests must be submitted to the Q&A Board in eMACS using Attachment M – Contract Exception Request Template by the Closing Date for Receipt of Contract Requests found in the Schedule of Events; and 2. Attachment M – Contract Exception Request Template must detail specific requests. Requests must include an explanation detailing why the exception is being sought, what specific effect it will have on the Offeror's ability to respond to the RFP or perform the Contract and include any proposed language or changes to the RFP; and 3. For each specific topic, the Offeror must completely and accurately fill out Attachment M – Contract Exception Request Template; and 4. The Department agrees, in whole or in part, to negotiate the specific topic presented by an Offeror; or 5. The Department, at its sole discretion, identifies topics that will be included in Contract negotiations. See Sections 1.5.1 and 2.5.1 for additional details regarding Contract Exception Requests.

ATTACHMENT D: MECT MAPPING

This attachment consists of the mapping of MECT 2.0 checklist criteria to the associated business requirement for the applicable MPATH module being procured.

ATTACHMENT E: CLAIMS PROCESSING AND MANAGEMENT SERVICES

This attachment provides program and member information related to Claims Processing and Management Services for Montana Healthcare Programs.

ATTACHMENT F: REQUIREMENTS RESPONSE MATRIX

Attachment F – Requirements Response Matrix Contains a list of all requirements related to the module scope of work. Offerors shall respond to all requirements contained in the Requirements Response Matrix.

ATTACHMENT G: PRICING SCHEDULES

This attachment consists of the pricing schedules associated with the applicable MPATH module being procured.

ATTACHMENT H: RESOURCE ALLOCATION SCHEDULES

This attachment consists of the resource allocation schedules that serve as the representation of Offeror's plan for staffing the project by resource type for the module Scope of Work.

ATTACHMENT I: EVALUATION AND SCORING

This attachment provides the criteria for evaluating Offeror's technical proposal, product demonstration/question & answer and cost proposal for this module.

ATTACHMENT J: SERVICE LEVEL AGREEMENT REQUIREMENTS

This attachment details the Service Level Agreements

ATTACHMENT K: BUSINESS ASSOCIATE AGREEMENT

This attachment is the Business Associates Agreement required in Attachment B – Contract.

ATTACHMENT L: TECHNOLOGY MATRIX

This attachment consists of the Technology Matrix associated to the applicable MPATH module being procured.

ATTACHMENT M: CONTRACT EXCEPTION REQUEST TEMPLATE

Attachment M – Contract Exception Request Template represents all Contract Exceptions requested by the Offeror and **must be submitted to the Q&A Board in eMACS by the Closing Date for Receipt of Contract Requests** found in the Schedule of events.