AMENDMENT 2
FOR
RFP NUMBER 0A06007

DATE AMENDMENT ISSUED: July 28, 2006

The state of Ohio, through the Office of Information Technology, Investment and Governance Division, for the Department of Job and Family Services is requesting proposals for:

Medicaid Information Technology System (MITS)

DATE RFP ISSUED:	**May 25, 2006**
OPENING DATE:	**August 17, 2006**
OPENING TIME:	**11:00 A.M.**
OPENING LOCATION:	**Office of Information Technology Contract Management Bid Room 30 East Broad Street, 40th Floor Columbus, Ohio 43215**

The attached page(s) represent the Request for Proposals (RFP) amendment for the RFP listed above. Please use replacement pages contained in this document to replace the page(s) previously issued by the State.

Specifications and requirements that have been revised are surrounded by double asterisks, bold type and when applicable, strikethrough.

REQUEST FOR PROPOSALS

RFP NUMBER: 0A06007
DATE ISSUED: May 25, 2006

The State of Ohio, through the Office of Information Technology, Investment and Governance Division, for the Department of Job and Family Services is requesting proposals for:

Medicaid Information Technology System (MITS)

INQUIRY PERIOD BEGINS:	**May 25, 2006**
INQUIRY PERIOD ENDS:	**~~July 19~~**August 4**, 2006**
OPENING DATE:	**~~July 27~~**August 17**, 2006**
OPENING TIME:	**11:00 A.M.**
OPENING LOCATION:	**Office of Information Technology Contract Management Bid Room 30 East Broad Street, 40th Floor Columbus, Ohio 43215**
PRE-PROPOSAL CONFERENCE DATE:	**June 13, 2006, at 9:00 a.m.**

This RFP consists of five Parts and 12 Attachments, totaling 180 consecutively numbered pages. Supplements also are attached to this RFP with a beginning header page and an ending trailer page. Please verify that you have a complete copy.

Project Manager Mandatory Requirements	Pass	Fail
A minimum of 60 months full-time experience as a project manager.		
Experience as the project manager on a minimum of two projects that encompassed the full system development life cycle from initiation through post implementation on a large scale project where one of the projects lasted a minimum of 18 months.		
Technical Manager Mandatory Requirements	**Pass**	**Fail**
A minimum of 36 months full-time experience as a technical manager for projects involving an enterprise-wide architecture, networking, multiple systems integration, hardware, and software.		
Experience managing a technical team and its activities from inception through implementation on a minimum of one project of similar size and complexity to MITS.		

Calendar of Events

The schedule for the Project is given below. The State may change this schedule at anytime. If the State changes the schedule before the Proposal due date, it will do so through an announcement on the State Procurement Website's question and answer area for this RFP. The Website announcement will be followed by an amendment to this RFP, also available through the State Procurement Website. After the Proposal due date and before the award of the Contract, the State will make schedule changes through the RFP amendment process. And the State will make changes in the Project schedule after the Contract award through the change order provisions in the General Terms and Conditions Attachment to this RFP. It is each prospective offeror's responsibility to check the Website question and answer area for this RFP for current information regarding this RFP and its Calendar of Events through award of the Contract.

Dates

Firm Dates

RFP Issued:	May 25, 2006
Inquiry Period Begins:	May 25, 2006
Pre-Proposal Conference Date:	June 13, 2006
Inquiry Period Ends:	~~July 17~~ ****August 4****, 2006
Proposal Due Date:	~~July 25~~****August 17****, 2006 at 11:00 a.m.

Estimated Dates

Contract Award	January 5, 2007

There are references in this RFP to the Proposal due date. Prospective offerors must assume, unless it is clearly provided to the contrary in this RFP, that any such reference means the date and time (Columbus, Ohio local time) that the Proposals are due and not just the date.

Proposal Submittal

On the Proposal due date, each offeror must submit a technical section and a cost section as part of its total Proposal. The offeror must submit the technical section as a separate package from the cost section, and each section must be submitted in its own separate, opaque envelope. The technical section may not exceed a total of 400 8.5 by 11-inch numbered pages (400 single sided or 200 double sided pages). Offeror's Proposal may include 11 by 17-inch pages, but 11 by 17-inch page will count as two pages. All pages must have 1-inch (or more) margins at the top, bottom, left and right sides of each page and with text in at least 10-point font size. A smaller font size may be used for graphics and Microsoft Project WBS text. Tables of contents, tables of figures, tab sheets, page dividers, or state-required supplements and state-required attachments such as the profile summaries do not count toward the 400-page limit. Attachment Two contains an indication of whether each required section of the Proposal is included or excluded from the page limitation count.

The envelope with the technical section of the Proposal must be sealed and contain eight complete and signed copies of the technical section of the Proposal (one original signature and seven copies), and the envelope with the cost section also must be sealed and contain three complete and signed copies of the cost section of the Proposal (one original and two copies). Further, the offeror must mark the outside of each envelope with either "0A06007 - JFS – MITS RFP – Technical Section" or "0A06007 - JFS – MITS RFP – Cost Section," as appropriate.

Included in each sealed envelope, the offeror also must provide an electronic copy of everything contained within the package on CD-ROM in Microsoft Word 2000 ****or higher****, Microsoft Excel 2000 ****or higher****, Microsoft Project 2002 ****or higher****, and PDF format, as appropriate. If there is a discrepancy between the hard copy and the electronic copy of the Proposal, the hard copy will control, and the State will base its evaluation of the offeror's Proposal on the hard copy.

Proposals are due no later than 11:00 a.m. on the Proposal due date. Proposals submitted by email or fax are not acceptable, and the State may reject them. Offerors must submit their Proposals to:

Office of Information Technology
Contract Management Bid Room
30 East Broad Street, 40th Floor
Columbus, Ohio 43215

The State may reject any Proposals or unsolicited modifications that it receives after the deadline. An offeror that mails its Proposal must allow for adequate mailing time to ensure its timely receipt. Additionally, offerors must allow for potential delays due to increased security. The Ohio Building Authority has stationed x-ray equipment on the Rhodes Tower loading dock and uses it to x-ray in-coming deliveries and mail. Loading dock hours are from 7:00 am to 5:00 pm, Monday through Friday, excluding State holidays. No deliveries will be accepted before or after these hours without prior arrangements. Further, all deliveries to Rhodes Tower must be made through the loading dock, where they will be scanned and tagged. Moreover, any visitors attempting to bring packages through the Rhodes Tower lobby that cannot be opened for inspection will be redirected to the loading dock to have their packages scanned and tagged. Offerors must allow sufficient time for this additional security process, since the State may reject late Proposals regardless of the cause for the delay.

Each offeror must carefully review the requirements of this RFP and the contents of its Proposal. Once opened, Proposals cannot be altered or withdrawn, except as allowed by this RFP.

By submitting a Proposal, the offeror acknowledges that it has read this RFP, understands it, and agrees to be bound by its requirements. The State is not responsible for the accuracy of any information regarding this RFP that was gathered through a source other than the inquiry process described in the RFP.

Revised Code §9.24 prohibits the State from awarding a contract to any entity against whom the Auditor of State has issued a finding for recovery (a "Finding"), if the Finding is unresolved at the time of the award. This also applies to renewals of contracts. By submitting a Proposal, the offeror warrants that it is not subject to an unresolved Finding under ORC 9.24 at the time of its submission. Additionally, the offeror warrants that it will notify OIT in writing immediately upon becoming subject to such an unresolved Finding after submitting its Proposal and before the award of a Contract under this RFP. And should the State select the offeror's Proposal for

In addition to the metrics and timeframes established for correcting application defects, the Contractor must ensure, at a minimum, that the following metrics are included and documented for problems encountered during the stabilization period:

- Severity of problem;
- Type of problem;
- Number of problems;
- Anticipated fix date;
- Resolution;
- Frequency of problem occurrence; and
- Problem source(s).

The Contractor must use criteria and thresholds based on the metrics described above, when assessing the stability of MITS. At the conclusion of the stabilization period, the Contractor must provide a written certification letter that stabilization is complete and MITS is ready for the performance period.

The Contract must also make provisions to support any planned special processing risk areas that may fall outside the Stabilization period (for example, State Fiscal Year-end processing).

Final Implementation Report. The Contractor must produce an implementation report detailing the results of all implementation activities.

Present MITS to the State for Final Acceptance. Upon successful completion of the stabilization period, the Contractor must submit MITS for acceptance. Both Phase 1 and Phase 2 must undergo a successful stabilization and performance period before State acceptance of MITS. The performance period as defined in Attachment 3, Standards of Performance and Acceptance, must be successfully completed before the Contractor presents MITS to the State for acceptance. The system presented for final acceptance must account for all required functionality, training, conversion, documentation and any other requirements of this RFP for that particular phase.

Performance Period Report. To determine the growth and reliability of the system, the Contractor must perform benchmarking during the performance periods (to include tests against predetermined response times), as designed by the Contractor, before final system acceptance. All Performance monitoring results and summaries must be made available to the State for review on a daily basis. The Contractor must perform all application software, file structure, database and system software modifications necessary to ensure system performance reaches acceptable levels in the production environments, based upon the results of the benchmarks or the capacity simulation models. Capacity projections must account for system usage and data growth over a 24-month horizon. Performance monitoring results and summaries, benchmarking results, capacity simulation results and documentation of all changes made to address system defects or system performance made must be provided in a Performance Period Report.

~~Once the State accepts the final MITS (both Phases 1 and 2),~~ The Contractor will be required to provide 12 months of warranty coverage ****per the terms and conditions**** for ****all deliverables that include software** ~~software warranty for MITS~~, including the third party COTS packages at no additional cost to the State.

System Documentation. The Contractor must provide to JFS all system documentation at the time the system is implemented, however, the system documentation must be updated throughout the support, maintenance, and enhancement period. System documentation must be versioned using the State's configuration management tool. MITS Systems Documentation must be provided within 60 days following production. During the conclusion of the implementation task, the Contractor must prepare updates to MITS systems documentation to incorporate all changes, corrections, and enhancements to MITS made as a result of the completion of all open items and defects.

One electronic copy of the final version of MITS systems documentation must be provided to JFS. The Contractor must supply any additional copies of MITS systems documentation required by CMS.

The MITS systems documentation must:

- Be available and updated on electronic media as approved by JFS and must be maintainable after turnover;

Task 10 – Transition

Upon the completion of the work through task 9, the MITS application software support, maintenance, and enhancement must be effectively and efficiently transitioned to JFS for operations, support and maintenance ****that was procured for MITS development****. All licenses including the development licenses for all MITS COTS application code must either be transferred to the State or licensed in the State's name. JFS MIS will assign a MITS Technical Representative for the duration of the Project who will be responsible for managing the technical aspects of the project in accordance with the various planning documents required in the RFP. JFS MIS will also assign adjunct technical staff as necessary to complete JFS technical commitments as defined in this RFP. Upon implementation of Phase 1, the Contractor must begin transition activities in accordance with the State accepted transition plan. Technical training in day to day operations, support, maintenance, enhancement, stabilization, and other routine tasks must run parallel to transition activities. Transition activities will also run parallel to the operation, maintenance, and enhancement task. The transition ****may** ~~may~~ **includes**** the transition of ownership of all hardware and software from the Contractor to the State ****that was procured for MITS development. JFS realizes the Contractor may choose to use existing hardware/software for the development environment and, in this case, the Contractor must provide a detailed listing of hardware/software (including the number of licenses) and all configuration specifications to JFS 90 days prior to the date needed for JFS use**.** The Contractor must provide a full knowledge transfer to JFS staff before executing the transition. Additionally, JFS may opt to delay the transition by extending the services of the Contractor for the maintenance and enhancement of MITS (see Task 11). Through the duration of the Contract, the Contractor must provide technical and troubleshooting assistance to the State 24 hours per day, 7 days per week, and 365 days per year. No holiday exclusions apply to this technical assistance requirement. Contractor technical assistance must be reachable by telephone with a response time based upon impact severity. Impact severity is defined in Task 11.

Contractor Responsibilities. During this task, the Contractor must execute the agreed upon MITS system transition plan, which will help address system transition to JFS business users, technical and development staff, project representatives, and business configuration staff.

Update System Transition Plan. The Contractor must work with the State to update the system transition plan submitted with the Proposal with the current MITS Project status.

Letter of certification of MITS System Transition. The Contractor must provide a letter of certification stating that MITS has been transitioned to JFS in accordance with the agreed upon system transition plan.

Contractor Deliverables. Deliverables to be produced by the Contractor for this task include the following:

80. Updated system transition plan;
81. MITS system transition conducted and completed; and
82. Letter of certification of MITS system transition.

Task 11 – Maintenance and Enhancement Task

Successful completion and acceptance of all the pre-production tasks and Deliverables will constitute the end of the DDI activities and the beginning of the production activities. This task describes the Contractor's responsibilities for the maintenance (and support) and enhancement, of MITS and all its component parts, such as MITS, EDMS, and CRM, once MITS ****Phase 1**** is ****accepted by the State**** ~~moved into the production environment~~.

Ongoing corrections of MITS will be characterized as maintenance and ongoing changes to MITS for additional functionality will be characterized as an enhancement. Maintenance, support, and enhancements will be required for the operational MITS.

Contractor Responsibilities

Maintenance and Support Plan: Before the initiation of this task, the Contractor must provide a maintenance and support plan for this effort. The maintenance and support plan must contain at a minimum:

- Service level agreements consisting of key system metrics agreed upon between JFS and the Contractor (e.g., system availability; correction of application defects; system enhancements; system updates, patches and repairs; and software upgrades); and
- Resource needs from Contractor and State.

The correction of application defects described in this task includes requirements that must be incorporated into the service level agreements and system metrics provided as part of the maintenance and support plan.

The Contractor must provide maintenance and support for ****up to**** 48 months once MITS ****Phase 1 has been accepted by the State**** ~~is migrated to the production environment~~. The operational support provided by the contractor includes On-Call, abend, Ad Hoc, etc. types of support.

Execution of the Approved Maintenance and Support Plan: The Contractor must execute the approved maintenance and support plan and provide to JFS status reports and performance reports on a regular basis (i.e. weekly, monthly, quarterly).

The Contractor is responsible for maintaining the MITS application, which involves updating, patching, and repairing application software components and resolving deficiencies in the application.

Updates, Patches and Repairs: The Contractor must update, patch, and repair the application software components in the development, test, and training environments, and package software changes for promotion to production.

The Contractor must follow the deployment processes approved by JFS. When installing new application updates, patches and repairs, the Contractor must evaluate the impact on current configurations. If the proposed MITS includes third party COTS products that are integral to the application, the Contractor must disclose the software license agreements for the COTS products. All software license agreements must include provisions for regular software updates, patches, and repairs. The Contractor must provide such updates, patches and repairs as specified in the software license agreements until MITS is successfully transitioned to the State. Any and all updates, patches, and repairs must be fully and successfully tested before migration to production.

For implementation of updates, patches, and repairs of MITS the Contractor must work with JFS to coordinate the release of the updates, patches, and repairs with regularly scheduled maintenance releases.

Correction of Application Defects: The Contractor must correct application defects, which are application malfunctions or functional deviations from JFS approved application design. No requirements or design changes are involved in the correction of application defects. The Contractor must take corrective action and ensure that the application performs as designed.

The Contractor must use the following definitions of resolution priority for application defects discovered during production:

- **Urgent**: issue/problem has caused, or has potential to cause, the entire system to go down or to become unavailable;
- **High**: issue/problem directly affects the public, or a large number of stakeholders are prevented from using the system. High-priority problems include those that render a site unable to function, make key functions of the system inoperable, significantly slow processing of data, severely impact multiple stakeholders, lead to federal penalties, misdirect payments, or severely corrupt data;
- **Medium**: all other issues/problems. Medium-priority problems include those errors that render minor and non-critical functions of the system inoperable or unstable, and other problems that prevent stakeholders or administrators from performing some of their tasks; and
- **Low**: all service requests and other problems that prevent a stakeholder from performing some tasks, but in situations where a workaround is available.

The Contractor must report all application defects to the JFS Project Representative or designated back-up JFS representative according to the following schedule based on the priority assigned to the inquiry/problem:

- **Urgent and High Priority:** Report via phone and/or pager immediately on a 24 hour per day schedule; and
- **Medium and Low Priority:** Report via email within two business hours.

Testing (EPSDT)
- Reference File
- Drug Rebate
- Benefit / Coverage Pre-Determination

Customer Relationship Management
- General MITS CRM System
- Consumer Interface
- Provider Interface
- Provider Enrollment/Maintenance

Contract Management
- Managed Care Plan Provider Agreements
- Sub-recipient State Agency Contracts
- JFS Administered Home and Community Based Services (HCBS) Waiver Case Management Contracts
- Provider Satisfaction
- Case Management

~~Business Intelligence~~ Operational Reporting
- External Reporting
- Operational/Administrative Reporting – Cost/Benefit
- Program Analysis and Development

Program Integrity
- Provider Utilization Management/Fraud Waste and Abuse Prevention (FWAP)
- Consumer Utilization Management/FWAP
- Retrospective Drug Utilization (DUR)
- Sub-recipient State Agency Reviews
- Provider State Hearing Rights

Privacy and Security
- Privacy Requests Management
- Security Management

For each business sub-process, the offeror must provide:

- A narrative description of its solution, including:
    - A high-level view of how its solution is structured and how it operates to provide the required business functionality
    - A summary of what types of changes (e.g., changes to benefit packages, claims adjudication and edits, etc.) can be easily accomplished via configurable parameters such as rules and tables
    - A summary of what, if any, COTS products will be used in carrying out the business functions described in the requirements

  Additionally, the offeror must complete the business requirements matrix provided in Supplement Nine. Supplement 9 is excluded from the maximum page number limit. For each requirement identified in the business requirements matrix, the offeror must use only one of the following response codes:

  F - Requirement will be **F**ully met in the delivered transfer system (without configuration, extension, or modification)

  P - Requirement will be **P**artially met in the delivered transfer system (without configuration, extension, or modification). When "P" is used in responding to a requirement, the offeror must provide a description explaining the extent to which the requirement is met and not met. ****A row may be added below the requirement in the Supplement 9 spreadsheet that contains the description or**** ~~The~~ ****the**** offeror ~~must~~ ****may**** use the Proposal Reference column to point back to that description in the Proposal.

  C - Requirement will be met via **C**onfigurable parameters (e.g., tables, rules)

  E - Requirement will be met via **E**xtensions to existing code

  M - Requirement will be met via significant **M**odification to the solution (e.g., via new functional modules). ****When "M" is used in responding to a requirement, the offeror must provide a description explaining the modification needed to meet the requirement. A row may be added below the requirement in the Supplement 9 spreadsheet that contains the description or the offeror may use the Proposal Reference column to point back to that description in the Proposal. ****

  N - Requirement will **N**ot be met. ~~When "N" is used in responding to a requirement, the offeror must provide a description explaining why the requirement will not or cannot be met. The offeror must use the RFP reference column to point back to that description in the Proposal.~~

~~**Proposal Reference** - This field must be completed with the section, page, and paragraph numbers of the Proposal to reference exactly where the Proposal states how the offeror's solution will meet the requirement. If this field is left blank, the evaluation team has the right to assume that the requirement is not met.~~

****NA – Not Applicable - functions would still be performed in the other system(s).****

Phase – The offeror must indicate if the stated requirement will be implemented in Phase 1 or Phase 2.

Technical Requirements: The offeror must provide a detailed technical architecture that meets the requirements of MITS. The offeror must clearly state how the proposed solution meets the technical requirements in Supplement Four of this RFP. The offeror must indicate its degree of knowledge and method of compliance with each of the technical requirements enumerated in Supplement Four.

Additionally, the Contractor must describe the previous architecture for each MITS component that has been modified to run on Web technology but was not originally built using Web architecture.

If client-downloaded components are required for any MITS user category, they must be identified and supplemented with business and technical justifications.

JFS standards and best practices related to the identified preferred solutions are provided as a supplement to the RFP for specific technology categories. Should the offeror propose alternate solutions for the identified technology categories, the offeror must briefly describe the proposed alternate standard or best practice and provide a description of the business and technical justifications for proposing the alternatives.

Additionally, the offeror must complete the technical requirements matrix provided in Supplement 10. Supplement 10 is excluded from the maximum page number limit. For each requirement identified in the matrix, the offeror must use one of the following response codes:

D – Available as delivered without configuration, extension, or modification;

P – Partially available as delivered without configuration, extension, or modification. When "P" is used in responding to a requirement, the offeror must provide a description explaining the extent to which the requirement is met and not met. ****A row may be added below the requirement in the Supplement 10 spreadsheet that contains the description or the offeror may use the Proposal Reference column to point back to that description in the Proposal.****

C – Available with configuration;

M – Requires a modification.~~; and~~ ****When "M" is used in responding to a requirement, the offeror must provide a description explaining the modification needed to meet the requirement. A row may be added below the requirement in the Supplement 10 spreadsheet that contains the description or the offeror may use the Proposal Reference column to point back to that description in the Proposal. ****

N – Not available.

~~**Proposal Reference** - Offeror must provide a Proposal reference to the location in its Proposal where an explanation can be found for any requirement with a response code of P, C, or M.~~

Phase – The offeror must indicate if the requirement will be implemented in Phase 1 or Phase 2.

MITA Alignment: The proposed solution must align with the MITA architecture.

Basic MITA Requirements: The offeror must describe how the proposed solution meets the following MITA requirements and indicate where in its Proposal the requirements are addressed:

- Industry based, open architectural standards;
- Modular components;
- Relational database;
- Web and real-time processing;

- Rules engine management;
- Data privacy, security, and integrity with access limited by staff role; and
- Interoperable systems that support e-communication and processing between systems.

Business Architecture and SOA Approach: The offeror must propose a detailed business architecture framework and SOA for MITS. The offeror's proposal must emphasize and demonstrate the implementation of platform independent, self-contained, reusable, scalable, and dynamic business services in the MITS domain, and must demonstrate how its solution is aligned with the MITS business model and MITS business requirements in Supplement Two. In developing its Proposal, the offeror should refer to the business architecture framework /service oriented architecture and service migration plan documented in Supplement Five.

Long-term MITA Vision: The offeror must describe its long-term vision for MITA and lay out a framework and roadmap to achieve MITA maturity and capability to level five as outlined in the business architecture framework and SOA document (Supplement Five) over a ten year period from the start date of this Project.

Best of Breed COTS: The use of best of breed COTS products is a MITA principle and JFS strongly recommends that the offeror propose best of breed COTS solutions to implement MITS business requirements not met by the base transfer system. The offeror must describe as part of the Proposal what COTS products it proposes to use, why that COTS product was chosen, and why it is best of breed. The explanation must include at a minimum:

a. Market share of the COTS product;

b. Ease of integration that ensures interoperability with the proposed transfer system; and

c. Offeror's experience in implementing and integrating the COTS product.

Certified Base Transfer System: The offeror must propose an MMIS-certified base system or a base system that is certifiable that is a derivative of a previously certified base system that will meet CMS certification requirements at the completion of Phase 1. The proposed base transfer system must be configured, modified, and enhanced to support all requirements addressed in this RFP or discovered during the systems analysis and design tasks.

The offeror must provide federal/CMS certification plan for the proposed solution. The certification plan must at a minimum:

a. State whether the offeror's proposed transfer system is currently CMS certified. Explain all conditions, if any, CMS imposed on the certification of the proposed transfer system. If the proposed transfer system is developed/implemented and is in the certification process, specify the status of this process and the expected date of certification.
b. Agree that it is the offeror's responsibility to design, develop and implement a fully certified MMIS to Ohio. Affirmatively and explicitly state offeror's commitment to deliver an MMIS, including all sub-systems and components that will meet or exceed all CMS MMIS certification requirements. Further, offerors must demonstrate an understanding of the certification requirements and the process for obtaining CMS certification by describing, in detail, the steps the offeror will take to achieve certification, including how the offeror will support JFS in the CMS certification process.
c. Include a proposed timeline for preparation of certification materials and presentation of the materials to the JFS Project Representative.
d. Describe the offeror's experience with MMIS Certification with other states, including experience of key personnel.
e. Describe the offeror roles and responsibilities during this stage.
f. Describe the State roles and responsibilities during this stage.
g. Describe the deliverables from this stage (See Task 9).
h. Describe the milestones to be achieved through this stage.

Data Conversion: The offeror must describe its overall strategy and approach to assuring that data conversion is done accurately and on time. MITS data conversion requirements are documented in Supplement Seven. The proposed solution also must specify what data conversion tools the offeror will use and must include a detailed data conversion plan. The data conversion plan must be in compliance with the plan requirements found in task 6.

Integration Architecture: The offeror must address the requirements described in the integration architecture requirements document in Supplement Six. The offeror must provide a written narrative that shows that the offeror understands the work effort required for integration of, or interfacing with, the internal and external systems described in the integration architecture requirements document and how the offeror's proposed solution meets those requirements.

System Transition - The offeror's proposal must include a transition strategy and plan that details all activities that are required for the transition of MITS to JFS. This plan must be developed in accordance with OHP objectives and must include, but not be limited to, the following topical areas:

- Transition objectives;
- Dependencies;
- Contingencies;
- Risks;
- Facilities;
- Staffing requirements (both numbers and skills required);
- Training requirements;
- Hardware/Software requirements; and
- Transition schedule.

Work Plan

This section is included in the page number limit.

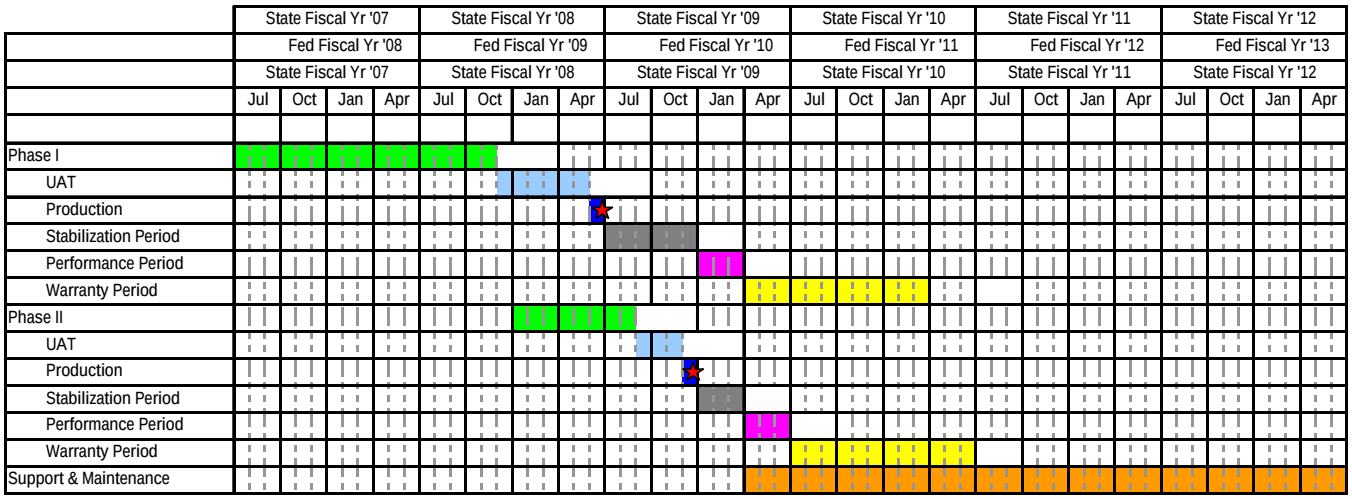
The offeror must fully describe its approach, methods, and specific work steps for doing the work on this Project and producing the Deliverables. The State encourages responses that demonstrate a thorough understanding of the nature of the Project and what the Contractor must do to get the Project done well.

The State seeks insightful responses that describe proven, state-of-the-art methods. Recommended solutions should demonstrate that the offeror will be prepared to quickly undertake and successfully complete the required tasks. The offeror's work plan should clearly and specifically identify personnel assignments and the number of hours by individual for each task.

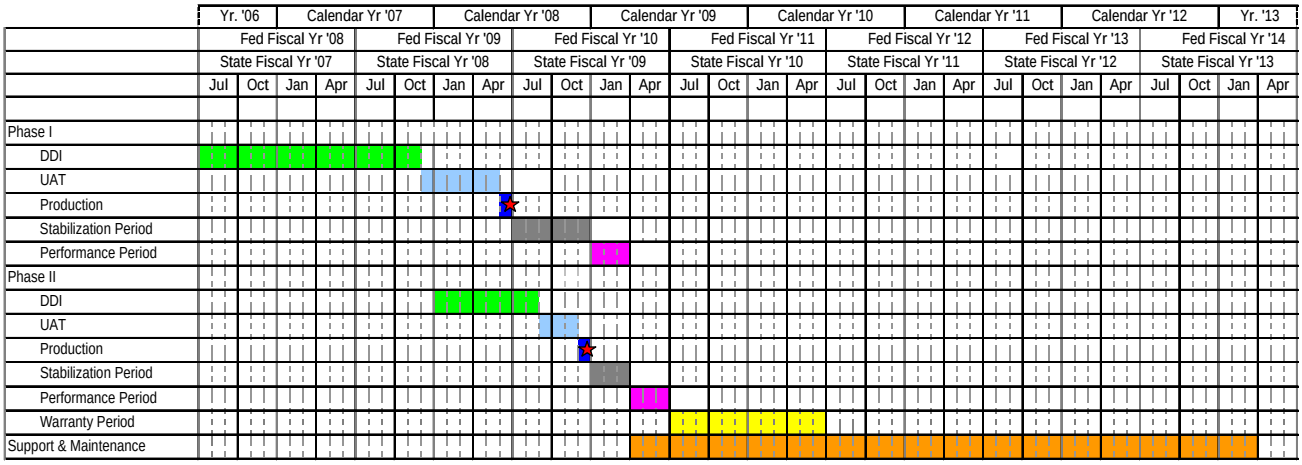
A work plan must be completed for each task described in Attachment One. Additionally, the offeror must indicate in the work plan for each task, how many iterations are being proposed for each set of deliverables that correspond with the chart in Contractor Payment Structure section.

The Contractor should use the following chart to build its project plan for the development and implementation of MITS Phase 1 and 2.

****Revised Chart demonstrating two warranty periods, one for Phase 1 and one for Phase 2****



**** The Chart below has been replaced with the one above****



★ Indicates Production Milestone

DDI	Design Development and Implementation
UAT	User Acceptance Testing & Operational Readiness Test
Production	Production Dates – 24 months after start of work for Phase 1 and Phase 2 may be implemented as soon as 6 months, but no more than 12 months after implementation of Phase 1
Stabilization Period	As outlined in Task 8
Performance Period	Performance periods of 180 days as outlined in Attachment 3, for final system acceptance
Warranty Period	As per Terms and Conditions
Support & Maintenance	As per Task 11 -- Up to 48 Months

The above graphical illustration represents the JFS' initial view of an overall MITS timeline. The following are the constraints to which the Contractor must comply when developing its MITS plan.

a. MITS Phase 1 must go into production no more the 24 months after start of project;
b. MITS Phase 2 must go into production no later than 12 months after Phase 1 goes into production;
c. There must be no overlap between stabilization and performance Periods;
d. The Contractor must provide for a stabilization period for six months after implementation of Phase 1;
e. The Contractor must provide mandatory warranty for one year starting upon acceptance of ****each**** MITS Phase ****1 and 2****;
f. The Contractor must provide for a stabilization period of three months after implementation of Phase 2; and
g. The Contractor must work with JFS to provide a three month performance period for MITS Phase 1 and Phase 2 after the stabilization periods for Phase 1 and 2.

Staffing Plan

This section is included in the page number limit.

The offeror must provide a staffing plan that identifies all the personnel by position that the offeror proposes to complete the Project. The staffing plan must show each position's responsibilities on the Project. The State also requires the staffing plan to match the proposed Project key personnel and qualifications to the activities and tasks that will be completed on the Project. Key personnel are those individuals identified and evaluated in the proposal. In addition, the plan must have the following information:

- A contingency plan that shows the ability to add more staff if needed to ensure meeting the Project's due date(s);
- The depth of personnel available to the offeror to perform the MITS Project, as well as concurrent offeror projects;
- A qualified personnel replacement plan that shows the offeror's ability to replace qualified staff should the need arise to meeting the Project's due date(s); and

- A plan that describes how and where the offeror will house all Offeror staff members working on the project. This must include the location for all project activities. The State requires that interaction with State staff, such as meetings, design efforts, and UAT, be in a face-to-face format at the primary project site.

Time Commitment

This section is included in the page number limit.

The offeror must submit a statement and a chart that clearly indicate the time commitment of the proposed Project Manager and the offeror's proposed key Project personnel for this Project during each phase of the SDLC. The offeror also must include a statement indicating to what extent, if any, the Project Manager may work on other projects during the term of the Contract. The State may reject any Proposal that commits the proposed Project Manager or any proposed key Project personnel to other projects during the term of the Project, if the State believes that any such commitment may be detrimental to the offeror's performance.

Assumptions

This section is included in the page number limit.

The offeror must list all the assumptions the offeror made in preparing the Proposal. If any assumption is unacceptable to the State, the State may reject the Proposal. No assumptions may be included regarding negotiation, terms and conditions, or requirements.

Project Plan

This section is included in the page number limit.

The State encourages responses that demonstrate a thorough understanding of the nature of the Project and what the Contractor must do to get the Project done properly. To this end, the offeror must submit a Project Plan that the offeror will use to create a consistent and coherent management plan for the Project. The Project Plan must include detail sufficient to give the State an understanding of how the offeror's knowledge and approach will:

- Manage the Project;
- Guide Project execution;
- Document planning assumptions and decisions;
- Identify and Mitigate Risk;
- Facilitate communication among stakeholders;
- Define key management review as to content, scope, and schedule; and
- Provide a baseline for progress measurement and Project control.

The offeror's Project plan, included as part of the offeror's submittal, must include at a minimum the following:

Management Plan. The description must describe the offeror's liaison duties with the JFS Project Representative including communications, work coordination, status meetings and reports, etc. The contents of this narrative must contain sufficient detail and be designed to convince the State that the offeror understands the nature and objectives of the required work and the level of effort necessary to successfully provide and manage the required services. In addition, this narrative must convince the State that the offeror's approach and plans to undertake the provision of the required services are appropriate to the required level of effort necessary to ensure successful Contract performance.

The management plan must also address the following areas:

Project Management Methodology. The offeror must describe the approach, method(s), and specific work steps it plans to use to manage the Project. The project management methodology must be as complete as possible at the time of submission. It must address the following topics: Project integration, Project business transformation management, Project scope management, Project quality management, Project communications management, Project risk management, Project resource management, and Project reporting procedures.

In addition, the narrative must address the following:

definition, requirements gathering, design, development, conversion, testing, benchmarking, implementation, training, and transition, as applicable;

- Detailed Project schedule for all Project Deliverables and milestones. The Project schedule must be delivered as a Microsoft Project® 2002 ****or higher**** Gantt chart, showing all major Project tasks on a week by week schedule to serve as the basis for managing the Project. The schedule must clearly demonstrate how the Project will become fully operational by the delivery date. The detailed Project schedule must be submitted as part of the offerors electronic copy of its proposal in Microsoft Project 2002 ****or higher****. The offeror must give dates for when the Deliverables/milestones will be completed and start and finish dates for tasks. Deliverable Milestones must clearly indicate the Deliverable number. The offeror must provide dependency details for tasks as a part of the project schedule. The offeror also must identify and describe all risk factors associated with the forecasted milestone schedule;
- Who is assigned responsibility for each Deliverable within the WBS to the level at which control will be exercised;
- Performance measurement baselines for technical scope and schedule;
- Major milestones and target date(s) for each milestone that are consistent with this RFP's dates;
- Key or required staff and their expected effort;
- Description of the offeror's proposed organization(s) and management structure responsible for fulfilling the Contract's requirements;

Support Requirements

This section is included in the page number limit.

The offeror must describe the support it wants from the State other than what the State has offered in this RFP. Specifically, the offeror must address the following:

- Nature and extent of State support required in terms of staff roles, percentage of time available, and so on;
- Assistance from State staff and the experience and qualification levels required;
- Other support requirements;
- The Offeror's key project team members must maintain a presence and an office at the primary project site;
- JFS will provide a knowledgeable, dedicated project team whose composition includes both business and technical staff. JFS intends some of these individuals will function on the project team for only short periods of time while others will remain on the team for the duration of the project. The state will supply up to 16 full time equivalents from Ohio Health Plans and up to 20 full time equivalents from Management Information System. The key persons for the State's project team will consist of the Medicaid Project Sponsor, JFS Project Representative, MIS Technical Representative, Technical Architect, core MITS team, and subject matter experts (SMEs) from the business area, Management Information Systems, and others; and
- The Offeror must provide administrative support for its staff.

The JFS Project Representative will be committed to coordinating and providing access to all necessary Medicaid resources for the duration of the Project. The SME's and team members will be available to the project on an as-need basis for the duration of the Project and required by the work plan and Personnel Interface Matrix.

The State may not be able or willing to provide the additional support the offeror lists in this part of its Proposal. The offeror therefore must indicate whether its request for additional support is a requirement for its performance. If any part of the list is a requirement, the State may reject the offeror's Proposal, if the State is unwilling or unable to meet the requirements.

SDLC Overview

This section is included in the page number limit.

The State seeks insightful responses that describe proven, lifecycle system development methods. Recommended solutions must demonstrate that the offeror will be prepared to quickly undertake and successfully complete the required tasks.

Supplement 2

MITS Business Requirements Amendment Replacement Pages

- Authorized services (units, effective dates)
- Miscellaneous codes with notes field (for contractors)
- Rates
- Dollar cap
- Local provider information
- Provider demographic and rate data
- Limits
- Certification information
- Room and board
- Health costs
- Waiver start date
- Waiver program (benefit package)
- Waiver wait list data
- Cost share data
- ~~For miscellaneous codes, descriptions must be available on the PA request form.~~

1.1.7.22 Allow for expansion and addition of fields to the on-line PA request form.

1.1.7.23 Allow providers the ability to view alerts and notifications generated by ODJFS staff via MITS to include:

- The need for additional information on an already submitted PA request
- Reminders of missing information
- Approval or denial of the PA
- System updates/policy changes
- Duplicate or possible duplicate requests.

1.1.7.24 Generate approval or denial notices as soon as the determination has been made.

1.1.7.25 Provide the ability to automatically approve certain PA requests based on information entered as identified by ODJFS.

1.1.7.26 Retain incomplete PA request submissions for a minimum number of days, to be defined by ODJFS, before deleting the record.

1.1.7.27 Maintain a rolling thirteen-month period of on-line PA history.

1.1.7.28 Allow PA request forms to be available on the Medicaid Portal for download by users.

1.1.7.29 Link to Ohio administrative rules/program information.

1.1.7.30 Provide an on-line PA submission tutorial.

- Document-centric collaboration
- Workflow management including document workflow.

1.2.1.2 Utilize open architecture standards and scalability to promote integration throughout all MITS business processes and sub-processes.

1.2.1.3 Align with MITA standards.

1.2.1.4 Employ a security approach that integrates with other MITS components to provide role-based access with a single log-on.

1.2.1.5 Integrate with and provide support to various MITS components such as:

- Customer Relationship Management (CRM)
- Medicaid Portal
- Security system.

1.2.1.6 Accept documents through various input methods such as:

- Medicaid Portal
- E-mail
- Facsimile
- Internal creation from Personal Computers (PCs)
- Imaging
- Mailroom.

1.2.1.7 Store both electronic and imaged paper documents and make them available on-line through a single user interface to promote a total view of current and historical information.

1.2.1.8 Provide for on-line retrieval and access to documents and files for up to seven (7) years rolling.

~~1.2.1.9 Provide backup and storage of documents as defined by ODJFS.~~

1.2.2 **Document Management**

1.2.2.1 Associate with all documents parameters such as:

- Document type
- Document format
- Storage location
- Barcode formats
- Security levels
- Size
- Field validation.

1.2.3.4 Provide backup capability for manually indexed scanned documents.

1.2.3.5 Provide the capability to adjust scan preferences for each document type to include:

- Resolution
- File numbering
- Storage location.

1.2.3.6 Include at a minimum the following imaging and document management capabilities:

- Scan both single and dual sided documents
- Scan complete or scrapped documents
- Scan color, black and white, and grayscale images
- Provide capability to handle special characters
- Support a wide range of compression methods
- Retrieve images through the use of key word searches.

1.2.3.7 Provide the capability to manipulate images to include:

- Rotation
- Inversion
- Zoom
- Brightness/contrast.

1.2.3.8 Use imaging/document management technology that handles multiple types of letters, forms, publications, and other State designated documents, files and automates workflow processing to include:

- Provider certification materials
- Claim forms and attachments
- PA forms and attachments
- COB (including casualty)
- Estate recovery
- Employer verification of earnings and health insurance
- Provider correspondence
- Consumer correspondence
- Medicaid Portal correspondence
- ~~Consumer enrollment materials~~
- Notices
- Letters
- Audit materials.

- Single-sided or double-sided print
- On-line (e.g., PDF)
- Customization of report templates
- Standard format that includes header, footer, etc.

1.4.1.2 Support automatic Windows-based report production and distribution to the State via the State Local Area Network (LAN).

~~1.4.1.3 Phase 2 Provide workflow tracking, version control, and near real-time reporting functionality from legislation to law, to administrative rule, contract, business rule and audit activity and resolution repository. (This may involve interfacing with sub-systems such as the Legislative Information System (LIS) and LawTrac.)~~

1.4.1.4 Provide the ability to display a graphical representation that identifies the near real-time status of critical MITS system and processing functions (e.g., “vital signs” such as claim volume, pended claims, calls on hold, exceptions posted, etc.) This feature must run in near real-time or near near real-time with very little delay.

1.4.1.5 Provide a flexible reporting system that meets ODJFS business requirements.

1.4.1.6 Download reports in various formats.

1.4.1.7 Allow information via various presentation methods with the preferred format web-based (e.g., PDF).

1.4.1.8 Allow users to run a series of standard reports on a scheduled basis.

1.4.1.9 Provide the ability to export reports for enhanced manipulation and analysis.

1.4.1.10 Provide the capability and flexibility for multiple simultaneous users to create and run in near real-time, ad hoc and canned reports without going through a formal change control process.

1.4.1.11 Produce operational reports.

1.4.1.12 Create reports that provide supervisory and management with detailed or summary reports by staff person or unit.

1.4.1.13 Allow users the ability, with help screens, to extract data from management reports, manipulate the extracted data, and specify the desired format and media of the output.

1.4.1.14 Support near real-time on-line notification to the case manager of a consumer hospitalization, nursing home admission, Intermediate Care Facility for Mentally Retarded (ICF-MR) admissions and emergency room use.

1.4.1.15 Provide flexible query tools allow staff to customize information retrieved and analyze data to answer specific program questions and support management decisions.

1.4.1.16 Provide query tools that are easy to learn, with the flexibility to support data changes.

1.4.1.17 Provide on-line access to metadata.

1.4.1.18 Provide the following on-line metadata information including:

- Describe the report
- Provide the definitions of fields
- Define any calculations
- Built-in statistical measure objects.

1.4.1.19 Provides for the electronic delivery of reports to identified destinations.

1.4.1.20 Interface to the Legislative Information System (LIS) to track the status of rules filed.

1.4.1.21 Provide the capability to produce multi-dimensional, flexible, ad hoc reports across business functions ~~using~~ which meet the following reporting needs such as:

- Financial reporting
- Budget forecasting
- Fiscal planning and control
- Claims payment accuracy
- Cash flow
- Timely reimbursement analysis
- Recipient cost and user of services
- Cost/benefit analysis
- Third party recovery
- Estate recovery
- Prescription drug policy
- Cost and user of prescription drugs
- Recipient participation
- Eligibility and benefit design
- Geographical analysis
- Program planning
- Policy analysis
- Federal waiver program evaluation
- Program performance monitoring
- Provider reimbursement policy
- Institutional rate-setting
- Medical assistance policy development

1.4.1.36 Provide for the electronic delivery of reports to identified destinations.

1.4.2 **Data Retention, Archival, Retrieval and Purge**

1.4.2.1 Ability to maintain an unlimited number of historical records of each consumer eligibility change.

1.4.2.2 Provide the capability for ODJFS to specify/modify auto archive rules.

1.4.2.3 Provide the ability to retain and access historical reference file data according to ODJFS retention requirements.

1.4.2.4 Provide the capability to retain historical reference file data on-line for up to seven years.

1.4.2.5 Provide the ability to retain up to seven years of claims history on-line, to include adjustments and all supporting financial transactions.

1.4.2.6 Provide the capability to retain PA determinations on-line for up to seven years.

1.4.2.7 Provide the capability to restore archived data for reviewing, copying and printing.

1.4.2.8 Provide the capability to purge archived data in accordance with ODJFS archival and purge schedules.

1.4.3 **E-Library (General Report Repository and Management)**

1.4.3.1 Track and store detailed information regarding all reporting requests including:

- Who requested the information
- Date
- Time
- What the report included
- Report storage upon completion
- Route the entire history on-line.

1.4.3.2 Provide the ability to categorize and organize reports by source system, data content, purpose, frequency and other staff selected options.

1.4.3.3 Provide the ability to print to compatible networked printers.

1.4.3.4 Provide the ability to access all operations, administrative, financial, **** and **** Surveillance Utilization and Review (SUR)~~, external, Decision Support System~~ reports through a web- based reports repository.

1.4.3.5 Provide the ability to establish and maintain a master reports list that staff will browse and select reports from.

1.4.3.6 Provide the ability to add change, delete report categories in the master reports list.

- Claim edits and audit disposition
- Benefit plan creation and maintenance.

1.5.1.5 Use rule-based logic for MITS business functions such as claims and PA processing, document and work flow management, ~~eligibility determination,~~ and benefit package definition.

1.5.1.6 Match data attributes of the claim to the rule repository that include rules regarding ODJFS policy/benefit package and edit disposition.

1.5.1.7 Provide role-based on-line, real-time modifications of rule-based tables and configuration of benefit packages.

1.5.1.8 Provide on-line capability to easily add, end date, or modify health plan(s) and/or its related components.

1.5.1.9 Use Windows interface to configure policy by relating attributes available in drop-down menus.

1.5.1.10 Provide on-line help features.

1.5.1.11 Retain an audit trail for all rule-based user actions (e.g., add, change, or end date).

1.5.1.12 Limit or eliminate the need for programming /technical support.

1.5.1.13 Provide the capability to instantly view the effect of changes.

1.5.1.14 Provide the capability to view on-line rules used to process a claim, claim adjustment, or prior authorization.

1.5.1.15 Utilize plain language business rules and processes to define program logic.

1.5.2 **Rule Representation/Administration/Scalability**

1.5.2.1 Provide the rule representation such as:

- Jump start vocabularies
- Multiple rule representation (e.g., decision tables, pseudo-linguistic with context)
- Rule sequencing
- Definition of macros and cascading meanings
- Rule inheritance
- Rule consistency checks
- Rule collision checks
- Rule overlap and “under-lap” checks
- Lexicon support
- Upon rule entry, link rule test to the rule.

1.5.2.2 Provide easy administration such as:

- Easy to change rules

1.7.1.5 Provide back-up and disaster recovery plan for information submitted to Medicaid Portal, but not yet entered into MITS.

1.8 Notifications/Alerts

1.8.1 **Overall Requirements**

1.8.1.1 Provide the ability to generate alerts.

1.8.1.2 Provide the ability to generate individual system generated alerts with user-defined criteria (e.g., time intervals, events).

1.8.1.3 Provide the ability to generate alerts when changes are made to policies and procedures and system tables or functionality.

1.8.1.4 Provide the ability to generate alerts when the anticipated return time on a query or report job exceeds a defined time limit.

1.8.1.5 Provide the ability to generate alerts that assist in monitoring time-sensitive activities.

1.8.1.6 Provide the ability to generate alerts to a user-defined group or individual.

1.8.1.7 Provide the ability to generate alerts to staff based on the status or prior authorizations.

1.8.1.8 Provide the ability to generate alerts to notify staff when they need to take action in connection with workflow events.

1.9 General System Performance Expectations

1.9.1 **Overall Capacity and Throughput**

1.9.1.1 Provide, without any degradation in performance, concurrent access, through the State Wide Area Network (WAN), for at least five thousand (5,000) users. This includes eighty-eight (88) counties, sub-recipient State agencies, stakeholders and other State contractors.

1.9.1.2 Provide sufficient capacity to handle the following processing volumes during times of peak operation while also meeting system response time requirements:

- Adjudicate at a minimum 875,000 claims per day
- Adjudicate at a minimum 200,000 encounters per day
- Capacity to accept at a minimum 3.375 million pharmacy claims into payment on a monthly basis
- Process at a minimum 1,750 claim adjustments per month
- Process at a minimum 20,000 Prior Authorization (PA) requests per month
- Support at a minimum 11,250 refunds per month
- Support at a minimum 12,500 ~~various~~ ****other**** types of **** adjustments ****per month, **** excluding LTC adjustments ****

- Support at a minimum 25,000 LTC adjustments per month
- Support at a minimum 6,250 claim reversals per month
- Support at a minimum 500,000 adjustments per month when mass/gross adjustments are executed
- Image, index, and store at a minimum 50,000 pages per day
- Handle workflow management for simultaneous processes (e.g., contracts, benefit package definition, etc.)
- Support up to 50 reports running concurrently
- Receive, log, and address at a minimum 55,000 customer calls through CRM per month.

1.9.1.3 Provide sufficient data communication and processing capacity during times of peak operation to receive and process:

- EDI transactions
  - Process at a minimum **** 3.7**** ~~0.3~~ million Accredited Standards Committee (ASC) X12 270/271 eligibility inquiries and responses per month
  - Process at a minimum 3 million American National Standards Institute (ANSI) X.12 276/277 claim status inquiries and responses per month
  - Process at a minimum 6 million ANSI X.12 835 remittance transactions per month
  - Process at a minimum 3.7 million ANSI X.12 837 claim transactions per month
  - Process at a minimum 4.8 million responses or turnaround transactions (824, U277, 997, 999, TA1) per month.

1.9.1.4 Build into the MITS architecture sufficient scalability to handle a 5% annual increase from “day one” peak volumes for a minimum of ten years.

1.9.2 **Response Times**

1.9.2.1 Meet system response time requirements. Response time shall be measured during normal working hours, which are 6:00 a.m. to 7:00 p.m., Eastern Time, Monday through Friday, and on Saturdays 8:00 a.m. to 12:00 p.m., Eastern Time except for State observed holidays. The Medicaid Portal response times will be measured 7 days a week, 24 hours a day, except during agreed upon downtime. The response time definitions do not apply to the data warehouse/DSS. The Vendor will only be responsible for that portion of the system and communication link for which the Vendor has responsibility and control. For example, the Vendor will not be responsible for the response times while a transmission is traveling over the State's LAN. The same logic will apply to transactions

over the network controlled by the switch vendor, or individual providers, or their billing agents and services. The following definitions apply to networked workstations:

- Record Search Time -- The time elapsed after the search command is entered until the list of matching records appears on the monitor
- Record Retrieval Time -- The time elapsed after the retrieve command is entered until the record data appears on the monitor
- Screen Edit Time -- The time elapsed after the last field is filled on the screen with an enter command until all field entries are edited with the errors highlighted
- New Screen/Page Time -- The time elapsed from the time a new screen is requested until the data from the screen appears on the monitor
- Print Initiation Time -- The elapsed time from the command to print a screen or report until it appears in the appropriate queue
- Medicaid Portal Response Time -- The elapsed time from the command to view a response until the response begins to appear on the screen.

1.9.2.2 Ensure that MITS components' response times meet the following minimum standards. Times will be measured for adherence to the requirements at the ODJFS' discretion. The Vendor must provide a system to monitor and report on response times. The response time requirements do not apply to the data warehouse/DSS.

- Record Search Time -- The response time must be within four (4) seconds for 95 percent of record searches
- Record Retrieval Time -- The response time must be within four (4) seconds for 95 percent of records retrieved
- Screen Edit Time -- The response time must be within two (2) seconds for 95 percent of the time
- New Screen/Page Time -- The response time must be within two (2) seconds for 95 percent of the time
- Print Initiation Time -- The response time must be within two (2) seconds for 95 percent of the time
- Medicaid Portal Response Time -- The response time must be within four (4) seconds for 99 percent of the time.

1.9.2.3 ****Operational**** ~~R~~reports must be generated according to the following timelines:

- Daily reports delivered by noon of the next business day
- Weekly reports and cycle processing report by noon of the next business day after the scheduled run
- Monthly reports by noon within five (5) business days following the end of the month

- Quarterly reports by noon within five (5) business days following the end of the quarter
- Annual reports by noon within ten (10) business days following end of the year (Federal fiscal, State fiscal, or other annual cycle).
- Ad-hoc and on-demand reports within the timeframes defined by ODJFS in the report request ~~but normally within five (5) seconds after the request is initiated 95% of the time~~. **** The State and the Contractor are to work collaboratively to define and set benchmark data queries to support the evaluation of ad hoc reports performance during the design phase of the project.****

1.9.3 **Availability**

1.9.3.1 MITS access must be available at a minimum during ODJFS core working hours, which are 6:00 a.m. to 7:00 p.m., Eastern Standard Time, Monday through Friday, and on Saturdays 8:00 a.m. to 12:00 p.m., Eastern Standard Time, except for State observed holidays, and on an emergency basis if requested by the State.

1.9.3.2 Data base system is available and accessible to multiple users 24X7 except for ODJFS-approved time for system maintenance.

1.9.3.3 The Medicaid Portal, and other system components as required by ODJFS, must be available 7 days a week, 24 hours a day, except agreed upon downtime.

1.9.4 **Error Handling and Trouble Reports**

1.9.4.1 Submit system trouble reports to ODJFS-designated staff no later than close of business on the day the problems are identified.

1.9.4.2 Notify ODJFS-designated staff of any system problem within one (1) hour of problem discovery.

1.9.5 **Protection Against Unauthorized Access**

1.9.5.1 The system shall provide security from anticipated threats or hazards to its data and shall restrict the availability of data to appropriate State staff and to other designated individuals and organizations through standardized system applications and data security capabilities.

1.9.5.2 Ensure that all applications are protected against unauthorized access according to State and Federal guidelines. Additionally, all transmission lines and communications services and linkages between the data and each information system, and between each system and the LAN, must be secure from unauthorized access at all times.

2.2.1.14 Provide monthly verified TPL data, including Medicare, to the ODJFS contracting Medicaid MCPs.

2.2.1.15 Provide a daily file of verified TPL data, including Medicare, to the Selection Services Contractor (SSC).

2.2.1.16 Provide the ability to update TPL data on-line based upon authorized role-based access and with appropriate audit trails.

2.2.1.17 Generate verification at ODJFS-defined intervals, of TPL information for Medicaid consumers using TPL clearinghouses utilizing EDI 270/271.

2.2.1.18 Provide for on-line letter creation, generation, maintenance, modification, tracking, storage, and historical viewing of standard and ad hoc letters.

2.2.1.19 Provide for mass change or archiving of TPL records affected by dissolved insurance companies or employers.

~~2.2.1.20 Integrate functions within an existing TPL contract, an EDI exchange contract, and a child support contract, as needed.~~

2.2.1.21 Provide statistical reports from the TPL interface tracking file, the TPL Master File, and the 270/271 exchange.

2.2.1.22 Provide near real-time access of the TPL database to contributing source systems using role-based access defined by the ODJFS.

2.2.2 **Performance Expectations**

2.2.2.1 New information and changes to TPL coverage information received electronically is updated in MITS and available for on-line inquiry and claims adjudication within 1 business day of receipt.

2.2.2.2 Process manually entered updates in near real-time from the eligibility systems.

2.2.2.3 Failed manual and electronic TPL edits resolved in near real-time.

2.2.2.4 Insurance carrier disclosure information processed in near real-time upon receipt of the 271.

2.2.2.5 Medicare coverage (i.e., Parts A, B, C, D, etc) information updated in MITS within one (1) business day of receipt.

2.2.3 **Inputs**

2.2.3.1 County entered TPL information

2.2.3.2 BENDEX/CMS EDB file (Medicare)

2.2.3.3 TPL information from providers

2.2.3.4 Insurance disclosure files

2.2.3.5 Post pay recovery vendor TPL eligibility information

2.2.3.6 NAIC insurance carrier list

2.2.3.7 SSA/CMS query responses

2.2.3.8 DEERS

2.3.1.26 Assign eligible consumers to MCPs based on MCP service area and/or program type according to ODJFS-defined criteria.

2.3.1.27 Exempt certain terminated members from the auto-reenrollment process, based on ODJFS-defined criteria.

2.3.1.28 Provide the capability for the SSC to enter membership additions/changes/deletions on-line or in batch mode, per ODJFS policy.

2.3.1.29 Provide the capability to the SSC or other enrollment entity to enter MCP and other capitated programs membership data using on-line screens per ODJFS-defined criteria.

2.3.1.30 Limit MCP membership changes to periods of time based on ODJFS-defined criteria.

2.3.1.31 Generate and send via the CRM ODJFS-approved MCP membership materials to eligible individuals, at a minimum, on a weekly basis.

2.3.1.32 Generate and electronically transmit eligibility and demographic information for all MCP eligible consumers to the SSC on a daily basis.

2.3.1.33 Generate and send letters via the CRM to MCP new members and terminating members per ODJFS policy.

2.3.1.34 Maintain and display on-line MCP member data including the following:

- The MCP for each effective data span
- Effective date of membership
- Effective date of termination of membership
- MCP lock-in dates and assignment indicator
- Reason codes for membership or termination of
- Membership exemption codes
- ~~MCP morbidity codes~~
- County or region-specific codes.

2.3.1.35 Provide for the automatic re-enrollment in the same MCP for members who lose Medicaid eligibility but regain eligibility within a specified period of time without the members having to go through the initial enrollment process.

2.3.1.36 Accept and process MCP membership data received electronically from ODJFS' eligibility system(s), and ****data entered**** manually ****by MITS users**** ~~from other sources~~.

2.3.1.37 Allow authorized, role-based access to users to override MCP membership, as defined by ODJFS.

2.3.1.38 Generate electronic and/or hard copy reports of members for distribution to MCPs. Electronic transmissions (e.g., 834 transactions) must comply with State and Federal requirements.

- Summary and detail reports to track and summarize PAs processed by adjudication mode (e.g., automated or manual)
- Summary reports that include consultant hours worked and projects worked on

3.7.1.74 Accept level of care data electronically from ODJFS and its contractors.

3.7.1.75 Provide ODJFS with on-line access to waiver services data.

3.7.1.76 Allow for on-line entry, registration, and submission of PA data to the MITS via the Medicaid Portal. Data fields include:

- ~~Individual ID~~ ****Consumer billing number****
- Service
- Provider name and ID
- Dates of service
- Authorized services (units, effective dates)
- Miscellaneous codes w/ notes field (for contractors)
- Rates
- Dollar cap
- Local provider information
- Provider demographic and rate data
- Limits
- Certification information
- Room and board
- Health costs
- Waiver start date
- Waiver program (benefit package)
- Waiver wait list data
- Cost share data.

3.7.1.77 Authorize waiver services for a specific time period (e.g., six (6) months or one (1) year).

3.7.1.78 Approve service authorization requests for waiver services up to a specific dollar amount.

3.7.1.79 Generate on-line reports at times specified by ODJFS for the following including:

- Waiver functional eligibility
- Outstanding liability from claims and PA
- Outstanding consumer liability
- Open Prior authorizations at any give time
- Obligation based on authorization data.
- Prior authorizations versus claims.

- Other related calls/contacts.

4.1.1.45 Ability to transfer, refer and track call/contacts to and from contractor or ODJFS staff for follow-up.

4.1.1.46 Provide the ability to include the following information for referrals:

- Call/contact priority
- Referral date
- Resolution due date (ability to calculate date as defined by the State)
- Resolution date
- Referral unit/person ID
- Name and ID of person resolving the call
- Track resolution/disposition of calls.

4.1.1.47 Ability to archive and purge calls/contacts/correspondence from the CRM as directed by ODJFS.

4.1.1.48 Allow inquiry and on-line display of call/contact/correspondence records by type, original call/contact date, consumer or provider name or number, caller name (if different than consumer), customer service correspondent name or ID, or any combination of these data elements.

4.1.1.49 Support easy navigation from call/contact/correspondence logging screens to other data relevant screens or other relevant system screens.

4.1.1.50 Allow multiple screens to be displayed at one time.

4.1.1.51 Provide inquiry routing and escalation capabilities based on priority and length of time as defined by ODJFS for inquiries that are outstanding.

4.1.1.52 Generate a system notification to alert a customer service correspondent or other ODJFS staff that a call/contact/correspondence has been assigned to them.

4.1.1.53 Include analytic functionality to collect customer (e.g., consumer, provider, county) information and the ability to classify customers into segments and by educational information.

4.1.1.54 Provide on-line tutorial CRM user training for State staff.

~~4.1.1.55 Interface and exchange data with other State-identified CRM systems.~~

4.1.1.56 Verify that consumers and/or their representatives are verified/authenticated prior to releasing information in accordance with the State and Federal PHI requirements.

4.1.1.57 ****Access**** ~~Interface with~~ the ****MITS-based**** Patient Disease Registry,~~ or~~ ****and/or interface with external**** ~~other such~~ databases, and send alerts regarding clinical

4.4.1.11 Incorporate electronic signatures that comply with Ohio Administrative Rule 123:3-1-0, with provider enrollment applications and updates.

4.4.1.12 Use a zip code application to automatically populate on-line screen fields such as county and city.

4.4.1.13 Edit and verify accuracy of all entered data for presence, format, validity and consistency with other data in the update transaction and on the provider subsystem (e.g., prevent duplicate provider enrollment).

4.4.1.14 Provide the capability to update the provider subsystem in near real-time.

4.4.1.15 Provide the capability to update the provider files with service restrictions requested by ODJFS. Allow authorized users to add, change or delete all provider data on-line, near real-time contingent on role-based criteria defined by ODJFS with a tiered approval and management approach.

4.4.1.16 Allow authorized users to add, change or delete all provider data on-line, near real-time contingent on role-based criteria defined by ODJFS with a tiered approval and management approach.

4.4.1.17 Identify applications and updates by provider types that are assigned by ODJFS.

4.4.1.18 Retain all open and closed segments along with information such as user identification, date and time for both the before and after image.

4.4.1.19 Identify providers with a unique provider number using the ten (10) digit National Provider Identifier. Unique identifier information should include all locations, provider types, specialties, provider taxonomy, authorization/certifications/licensing for services, and all other appropriate information for that provider as a logical record linked to the one provider number.

4.4.1.20 Provide the ability to assign provider identification numbers to non-medical providers.

4.4.1.21 Crosswalk from legacy provider number to NPI.

4.4.1.22 Store multiple provider addresses including: physical, contact, and pay to.

4.4.1.23 Use industry standards for provider specialty information.

4.4.1.24 Provide on-line, near real-time creation and modification of provider types, program specialties and associated information.

4.4.1.25 Provide on-line ability to identify, add and update transfer of funds to ****sub-recipient State agencies**** ~~providers~~.

4.4.1.26 Input supporting documentation included in the enrollment process, such as paperwork related to verification of the license, into a document imaging application and then

4.4.1.77 Purge, transfer, and archive provider records to storage for those providers who have been inactive for a period of three years or as identified by ODJFS.

4.4.1.78 Support on-line certification and reporting of the Federal OSCAR file.

4.4.1.79 Automatically update inpatient and outpatient rate information.

4.4.1.80 Assign trading partner vendor numbers and maintain a subsystem for trading partner information such as linkage of trading partner and provider numbers, transaction testing status, corresponding dates, and what transactions are approved for the EDI vendor/provider relationship and corresponding dates.

4.4.1.81 Integrate or interface with the MCP provider verification system as defined by ODJFS.

4.4.1.82 Automatically reconcile provider Medicaid data with Medicare provider information from Carriers and Intermediaries.

4.4.1.83 Provide on-line capability to establish provider hold and review information.

4.4.1.84 Provide the ability to include bankruptcy information proceeding for a provider to include the date of filing with ability to identify those claims pre-petition and post-petition.

4.4.1.85 Track, report and provide on-line capability for all information generated on the annual 1099 report and for previous years as defined by ODJFS.

4.4.1.86 **** Provide the ability to enter, view, and modify**** ~~Access~~ information such as fines, Internal Revenue Service (IRS) levies/liens, **** court (fraud) monies on Medicaid via criminal/civil proceedings, ****and ****required**** child support ****payments****.

4.4.1.87 Provide on-line capability to establish installment plans for providers based on ODJFS defined criteria.

4.4.1.88 Utilize on-line display and query for provider payment history as defined by ODJFS.

4.4.1.89 Utilize tools and technologies to support provider enrollment activities across multiple channels to include the ACD, IVR, Medicaid Portal, telephone, email, fax and other communication devices.

4.4.1.90 Integrate electronic channels with existing call center operations handing provider enrollment inquiries.

4.4.1.91 Integrate with CRM to systematically manage provider relationships by capturing claim data to anticipate/forecast the provider enrollment and training needs, incorporating learned information about the provider and generating individualized responses.

creation of standard and ad hoc reports regarding Medicaid claims payment data including:

- A history of all transactions, including dates, associated with the payment
- Warrant numbers associated with the actual payments
- Warrant dates associated with the actual payments
- Information about stop payments, re-issues, voids, etc.
- Medicaid claim numbers
- Medicaid claim types
- Dates of service
- Provider information
- Category of service
- Medicaid consumer.

6.4.1.15 Recognize and provide OAKS with the information as needed to reissue payments when appropriate after an initial payment is stopped, voided, or cancelled.

6.4.1.16 Accommodate automatic electronic feeds from the Federal Social Security Administration for information associated with SSI Benefits.

6.4.1.17 Provide flexible, rule-driven reporting and analytical capacity that can generate reports and perform calculations (MITS) on the basis of multiple sources of data in order to determine, or support the determination of, accurate amounts of payable funds associated with:

- Medicaid claims
- Claims adjustments
- Nursing Home reimbursements
- Intermediate Care Facility for the Mentally Retarded reimbursements
- Hospital Care Assurance Program
- Upper Payment Limit programs
- Cost settlements
- Other provider payments/adjustments/settlements/incentives/refunds
- Medicare Buy-In payments /adjustments
- Premium payments and adjustments
- Other supplemental provider payment programs
- County Cost Reimbursement payments
- ~~Drug Rebate refunds/interest~~
- Insurer refunds/premium payments

- Reports of examination
- Hearing and appeal information
- Waiver form by which the provider can agree to accept a particular amount to be paid and waive their right to a hearing
- Fiscal forms to assure that payments are credited to proper accounts.

6.6.1.17 Store, track, and provide ODJFS staff with easy access to electronic storage of all waiver forms and/or other documentation received from providers and other sources that pertain to the overpayment correction actions.

6.6.1.18 Automatically update the status of particular overpayment correction actions when waiver forms and other documents are received and logged on to the tracking system.

6.6.1.19 Automatically initiate the assembly and mailing of final adjudication orders associated with the overpayment correction process (CPAO) when waiver forms are received.

6.6.1.20 Generate data and reports as defined by the State or Federal Government and associated with adjudication orders and overpayment corrections as needed by the Office of Fiscal Services, Bureau of Federal Reporting, for preparation of relevant sections of the CMS 64 report.

6.6.1.21 Generate cost settlement information for the CMS 64 report on a timescale specified by ODJFS to meet Federal regulations.

6.6.1.22 Interface, or at least support a common data identifier, with OAKS.

6.6.2 **Hospitals**

6.6.2.1 Generate ****reports to identify**** “clean” paid claims within each provider’s reporting period.

6.6.2.2 Generate reports, on an ad hoc basis, of hospital summary data based on specific revenue centers, as defined in the cost report including the following criteria:

- Paid days
- Paid charges
- Total third party payments
- Total Medicaid payments
- Number of discharges
- Cost Outliers
- DRG.

6.6.2.3 Provide the capability to generate and view ad hoc reports on-line of claims adjustment information including the

- Medicaid Portal
- Other electronic devices such as hand held devices
- Application programming interface
- Paper.

7.2.1.2 Accept, process and prepare for transmission the content of any electronic transactions developed by any of the data standards maintenance organizations that support HIPAA (current and future) – including ASC X 12, HL 7, NCPDP and XML formats CDA and CICA. ****Also,**** ~~S~~support claims/encounters submitted in an ODJFS-approved proprietary ****electronic**** format.

7.2.1.3 Develop interfaces as needed to accommodate the receipt of cross-over claims, encounter claims, and claims from commercial insurance carriers and other information (such as attachments) to support claims processing.

7.2.1.4 Accept other claim, encounter and/or attachment inputs to MITS, including:

- Claims for Medicare coinsurance and deductible (cross-over claims), in both paper and electronic formats
- Adjustment forms 6766, 6768, 6767
- Medical review form 6653
- Ability to accept cost reports
- Paper claim types UB92, CMS1500, 6780, and ADA claim form, or current HIPAA compliant paper claim forms in use at the time of implementation
- Attachments required for claims adjudication including:
    - Coordination of benefits and Medicare explanation of medical benefits
    - Sterilization, abortion, and hysterectomy consent forms
    - X-rays
    - Surgical reports
    - Digitized photos
    - Manual or automated medical expenditure transactions which have been processed outside of MITS (e.g., spend-down and premiums for Medicaid Buy-In)
    - Non-claim specific financial transactions such as fraud and abuse settlements, insurance recoveries, and cash receipts.

7.2.1.5 Track claims/encounters that are rejected back to a provider, including:

- Provider

adjustment) or benefit package related (mass adjustment). This sub-process defines the processing of these adjustments.

7.4.1 **Requirements**

7.4.1.1 Maintain three years of on-line claim history to be used for adjustment processing upon implementation (e.g., 3 years available on day one of implementation), including encounter data.

7.4.1.2 Accept and process 837 adjustments and NCPDP transactions.

7.4.1.3 Link adjustments or replacement claims to immediate predecessor or original claims.

7.4.1.4 Associate all supporting documentation for gross adjustments to TCN assigned to the gross adjustment.

~~7.4.1.5 Suspend and review eligibility changes for consumers enrolled in MCPs.~~

7.4.1.6 Provide capability to easily turn suspend function off and on at a specific edit level.

7.4.1.7 Crosswalk and store third party submitted control numbers (e.g., Medicare ICN) for cross-over claims.

7.4.1.8 Copy a claim, manually enter data into the copied claims, and submit claims as an adjustment. This capability must be available for State staff and providers.

7.4.1.9 Track all incoming adjustment requests and claims regardless of input media and assign a unique tracking number and an adjustment type identifier.

7.4.1.10 Image claim adjustments requests from providers (including faxes).

7.4.1.11 Provide flexible reporting capability for analysis purposes (e.g., by provider, by reason, etc).

7.4.1.12 Provide customizable workflow routing for adjustments.

7.4.1.13 Provide management adjustments reporting capability for all adjustments requests, (e.g., aging, media type, provider).

7.4.1.14 Process returned warrants or EFTs. Functionality should include:

- Reestablishment of all claims into a to-be paid status
- Be able to redistribute the funds to appropriate accounts
- Reinstate units and dollars for prior authorized services.

7.4.1.15 Automatically recognize if an adjustment is a prior-authorized claim and adjust units and dollars related to the PA record.

7.4.1.16 Generate an alert to provider enrollment based on returned warrants (e.g., linked to auto payment stoppage) to reinstate the claims and adjust financial records.

7.4.1.17 Receive and maintain all managed care retroactive and current eligibility enrollment spans and trigger retroactive adjustment claims.

7.4.1.18 Pull paid claims history into adjustments record by multiple identifiers and assign a unique tracking number to each claim, as defined by the ODJFS (mass adjustments).

7.4.1.19 Trigger take backs or payments and generate the content of 820 remittance advice for premium payments to providers, at ODJFS-defined intervals.

7.4.1.20 Check for duplicate Medicare cross-over claims.

7.4.1.21 Utilize workflow capability to route gross adjustments requests to optional customizable approval criteria.

7.4.1.22 Provide on-line, role-based, approval for gross adjustments, as defined by ODJFS.

7.4.1.23 Adjust claims both retroactively and prospectively (e.g., take back or not pay) based in consumer resource information.

7.4.1.24 Allow adjustments for retroactive eligibility.

7.4.1.25 Allow adjustments due to third party prior payment and alert the cost avoidance unit.

7.4.1.26 Display both contracted agreement amount and actual payment amount.

7.4.1.27 Provide the capability to easily modify the adjustment process to support one-time adjustments, such as Combined Proposed Adjudication Order (CPAO), or recurring adjustments to recoup Civil Monetary Penalties (CMP), other types of fines and liens.

7.4.1.28 Establish weekly payment reductions or increases based on the following including: IRS levy/lien, child support, as defined by ODJFS.

7.4.1.29 Adjust a claim within a current month, (including re-billing).

7.4.1.30 Accommodate adjustments across multiple providers.

7.4.1.31 Provide for near real-time, on-line, mass adjustments, based on ODJFS-defined criteria

7.4.1.32 Designate the release of payments related to adjustments.

7.4.1.33 ****Provide on-line**** ~~A~~access to the internal ~~or external~~ rate adjustment tables used in adjustment calculations.

7.4.1.34 Find and replace claims by provider numbers.

7.4.1.35 Provide easily customizable / parameter driven mass adjustment selection and review process.

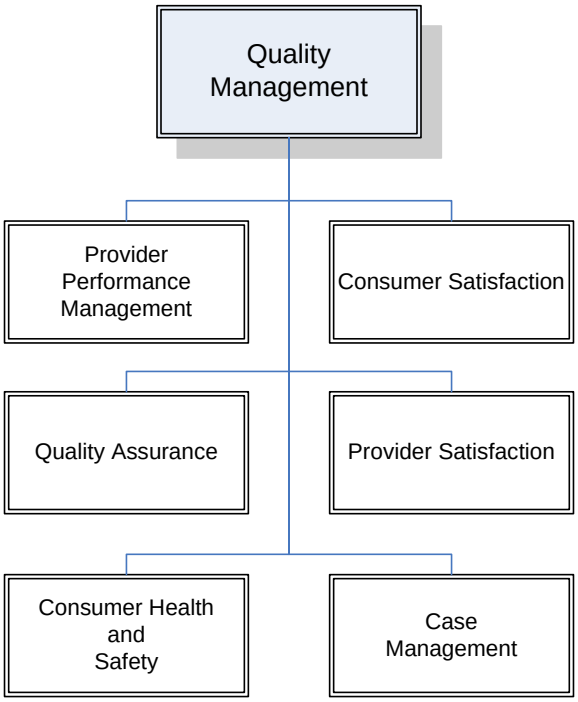
7.4.1.36 Establish and provide a sandbox environment that provides the functionality to create, test, modify and store fiscal impact scenarios.

7.4.1.37 Provide internal communication capabilities (notification/explanation) tied to mass adjustments when necessary (e.g., policy initiated mass adjustments).

8 Quality Management

JFS requires the delivery of MITS in two (2) phases. Business requirements are considered to be Phase 1 unless otherwise noted. Phase 2 business requirements will be identified with the words “Phase 2” at the beginning of the requirement or should the business requirements for entire sub-process be Phase 2 requirements, it will be noted at the start of the narrative for that sub-process. The labeling of a sub-process or business requirement as Phase 2 does not preclude the Contractor from providing that functionality in Phase 1.

Quality Management encompasses the tasks and activities that OHP staff performs to assure or improve the quality of care provided to Medicaid consumers. These activities involve actions to “assure quality” by establishing and enforcing minimum standards of care as well as efforts to “improve quality” by: 1) stimulating and supporting providers and clinicians to improve the quality of health care, or 2) empowering consumers to make more informed decisions about their health care. Efforts to improve quality apply immediately to the health care a particular consumer is currently receiving, while other efforts are focused on systemic improvements intended to improve quality of care as it manifests, on an aggregate basis, in patterns over time. Quality Management, as a business area within the MITS process model consists of the following six sub-processes.



8.1 Provider Performance Management

This is the process (data collection, monitoring, and analysis) by which health care providers are measured and compared across utilization, service quality, and cost dimensions. This process allows OHP and individual providers to understand practice patterns and other normative data to assist in quality of health care decisions. These dimensions are intended to assist providers while supporting OHP in its future contracting process, which may include the provision of financial and other incentives to encourage quality of care. This will be done through a system of automated standard reports, generated alerts, and ad hoc reports.

8.1.1 **Requirements**

8.1.1.1 Provide near real-time role-based HIPAA compliant access (updated in accordance with other business requirements) to electronic **** data **** ~~files~~ via the Medicaid Portal or other access channels. This access should be made available to medical service providers, other care manager professionals, and OHP staff, as permitted under State and Federal law using security protocols. Only information that is determined necessary to support informed, high-quality care management and best clinical practice in regard to the care provided to Medicaid consumers will be available. The system may need to provide access to service information at a stage in claims processing that precedes the claim's final adjudication and payment of the claim.

8.1.1.2 ~~Develop a Quality Management application for OHP to access and display the following information:~~ **** Provide role-based access to quality management supporting applications and information:**

- **Via links from the Medicaid Portal to: ****
- ~~Service information~~
    - Pharmacy benefit system ~~(if separate)~~
- ~~Encounter data~~
- ~~Eligibility data~~
- ~~Demographic data~~
    - Census data **** stored in the data warehouse/DSS ****
- ~~Provider information~~
- ~~Geographic location information~~
- ~~Benefits packages associated with various programs~~
- ~~Electronic medical records~~
- ~~Individualized waiver service plans~~
- ~~Reports of major unusual incidents~~
- ~~State Immunization Registry~~

- Clinical studies and recommendations **** stored in the data warehouse/DSS ****

~~• Lead poisoning database~~

- Quality reviews
- Information from other stand alone systems including:
  - data warehouse/DSS
  - Pegasus
  - Perseus
- Consumer satisfaction survey data, etc.
- **** HEDIS data within the data warehouse/DSS**

• **Via MITS screens that access: ****

- Service information
- Encounter data
- Eligibility data
- Demographic data
- Provider information
- Geographic location information
- Benefits packages associated with various programs
- ~~Electronic medical records~~
- Individualized waiver service plans
- Reports of major unusual incidents
- State Immunization Registry ****as stored in MITS ****
- Lead poisoning database as **** stored in MITS ****.

8.1.1.3 Phase 2 - **** Provide role-based access via links from the Medicaid Portal to data from the data warehouse/DSS that is used to** ** ~~M~~monitor, measure, and compare the performance of individual medical service providers and care manager professionals, and ~~comparisons of~~ **** to compare **** managed health care plans to variable pre-established standards of care for Medicaid consumers with particular diagnostic or demographic characteristics. This monitoring/comparison should be able to be aggregated according to specified reporting dimensions (e.g. county, MCPs, etc.). ~~Standards of care should include:~~

~~• Considerations of the types of medical services~~
~~• Health Plan Employer Data and Information Set (HEDIS), HEDIS-like, or other performance measures as defined by the state~~
~~• Timeliness of specific medical services~~
~~• Sequence of specific medical services~~
~~• Venues through which particular medical services are provided~~
~~• Other patterns of patient care and medical treatment or modalities, or outcomes.~~

8.1.1.4 Phase 2 - **** Provide role-based access from the Medicaid Portal to monthly (at a minimum) provider scorecards or report cards that include: **** ~~Produce~~

~~monthly (at a minimum) a provider scorecard or report card, as defined by ODJFS,~~ that ~~calculates and presents provider information: associated with specific performance measures, including:~~ **[Combined 8.1.1.12 with this BR.]**

- **** Information from MITS that provides a complete view of individual providers, including: ****
    - Information that clarifies their participation in various provider groups and practices
    - Services they provide or are qualified to provide
    - Their occurrence in various Medicaid groupings of provider types, specialization, or other qualifications
    - All tax IDs, provider numbers, and provider names under which they bill for Medicaid services, etc.
- **** Links to data in the data warehouse/DSS that presents specific provider performance measures, including: ****
    - Utilization measures
    - Quality of care measures
    - Comparisons across peer groups and relative to norms
    - Comparisons of performance over time
    - Outlier identification
    - Comparisons to strategic targets
    - Information examples include lead testing rates, immunization rates, emergency department visits, and inpatient length of stay analysis.

~~8.1.1.5 Phase 2 - Allow role-based access to information that includes clinical, utilization, financial and outcome based information in clear formats, with user-friendly query development, with flexible reporting capabilities, including fields and categories that can be selected on an ad hoc basis.~~

8.1.1.6 Automate an alert system to be sent directly to medical care providers, care managers, Medicaid consumers, Medicaid Managed Care Plans and/or OHP staff, as authorized. Alerts will be generated based upon considerations of the types of medical services (e.g., diabetes exams, hospitalization), the timeliness of specific medical services (e.g., Healthchek exams, lead screening test), or the sequence of specific medical services (e.g., immunizations, pap smears).

8.1.1.7 Include in the alert information the medical care that has been provided, medical care that may need to be provided, or in regard to other medical events, as defined by ODJFS, that are determined to be relevant to the quality or coordination of care provided to particular Medicaid consumers.

8.1.1.8 Ability for the system to generate timely alerts based upon the following criteria:

- Through the Medicaid Portal, automated telephone calls, and/or automatically generated and mailed hardcopy

correspondence or delivery mechanisms as defined by ODJFS

- Directly to medical care providers, care managers, Medicaid consumers, and/or OHP staff, as authorized
- Relative to pre-established variable standards of medical care for consumers with particular diagnostic or demographic characteristics
- To warn medical care providers, care manager professionals, Medicaid consumers, or OHP staff, as authorized, when the medical care that has been provided is determined by studies of clinical outcomes or the input provided to OHP by medical professionals, to potentially create adverse medical conditions or to otherwise increase the health risks of Medicaid consumers
- In which "timely" is defined by ODJFS in terms of the timeframes within which particular alerts need to be issued in order to have a probable positive impact on the quality or coordination of care provided to Medicaid consumers
- In which "automated" infers devices that trigger alerts, on a variable rule defined basis, when information indicating that a particular service has been rendered or that a medical event as defined by ODJFS has occurred, or when other pre-defined situations are determined to exist or to have occurred by an algorithmic analytical capacity that exits in data warehouse/DSS, in an enhanced Medicaid claims processing system, or elsewhere.

8.1.1.9 Phase 2 - Provide flexibility in MITS components to support pay for performance.

8.1.1.10 Phase 2 - Interface with claims pricing to ~~prompt~~ ** **trigger** ** payment adjustment (increase/decrease) for specific services paid to individual providers and care manager professionals based on their performance relative to variable pre-established standards of care for Medicaid consumers with particular diagnostic or demographic characteristics. Standards of care should include:

- Considerations of the types of medical services
- Timeliness of specific medical services, the sequence of specific medical services
- Venues through which particular medical services are provided
- Other patterns of patient care and medical treatment or modalities.

8.1.1.11 Phase 2 - Support the benefits and service administration business process to allow the potential of "rule-based" flexibility to manage incentive programs within provider groups (e.g., allow staff to view the top ten percent of providers within a certain category) and automatically assign or remove an incentive payment bonus to the reimbursement rate for a set period of time.

~~8.1.1.12 Phase 2 - Generate and display, through Medicaid Portal and other media, provider scorecards and/or other particular~~

~~provider performance information based on criteria as defined by ODJFS. This report/scorecard will provide a complete picture of individual providers including:~~ **[Merged this requirement into 8.1.1.4]**

- ~~Information that clarifies their participation in various provider groups and practices~~
- ~~Services they provide or are qualified to provide~~
- ~~Their occurrence in various Medicaid groupings of provider types, specialization, or other qualifications~~
- ~~All tax ID, provider numbers, and provider names under which they bill for Medicaid services, etc.~~

8.1.1.13 Automate interfaces with external public and private health care data sources (e.g., State Immunization Registry, Census information, lead poisoning database, and sub-recipient State agencies) to allow access to data that can be used to improve the quality or coordination of care provided to Medicaid consumers.

~~8.1.1.14 Interface with MITS, data warehouse/DSS component to perform algorithmic and other analytical capability to analyze claims and/or multiple data sources in order to identify; A) individual or classes of Medicaid consumers or B) individual or classes of Medicaid providers to include the following:~~

- ~~Patterns of treatment and diagnosis~~
- ~~Relationships among peer providers or providers and consumers correlations~~
- ~~Consumers' age or gender~~
- ~~Types or costs of services delivered.~~

8.1.1.15 Phase 2 - Through mechanisms as defined by ODJFS define, initiate, and track surveys of consumers and others in order to gather and generate performance information on individual or groupings of providers.

8.1.1.16 Phase 2 - **** Provide role-based access via links from the Medicaid Portal to data in the data warehouse/DSS that display provider profile reports that support **** ~~Phase 2 - Interface with MITS data warehouse/DSS component to generate provider profile reports using~~ on-line selection of providers from an exception report and ~~have the ability to do~~ **** that provide **** monthly aggregations of the data on units of service by provider type and category of service.

~~8.1.1.17 Provide consolidation of health care information and services across all providers.~~

8.1.2 **Performance Expectations**

8.1.2.1 Provide information determined necessary to support informed, high-quality care management and best clinical practice in regard to the care provided to Medicaid consumers and ensure that it is made available to providers, other care manager professionals, and OHP staff, as authorized, on as close to a "near real-time" basis

as possible; for example, the system may need to provide access to claims data at a stage in processing that precedes final adjudication and payment.

8.1.3 **Inputs**

8.1.3.1 Claims data

8.1.3.2 Encounter data

8.1.3.3 Pre-determined variable standards of care

8.1.3.4 Census data

8.1.3.5 State Immunization Registry data

8.1.3.6 Eligibility data

8.1.3.7 Electronic medical records

8.1.3.8 Geographic location information

8.1.3.9 Individualized waiver service plans

8.1.3.10 Reports of major unusual incidents

8.1.3.11 Sub-recipient State agencies

8.1.3.12 Clinical studies and recommendations

8.1.3.13 Lead poisoning database data

8.1.3.14 Information generated from quality reviews

8.1.3.15 Information from other MITS components such as data warehouse/DSS, Pegasus, and Perseus

8.1.3.16 Consumer satisfaction survey data

8.1.3.17 Reference file

8.1.3.18 Managed Care Plan administrative and financial data

8.1.3.19 Non claims data

8.1.3.20 **Provider information**

8.1.4 **Outputs**

8.1.4.1 Provider score cards or report cards

8.1.4.2 Alerts

8.1.4.3 Ad hoc and monthly standard reports

8.1.4.4 Provider service exception reports (i.e. service plan authorized in accordance with ODJFS rules)

8.1.4.5 On-line access to claims and other data

8.1.4.6 Analysis

8.1.4.7 Patient registry

8.1.4.8 Surveys

8.1.4.9 Adjusted rates

8.1.4.10 Provider ranking reports

8.1.4.11 Provider profiling reports

8.2 Quality Assurance

All business requirements in this sub-process are to be considered Phase 2 requirements.

In general, quality assurance includes activities performed to assure that quality services are delivered to Medicaid consumers. Activities include quality of care studies, pre-certification of services, and retrospective claims review. Quality studies are designed to assess the delivery of service within or across delivery systems, with the goal of identifying utilization patterns, determining appropriateness of care delivered, evaluating provider/patient compliance with national treatment guidelines and incorporating findings into quality improvement initiatives. Pre-certification of services ensures that consumers are receiving appropriate services in the appropriate setting. The retrospective review assures quality services were delivered by verifying the medical necessity of services and identifying other quality of care concerns.

MITS must include overall quality management capabilities and tools for identifying, classifying, analyzing, tracking, mitigating and reporting on quality issues across all business areas by supporting quality assurance activities as defined by State and Federal regulation including:

- Medicaid managed care regulation applicable to quality improvement
- Federal guidelines, recommendations, regulations and national clinical guidelines applicable to quality improvement for the Ohio Medicaid program
- Home and community-based waiver rules relating to quality management (quality assurance and quality improvement).

8.2.1 **Requirements**

8.2.1.1 Phase 2 - **** Provide role-based access via links from the Medicaid Portal to data in the data warehouse/DSS that supports the analysis of **** ~~Phase 2 – Analyze~~ multiple data sources ~~to include~~ **** including **** eligibility files and encounter/claims data ** **in order** ** to identify clinical and non-clinical areas of health care that need improvement. Examples of these areas are:

- Asthma
- Diabetes
- Acute Myocardial Infarction (AMI)
- Childhood immunization
- Blood lead screening
- Mental health services
- Pap tests.

8.2.1.2 Phase 2 - **** Provide role-based access via links from the Medicaid Portal to data in the data warehouse/DSS that display **** ~~Produce~~ quality and outcome review **** information **** ~~data,~~ such as Health Plan Employer Data and Information Set (HEDIS) and other clinical performance measures as specified by ODJFS.

8.2.1.3 Phase 2 - Through mechanisms as defined by ODJFS initiate and track surveys of Medicaid consumers and

others in order to gather and generate performance information on individual or groupings of providers.

8.2.1.4 Phase 2 - **** Provide role-based access via links from the Medicaid Portal to capabilities in the data warehouse/DSS that **** ~~P~~provide the flexibility to easily change the parameters that drive the performance measurement process.

~~8.2.1.5 Phase 2 - Provide on-line role-based access to encounter/claims and eligibility data for vendors identified by ODJFS to generate samples for studies/surveys.~~

~~8.2.1.6 Phase 2 - Perform a data import function to integrate and analyze data in various types of file formats such as Access, Excel, Text, Paradox, and Dbase external sources that are transmitted from external sources such as vendors and sub-recipient State agencies to ODJFS.~~

8.2.1.7 Phase 2 – Link to Medicaid consumer level data from quality studies to service providers.

8.2.1.8 Phase 2 - **** Provide role-based access via links from the Medicaid Portal to functions in the data warehouse/DSS that **** ~~C~~capture data extracted from ~~medical~~ record reviews ** **in order** ** to evaluate services provided to Medicaid consumers.

8.2.1.9 **Phase 2 - ** Provide role-based access via links from the Medicaid Portal to the data warehouse/DSS in order to **** ~~G~~generate reports and analytical finds for ODJFS staff on managed care plans, providers, county programs and other external stakeholders by addressing the following areas, at a minimum:

- Complex analysis and reporting of health care utilization and expenditure patterns and trends primarily using health care claims data
- Performance of specialized studies of access, quality, use and/or cost of health care
- Comparative analysis and profiling of health care providers, including the profiling of the clinical and financial performance of health care providers
- Complex clinically oriented analysis and reporting of access to and quality of health care
- Detection, analysis, and reporting of patterns and trends in access, quality, use and cost of health care
- Analysis of merged or multiple data sources (e.g. public health, lead data, immunization registration data).

8.2.2 **Performance Expectations**

8.2.2.1 All standing reports will be available in three minutes or less, ad hoc queries will be available in three hours or less. All information from studies will be incorporated into data base files as soon as available from the external quality review vendors.

8.2.3 **Inputs**

8.2.3.1 Claims data
8.2.3.2 Encounter data
8.2.3.3 Pre-determined variable standards of care
8.2.3.4 Census data
8.2.3.5 Eligibility data
8.2.3.6 Electronic medical records
8.2.3.7 Geographic location information
8.2.3.8 State Immunization Registry data
8.2.3.9 Clinical studies and recommendations
8.2.3.10 Lead poisoning data base data
8.2.3.11 Info generated from quality reviews
8.2.3.12 Information from other stand alone system such as data warehouse/DSS, Pegasus, and Perseus
8.2.3.13 Individualized waiver service plans
8.2.3.14 Reports of major unusual incidents
8.2.3.15 Consumer satisfaction survey data
8.2.3.16 Reference file
8.2.3.17 Managed Care Plan administrative and financial data
8.2.3.18 Non claims data
8.2.3.19 Provider information from sub-recipient State agencies

8.2.4 **Outputs**

8.2.4.1 Provider score cards or report cards
8.2.4.2 Alerts
8.2.4.3 Ad hoc and monthly standard reports
8.2.4.4 Provider service exception reports (i.e. service plan authorized in accordance with ODJFS rules)
8.2.4.5 On-line access to claims and other data
8.2.4.6 Patient registry
8.2.4.7 Surveys
8.2.4.8 Adjusted rates
8.2.4.9 Provider ranking reports
8.2.4.10 Provider profiling reports
8.2.4.11 Analysis
8.2.4.12 Reports

8.3 Consumer Health and Safety

The work undertaken by OHP staff to assure that consumer risk and safety considerations are identified and potential interventions are considered to promote independence, health, and safety with the informed participation of the consumer. This process includes review of provider qualifications and training, program eligibility, service plan

development, service utilization, and monitoring of trends/patterns of health and safety concerns for the most vulnerable consumers.

8.3.1 **Requirements**

8.3.1.1 Provide the capability to interface, accept, retain, track, analyze and report on incidents and provider occurrences that occur within ODJFS-administered Medicaid programs (e.g. Ohio Home Care Waiver), using Consumer and Provider Occurrence Report Tracking System (C-PORTS) as the functional model.

8.3.1.2 Convert data from C-PORTS to the applicable MITS component.

8.3.1.3 Interface MITS components with any other ODJFS or external incident reporting systems (e.g. ODMR/DD's Major Unusual Incidence (MUI) database) as identified by ODJFS.

8.3.1.4 Allow provider and/or care manager to complete on-line incident report.

8.3.1.5 Generate notice of deficiencies or correction action plans to the provider.

8.3.1.6 Issue timely alerts to medical care providers, care managers or OHP staff in regard to reports of health and safety related to incidents (e.g. e-mail, hardcopy letter).

8.3.1.7 Accept and track information associated with health and safety related incidents reported by providers, field review staff, consumers, and/or other entities identified by ODJFS.

8.3.1.8 Generate reports on health and safety incidents and related information by data such as provider or by Medicaid consumers.

8.3.1.9 Perform waiver (or other) program field (i.e., remote) data gathering / transmission functions via hand held wireless technology, systems or other mechanisms as identified by ODJFS.

8.3.2 **Performance Expectations**

8.3.2.1 Alerts must be near real-time as defined by ODJFS, in terms of the timeframes within particular alerts are issued in order to have a probable positive impact on the safety and/or well being of Medicaid consumers, or upon the quality of care provided to them.

8.3.2.2 Open incident reports will create an alert to ODJFS applicable staff every twelve hours with the system interfacing with other incident reporting databases that exist or will be created.

8.3.3 **Inputs**

8.3.3.1 Remote data

8.3.3.2 Incident report data

8.3.3.3 Data warehouse/DSS

8.3.4 **Outputs**

8.3.4.1 Alerts

8.3.4.2 Reports

8.3.4.3 Deficiency notices

8.3.4.4 Action plan requests

8.4 Consumer Satisfaction

All business requirements in this sub-process are to be considered Phase 2 requirements.

The effort by OHP staff to solicit consumer feedback on the quality of care they have received from Medicaid providers. In this process, formal, established survey tools are used to assess consumer experiences and perceptions as they relate to specialists, access to care, MCP customer service, provider communications, etc. Findings are compared to national benchmarks and across Medicaid providers and used to formulate and implement targeted quality improvement initiatives.

8.4.1 **Requirements**

8.4.1.1 Phase 2 - Generate a sampling frame or other types of a random sample, related to the eligible population and benefit package for the consumer satisfaction survey as specified by ODJFS. Provide flexibility to change the sampling frame used in analysis such as the eligible population and benefit package for the consumer satisfaction survey.

8.4.1.2 Phase 2 - Import and accept survey data from multiple sources (e.g., External Quality Review Organization (EQRO) vendor, sub-recipient State agencies) via multiple media types such as CDs, Medicaid Portal, wireless technology, systems, or other mechanisms as identified by ODJFS.

8.4.1.3 Phase 2 - Link survey data to the consumer and provider for use by OHP staff.

8.4.1.4 Phase 2 - Send and store survey response data in data warehouse/DSS.

8.4.1.5 Phase 2 - **** Provide access via links from the Medicaid Portal to **** external data sources as defined by ODJFS, such as ** **the** ** National Committee for Quality Assurance (NCQA) database.

8.4.1.6 Phase 2 - Produce quality management reporting related to the interaction and timely response to consumer contact (as defined by ODJFS).

8.4.1.7 Phase 2 - Perform waiver (or other) program field (i.e., remote) data gathering / transmission functions via hand

held wireless technology, systems or other mechanisms as identified by ODJFS.

8.4.1.8 Phase 2 - Trigger, at a minimum, customer satisfaction surveys automatically based on ODJFS specified criteria within 6 months of waiver program enrollment.

8.4.1.9 Phase 2 - Provide flexible parameter setting functionality to determine the frequency of various activities including:

- Surveys
- Reports.

8.4.2 **Performance Expectations**

8.4.2.1 The system will generate consumer surveys within 6 months of enrollment and every year thereafter.

8.4.3 **Inputs**

8.4.3.1 Data warehouse/DSS

8.4.3.2 All external data sources as identified by ODJFS.

8.4.4 **Outputs**

8.4.4.1 Sample frames

8.4.4.2 Surveys

8.4.4.3 Reports

8.5 Provider Satisfaction

All business requirements in this sub-process are to be considered Phase 2 requirements.

The provider satisfaction activities define the effort by OHP staff or contracted agents to solicit feedback from providers on their experiences and perceptions of Medicaid policies and procedures.

8.5.1 **Requirements**

8.5.1.1 Phase 2- Generate a “sample frame”, or random sample, related to the specified provider population for the provider satisfaction survey, as specified by ODJFS every six months.

8.5.1.2 Phase 2 - Import and accept survey data from multiple sources (e.g., External Quality Review Organization (EQRO) vendor and sub-recipient State agencies) via multiple media types such as CDs, Medicaid web portal, and wireless technology.

8.5.1.3 Phase 2 - Link survey data to consumer and provider for use by OHP staff.

8.5.1.4 Phase 2 - Send and store survey response data in the Decision Support System.

8.5.1.5 Phase 2 - **** Provide role-based access via links from the Medicaid Portal to **** external data sources as identified by ODJFS (e.g. NCQA database, sub-recipient State agencies).

8.5.1.6 Phase 2 - Produce quality management reporting related to the interaction and timely response to provide contact as defined by ODJFS.

8.5.1.7 Phase 2 - Perform waiver (or other) program field (i.e., remote) data gathering / transmission functions via hand held wireless technology, systems or other mechanisms as identified by ODJFS.

8.5.1.8 Phase 2 - Trigger, at a minimum, provider satisfaction surveys automatically based on ODJFS specified criteria within six months of waiver program enrollment.

8.5.1.9 Phase 2 - Provide flexible parameter setting functionality to determine the frequency of various activities including:

- Surveys
- Reports.

8.5.2 **Performance Expectations**

8.5.2.1 The system will generate provider surveys within 6 months of enrollment and every year thereafter.

8.5.3 **Inputs**

8.5.3.1 All external data sources as identified by ODJFS data warehouse/DSS

8.5.4 **Outputs**

8.5.4.1 Sample Frames

8.5.4.2 Reports

8.5.4.3 Surveys

8.6 Case Management

The Case Management sub-process includes ~~all decision support and~~ data collection, reporting and analysis necessary to support all activities performed by OHP staff, Ohio Home Care Case Management Agency staff, Medicaid managed care plans (MCPs) staff, and other sub-recipient State agency waiver program staff to identify, screen, assess and manage the care of Medicaid consumers with chronic or complex health care conditions. This sub-process includes the ability to respond to and initiate changes in case management, services, managed care and payment mechanisms. The new system must also have the ability to provide information to structure best practice approaches that promote program savings, greater staff efficiency, and more efficient development and initiation of new benefits.

8.6.1 **Requirements**

8.6.1.1 Provide the capability to accept, retain, track, analyze, and report on case management related quality of care and quality performance data in the aggregate, as well as at the individual case level.

8.6.1.2 Accommodate varying needs of case management initiatives and programs and other ODJFS-administered community-

based and institutional case management initiatives. Criteria and types of data will include:

- Identification/screening results
- Assessment results
- Treatment/service plan development status
- Level of intensity of services
- ~~CMS quality standards and initiatives~~ ~~Accept case management data and interface with internal (e.g. CRIS-E, MITS) and external sources and in a variety of mediums, including data acceptance via the Medicaid Portal~~.

8.6.1.3 Link case management performance data to the claims processing system (and/or other external interfaces, as defined by ODJFS) for purposes of monitoring and enforcing established case management contract expectations or performance standards including expectations, standards, or measures related to:

- Return on Investment
- Cost effectiveness of care
- Other performance expectations.

8.6.1.4 **** Provide role-based access via links from the Medicaid Portal to the data warehouse/DSS in order to generate **** ~~Generate~~ case management reports by program, service, or provider in pre-established formats and on a flexible ad hoc basis.

8.6.1.5 **** Provide role-based access via links from the Medicaid Portal to the data warehouse/DSS in order to **** ~~Provide variable role-based~~ access ~~to~~ case management data for case managers. Information should include the following: claims data, historical case, claims, and enrollment data, eligibility information, benefit packages, case notes, case activity codes, and incident and provider occurrence reports. Case Managers can be defined as any of the following:

- ODJFS staff
- Nurses
- Sub-recipient State agencies
- Contractors
- Social workers
- Primacy care providers
- Other entities as defined by ODJFS.

8.6.1.6 **** Provide role-based access via links from the Medicaid Portal to the data warehouse/DSS in order to access **** ~~Accept, retain~~ and maintain financial information associated with variable, pre-established budget caps or spending limits associated with individual cases that are being case managed. This should include the capability to allow ongoing and immediate entry of and adjustments to this financial information by designated ODJFS staff.

8.6.1.7 Automatically flag and send alerts to designated case managers or OHP staff, as designated, when the actual or expected cost of claims for services provided to individual Medicaid consumers exceed interim limits or caps, as defined by ODJFS.

8.6.1.8 **** Phase 2 - Provide role-based access via links from the Medicaid Portal to the data warehouse/DSS in order to generate **** ~~Generate~~ pre-defined data extracts and send the selected case management information (e.g., claims data and demographic information) to authorized entities at established intervals and/or upon request.

8.6.1.9 **** Provide role-based access via links from the Medicaid Portal to the data warehouse/DSS in order to **** ~~Provide variable role-based capability to~~ view ~~electronic files of~~ case management reports and other case management information from computer desktops in pre-established formats and on an ad hoc basis.

8.6.1.10 **** Accept case management data and interface with internal (e.g. CRIS-E, MITS) and external sources and in a variety of mediums, including data acceptance via the Medicaid Portal. ****

8.6.2 Performance Expectations

8.6.2.1 Case management reports, including standard and ad hoc reports, will be available no later than three hours for the ad hoc reports and three minutes for standard reports.

8.6.2.2 Internal staff should be able to view claims and eligibility data on a near real-time basis or at least allow access to data that is no older than one day; access to claims data should include an ability to view claims at an early stage in their processing well prior to final adjudication and payment.

8.6.2.3 Alert associated with actual or expected costs above a cap or limit should occur as early as possible after the receipt of claims that, upon payment, will cause total expenses to exceed the cap or limit and prior to the payment of those claims.

8.6.3 Inputs

8.6.3.1 Case management data from external sources

8.6.3.2 Case management quality performance data

8.6.3.3 Claims data

8.6.3.4 Historical case, claims, and enrollment data

8.6.3.5 Eligibility information

8.6.3.6 Benefit packages descriptions

8.6.3.7 Case notes

8.6.3.8 Incident and provider occurrence reports

8.6.3.9 Case management treatment and service plan data

8.6.3.10 Case management benchmark, outcomes, and/or performance reports

8.6.3.11 Analysis

8.6.4 **Outputs**

8.6.4.1 Case management data extracts

8.6.4.2 Case management reports

8.6.4.3 Case management alerts on-line access to case management data

8.6.4.4 Ad hoc and monthly standard reports exception reports.

9 **Operational Reporting** ~~Business Intelligence~~

~~JFS requires the delivery of MITS in two (2) phases. Business requirements are considered to be Phase 1 unless otherwise noted. Phase 2 business requirements will be identified with the words "Phase 2" at the beginning of the requirement or should the business requirements for entire sub-process be Phase 2 requirements, it will be noted at the start of the narrative for that sub-process. The labeling of a sub-process or business requirement as Phase 2 does not preclude the Contractor from providing that functionality in Phase 1.~~

~~Within this section Business Intelligence and Operational reporting requirements will be identified. ODJFS recognizes that with a new solution business intelligence functionality maybe part of the proposed operational reporting capabilities. For this reason this section will define expectations for operational reporting and business intelligence support.~~

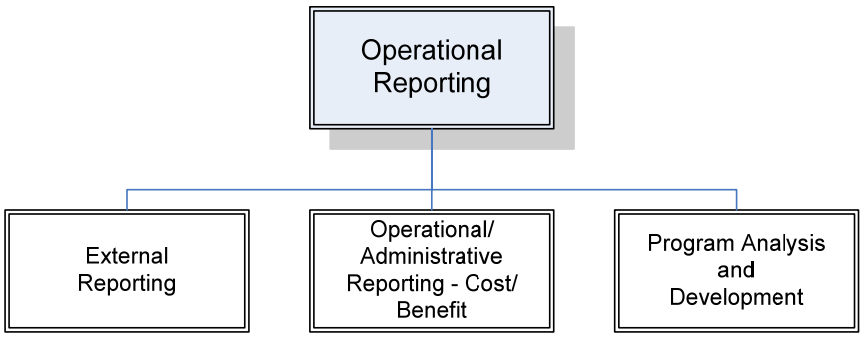
~~Business Intelligence scope includes providing and/or extracting data to be integrated in a DSS solutions. Business Intelligence functions is a specialized function and therefore a interface will be required that supports a current DSS system and or its replacement. MITS must include the ability to supply data to a DSS system.~~

****The Internal and External Operational Reporting requirements outlined below is a summary for standard pre-canned operational reports within the MITS system that are utilized for the business management of the MITS system. Business Intelligence Analytical functions and applications are in a separate Data Warehouse and Decision Support System RFP and is not included in the MITS RFP. The Data Warehouse and Decision Support system RFP includes the requirements to "pull" data from the MITS system.****

The reporting tools must be able to access and report all claims/encounters, financial, demographic, eligibility, pharmacy, provider, and other data for operational support in administrating the Medicaid program. These processes include three management information sub-processes: (1) External Reporting, (2) Operations/ Administrative – Cost/Benefit Reporting, and (3) Program Analysis and Development.

~~MITS must be interoperable with the Decision Support System (DSS) and one or more data warehouses or data marts (referred to collectively in this document as~~

~~data warehouse/DSS).~~ In this regard, MITS is the core operational system and must have full functionality for patient care and quality management including tools for operational reporting. MITS must also provide data to the DSS for long term reporting and analysis at the plan or population level.



9.1 External Reporting (Operational)

External Reporting includes providing the ability to receive and/or submit reports to outside requestors (outside Ohio Department of Job and Family Services) including contractors and vendors, State, county, Federal, provider and consumer entities through various flexible reporting methods including Medicaid Portal access, secure File Transfer Protocol (FTP) transmissions, paper reports, and PDF files. The scope of External Reporting is divided into the following three subsections: (1) Clinical Reporting, (2) Federal/State/Other Agencies Reporting, (3) Medicaid Reporting. External Reporting includes advanced reporting functions including the capacity to handle external reporting needs (e.g., transmission of reports via secure email, or Virtual Private Network (VPN) technology) in a timely fashion with real-time data as required and ad hoc information as requested. Staff must have role-based access. External Reporting supports all ODJFS daily, weekly and monthly external reporting needs and requests including supporting appropriate stakeholders needs. Reports that focus on operational needs or individual patient management will normally be generated by MITS using local data while reports that focus on a broader perspective at the plan or population level will normally be generated using DSS and data stored in the data warehouse/DSS.

9.1.1 **Clinical Reporting Requirements**

Blood Testing Reporting

9.1.1.1 Interface with other systems to generate Blood Testing Reporting results as specified by ODJFS.

Clinical Based Outcome Data Reporting

9.1.1.2 ****Provide operational reports based**** ~~Report~~ on data/information including preventive health indicators and screenings of waiver consumers.

9.1.1.3 ****Provide operational reports based**** ~~Report~~ on information including deaths & causes, vital statistics, and have the ability to identify cases of suspicious deaths.

9.1.1.4 ****Provide operational reports**** ~~Report~~ on waiver outcomes ****based**** on ~~County Medical Systems~~ participant experiences ~~and include data for benchmarking with other states~~.

9.1.1.5 Track EPSDT referrals.

*****Patient Disease**** *~~Disease Patient~~ Registry*

9.1.1.6 ****Provide the capability to generate operational reports based on clinical and disease-specific consumer information that is contained in**** ~~Include~~ a ~~Disease~~ Patient ****Disease**** Registry where the end user can easily extract consumer information ~~with specific condition~~ for targeted case management activities as specified by ODJFS ~~in a secure role-based access environment~~.

Immunization Reporting

9.1.1.7 Provide ~~the flexibility to~~ ****an**** interface (including receiving, storing and sending information) ****directly to the Ohio Department of Health Immunization Registry that will be used to populate a Patient Disease Registry within MITS**** ~~with immunization statistics and information/data regarding waiver consumers~~.

9.1.1.8 Interface (including receiving, storing, and sending information/data) directly related to Minimum Data Sets (MDS). Information and data needed includes:

- MDS summary data
- Case mix calculations and reports
- Policy updates
- MDS reporting information by providers and reports.

9.1.2 Federal/State/Other Agencies Reporting

Federal Reporting

9.1.2.1 Provide information to support Federal reporting requirements including:

- CMS 64 report to identify recovery efforts
- CMS 372 Cost Neutrality Assessment for Waivers
- CMS 416 (Healthchek Report)
- Medicaid Statistical Information System data reports.

9.1.2.2 Compile and aggregate the necessary data for ODJFS and Federal Healthchek and EPSDT reporting including the CMS 416 report that uses both fee-for-service and encounter data.

9.1.2.3 Generate the Medicaid Statistical Information System (MSIS) Data (formerly CMS-2082) according to CMS media requirements and timeframes and submit a copy to ODJFS on specified media for review and filing.

County Department of Job and Family Services Reporting (CDJFS)

9.1.2.4 Support the reporting needs of the counties and county boards including direct reporting interfaces with other sub-recipient State agencies including Mental Retardation and Developmental Disabilities (MR/DD), Department of Aging, etc.

9.1.2.5 ~~Provide a method to track and r~~ Report on incident tracking, Medicaid services and quality assurance processes.

9.1.2.6 Provide enhanced on-line, web-based reporting capabilities to CDJFS based upon a role-based security system.

9.1.2.7 Provide the capability for CDJFS to generate external reports through the Medicaid Portal.

Other State Agencies Reporting

9.1.2.8 Provide a direct secure interface to other survey information as identified by ODJFS such as Quality Assurance (QA) survey data (e.g., authorized & provider-reported services) and to other agencies (e.g., Ohio Department of Health Outcome and Assessment Information Set (OASIS) data).

9.1.3 **Medicaid Reporting**

External Contractors/Partners Reporting

9.1.3.1 Provide flexible reporting tools via the Medicaid Portal that interface directly to individual single providers, including:

- Reports to home care agencies for benchmarking across Agencies
- Reports to waiver case managers of independent providers
- Agency provider caseloads, services & reimbursements.

Contractors/Partners Reporting

9.1.3.2 Provide business contractors/partners on-line access through the Medicaid Portal to ****operational**** reports as specified by ODJFS including:

- Non-Claim business provider process information reporting
- Cost report trends
- Contract monitoring for waiver consumers.

Managed Care Plans (MCPs)

9.1.3.3 Interface directly with all MCPs and be able to provide on-line, web-based ****operational**** reporting information and data that includes:

- Care management membership and premium payment reports
- Performance measurement reports
- MCP progress reports
- Ad hoc reports as developed by ODJFS
- Capability to convert MCP files to specified formats.

9.1.3.4 Provide to MCPs the capability to access fee-for-service claims data utilization reports for their members as defined by ODJFS.

9.1.3.5 Capability to report on-line aggregate and summary data and store information on benefit packages.

9.1.4 **Performance Expectations**

9.1.4.1 Support at least fifty (50) concurrent reports running at the same time as defined by ODJFS.

9.1.4.2 Provide on-line reports within five (5) seconds after request is initiated ninety-five percent (95%) of the time.

9.1.5 **Inputs**

9.1.5.1 All licensing boards including: Ohio State Medical Board, Ohio State Dental Board

9.1.5.2 Breast & Cervical Cancer Program (BCCP) data

9.1.5.3 Bureau of Workers Compensation (BWC) data

9.1.5.4 Case mix table: Diagnosis Related Groups (DRG)

9.1.5.5 Claims data - Medicare

9.1.5.6 Claims data - Medicaid

9.1.5.7 Consumer data

9.1.5.8 Demographic data

9.1.5.9 Eligibility data - Medicare

9.1.5.10 Eligibility data - Medicaid provider

9.1.5.11 Eligibility data - Medicaid consumer

9.1.5.12 Encounter claim data

9.1.5.13 Enrollment data - program

9.1.5.14 Fee for service data

9.1.5.15 Financial data

9.1.5.16 Hospital utilization data

9.1.5.17 Lead screening data

9.1.5.18 Long Term Care Minimum Data Set (MDS-2)

9.1.5.19 Care Management Program cost reports data

9.1.5.20 MCP data

9.1.5.21 Medicaid Eligibility Quality Control data (MEQC)

9.1.5.22 Mental Retardation and Developmental Disabilities data (MR/DD)

9.1.5.23 Ohio Department of Health data

9.1.5.24 Outcome and assessment information data set (OASIS - Home Care Assessments Data)

9.1.5.25 Passport Assessment data

9.1.5.26 Pre-Admission Screening and Resident Review (PASSR - Patient Assessments Data)

9.1.5.27 Provider cost report data

9.1.5.28 Provider data

9.1.5.29 Provider licensure and certification data

9.1.5.30 Vital statistics data - mortality

9.1.5.31 Waiver program data

9.1.6 **Outputs**

9.1.6.1 Operational reports and graphs as defined above

~~9.1.6.2 System reports and graphs as defined above~~

9.1.6.3 Various reporting medias including web- based reports, paper reports, and graphs

9.2 Operational/Administrative – Cost/Benefit Reporting

Operations/Administrative – Cost/Benefit Reporting includes analyses of historical trends and the ability to predict impact of policy/program changes. The scope is divided into the following two subsections: (1) Financial Operational Reporting (2) Clinical Operational Reporting. This section provides programmatic, financial and statistical reports that satisfy State and Federal reporting requirements and assist with fiscal planning and control, program and policy monitoring and planning, and evaluation of all components of the ODJFS Medicaid program. These reports include analyses of historical trends and the ability to predict impacts of policy/program changes. Reporting must meet existing format and requirements for State and Federal reporting, and must provide maximum flexibility to accommodate future policy and data modifications with a minimum amount of technical support. These reporting functions are daily, weekly, monthly and ad hoc requests.

9.2.1 **Financial Reporting**

Financial and Budget Reporting

9.2.1.1 Provide a tool for use in financial and budget reporting, including:

- Cost report trends
- Rate to cost analyses
- Real-time checking of budgets by Case Management
- Budget development for waiver applications and renewals
- Premium payment reports by Managed Care plans.

9.2.1.2 Interface with authorized services to coordinate claims payment.

9.2.1.3 Provide automatic alerts that are easily programmed by end users, to case managers if cost limit approached/exceeded.

9.2.1.4 Provide trend reports of types and quantities of services authorized, such as:

- Detailed financial transaction registers
- Disbursement account control reports
- Recoupment by amount and time period for providers
- Aged accounts receivable, with flags on those that have no activity within a State-specified period of time.

9.2.1.5 Report on costing information for LTC facilities, MCPs, and all other institutional providers.

9.2.1.6 Generate ~~20~~ reports to identify various types of recoupment and collections, for example including fraud and abuse recoupment, account receivable collections, estate and casualty recovery cases, TPL, insurance collections, or other categories, as defined by ODJFS.

9.2.1.7 Report COB activities that impact management reporting including cost avoidance amounts, insurance post payment billing and collection, copays and insurance premiums. This coordination includes history-only adjustments, gross adjustments, and mass adjustments.

Claims Monitoring Reporting

9.2.1.8 Provide data, including reports, on a real-time basis to include:

- Claims paid for State-funded programs
- Claims & payments after each payment cycle
- Finalized input into weekly claims payment cycle
- Claims withheld from payment processing
- Specially-handled or manually-processed claims
- Monthly adjudicated claims file
- Paid & denied claims
- Summary report by adjustment and/or reason code
- Direct bill reporting
- Combined ~~Provider~~ ****Proposed**** Adjudication Order (CPAO)
- Trends & analyses of expenditure patterns
- Analyses of budget variances
- Generation of Federal cost neutrality reports for waivers
- Lag factors between date of service and date of payment based on expenditures to determine cash flow trends.

Contract Monitoring Reporting

9.2.1.9 Receive, store and provide reporting capabilities for Ohio Department of Health (and other sub-recipient State agencies) survey and certification data.

9.2.1.10 Provide information on cumulative data sets requiring periodic reports from waiver contractors for example, benefit plans.

Provider Measurement Reporting

9.2.1.11 Generate report of billing lags and processing time statistics by provider categories.

9.2.1.12 Generate claims processing summary reports that report expenditures by claim type, edit failures, percent of denials, and “input media”.

Consumer Measurement Reporting

9.2.1.13 Generate reports identifying claims paid under both Medicaid and State-funded programs when a client has switched program eligibility to monitor payment under the proper program.

9.2.2 **Clinical Reporting**

Case Management Reporting

9.2.2.1 Electronically provide community resource manuals in an on-line format that is easily accessible to case managers and consumers.

9.2.2.2 Generate clinical paths for tracking treatments versus clinical guidelines based upon claim data.

Breast & Cervical Cancer Program (BCCP) Reporting.

9.2.2.3 Provide reporting to track and report on BCCP hearings and BCCP hearing results.

Clinical Based Outcome Reporting

9.2.2.4 Provide identification and notification to case managers of multi-pharmacy abuse by consumers or providers.

9.2.2.5 Report on death certificates to consumers for identification of suspicious deaths.

Disease / Patient Registry (including Well Care)

9.2.2.6 Provide reports to allow case managers to review preventative assessments for consumers, managed care plans and their providers regarding care needed by members.

Incident Tracking Reporting

9.2.2.7 Ability to report on data relating to complaints and incidents.

9.2.2.8 Summarize and provide trend analyses regarding incident tracking and resolution outcomes.

9.2.2.9 Report on provider incident profiles, including termination of providers.

9.2.2.10 Generate Notification of Death and Cease and Desist letters.

9.2.2.11 Provide report cards and reports of provider sanctions, including automatic alerts to end-users.

Provider Measurement Reporting

9.2.2.12 Provide reporting feedback to providers and ODJFS including:

- LTC Beds Reporting
- MDS based audit risk analysis
- Maintenance of approved agency/provider type lists for waiver consumers
- Checking of provider licensures and Bureau of Criminal Investigation (BCI) status
- Identification of high reimbursement providers and those with "surges" in reimbursements
- Tracking of investigation/audit of outliers
- Linkage of provider investigative work to that by AG and provider licensure boards
- Monitoring of provider turnover for consumers.

Waiver Monitoring Reporting

9.2.2.13 Provide reporting for quality assurance administration.

9.2.2.14 Report movement of consumers in and out of waiver programs and to report on waiver trends.

9.2.2.15 Provide performance measure reporting capability.

9.2.3 **Performance Expectations**

9.2.3.1 Support at least fifty (50) concurrent reports or users running at the same time as defined by ODJFS.

9.2.3.2 Provide on-line reports within five (5) seconds after request is initiated ninety-five percent (95%) of the time.

9.2.4 **Inputs**

9.2.4.1 All licensing boards including: Ohio State Medical Board, Ohio State Dental Board

9.2.4.2 Breast & Cervical Cancer Program (BCCP) data

9.2.4.3 Bureau of Workers Compensation (BWC) data

9.2.4.4 Case mix table: Diagnosis Related Groups (DRG)

9.2.4.5 Claims data - Medicare

9.2.4.6 Claims data - Medicaid

9.2.4.7 Consumer data

9.2.4.8 Demographic data

9.2.4.9 Eligibility data - Medicare

9.2.4.10 Eligibility data - Medicaid provider
9.2.4.11 Eligibility data - Medicaid consumer
9.2.4.12 Encounter claim data
9.2.4.13 Enrollment data - program
9.2.4.14 Fee for service data
9.2.4.15 Financial data
9.2.4.16 Hospital utilization data
9.2.4.17 Lead screening data
9.2.4.18 Long Term Care Minimum Data Set (MDS-2)
9.2.4.19 Care Management Program cost reports data
9.2.4.20 MCP data
9.2.4.21 Medicaid Eligibility Quality Control data (MEQC)
9.2.4.22 Mental Retardation and Developmental Disabilities data (MR/DD)
9.2.4.23 National/geographic regions data
9.2.4.24 Nursing facility utilization data
9.2.4.25 Ohio Department of Health data
9.2.4.26 Outcome and assessment information data set (OASIS - Home Care Assessments Data)
9.2.4.27 Pharmacy utilization data
9.2.4.28 Pre-Admission Screening and Resident Review (PASSR - Patient Assessments Data)
9.2.4.29 Provider cost report data
9.2.4.30 Provider data
9.2.4.31 Provider licensure and certification data
9.2.4.32 Providers who bill ODJFS Medicaid for testing: for example, lead testing and other laboratory tests
9.2.4.33 Reference data
9.2.4.34 Specialty care utilization data
9.2.4.35 Third party liability data
9.2.4.36 Vital statistics data - mortality
9.2.4.37 Waiver program data

9.2.5 **Outputs**

9.2.5.1 Operational reports and graphs as defined above
9.2.5.2 System reports and graphs as defined above
9.2.5.3 Various reporting medias such as web-based reports, paper reports graphs

9.3 Program Analysis and Development

~~Program Analysis and Development includes providing data extracts and support for a Business Intelligence solution.~~ ODJFS currently has a data warehouse/DSS solution that provides the ability to perform sophisticated measurements; surveillance and utilization statistics; fraud detection

algorithms; and provider and consumer profile reports. This requirement addresses support for the current solution (MEDSTAT) and or expectations for interfacing with another industry proven decision support solution. Industry proven solution refers to a solution that is a licensed software product that can be purchased with pre built reporting models specifically for analyzing Medical Claims.

9.3.1 **MITS Support of General DSS Capabilities**

9.3.1.1 ****Supply data through data feeds and the Medicaid Portal to**** ~~Integrate with~~ the ****ODJFS data**** warehouse/DSS ****architecture****, which is based on a ~~singular~~ ****relational**** database ~~and technical~~ platform, which supports waiver program planning and evaluation, financial reporting, medical policy development, utilization management, eligibility analysis, actuarial rate setting, managerial-level program performance measurement, fraud and abuse detection and investigation, and a variety of other Medicaid healthcare reporting as defined by ODJFS.

~~9.3.1.2 Interoperate with the warehouse/DSS data model which is based on a Medicaid-proven and expandable design concept that is specialized for on-line analytical processing.~~

9.3.1.3 Supply data to the ****ODJFS data**** warehouse/DSS ****architecture through flat file extracts or other methods to**** ~~which~~ integrate~~s~~ data from the following sources into a single analytically-ready database that supports rapid and efficient population-based reporting across all systems and programs including:

- Multiple eligibility systems
- Capitation systems
- Claims systems (paid and denied claims, as well as claim adjustments in bulk and in detail)
- Managed care encounter data
- Carve-out contractors, such as pharmacy benefit managers, behavioral health plans, chip contractors
- Prior-authorization data

9.3.1.4 Supply data to the ****ODJFS data**** warehouse/DSS ****architecture**** to support features such as the Medstat Episode Grouper (MEG) or other Episode Grouper, CMS DRG, Diagnostic Cost Grouper (DxCG).

9.3.1.5 Supply ****detail**** data to the ****ODJFS data**** warehouse/DSS ****architecture**** to support ~~its true~~ drill-down capabilities ~~that enable a user to drill-down~~ to the lowest level of detail.

9.3.2 **Performance Expectations**

9.3.2.1 Refresh ****ODJFS data warehouse/****DSS ****architecture**** ~~database~~ at least monthly ****by having the extract cycles from MITS complete within 12 hours****~~, as defined by ODJFS~~.

~~9.3.2.2 Provide the capability for monthly updates to occur on a regular scheduled basis while continuing to enhance the DSS database.~~

9.3.3 **Inputs**

9.3.3.1 All State licensing boards including: Ohio State Medical Board, Ohio State Dental Board

9.3.3.2 Breast & Cervical Cancer Program (BCCP) data

9.3.3.3 Bureau of Workers Compensation (BWC) data

9.3.3.4 Case mix table -Diagnosis Related Groups (DRG)

9.3.3.5 Claims data - Medicare

9.3.3.6 Claims data - Medicaid

9.3.3.7 Consumer data

9.3.3.8 Demographic data

9.3.3.9 Eligibility data - Medicare

9.3.3.10 Eligibility data - Medicaid provider

9.3.3.11 Eligibility data - Medicaid consumer

9.3.3.12 Encounter claim data

9.3.3.13 Enrollment data - program

9.3.3.14 Fee for service data

9.3.3.15 Financial data

9.3.3.16 Hospital utilization data

9.3.3.17 Lead screening data

9.3.3.18 Long Term Care Minimum Data Set (MDS-2)

9.3.3.19 Care Management Program cost reports data

9.3.3.20 MCP data

9.3.3.21 Medicaid Eligibility Quality Control data (MEQC)

9.3.3.22 Mental Retardation and Developmental Disabilities data (MR/DD)

9.3.3.23 Ohio Department of Health data

9.3.3.24 Outcome and assessment information data set (OASIS - Home Care Assessments Data)

9.3.3.25 Passport Assessment data

9.3.3.26 Pre-Admission Screening and Resident Review (PASSR - Patient Assessments Data)

9.3.3.27 Provider cost report data

9.3.3.28 Provider data

9.3.3.29 Provider licensure and certification data

9.3.3.30 Vital statistics data - mortality

9.3.3.31 Waiver program data

9.3.4 **Outputs**

9.3.4.1 Operational reports and graphs as defined above

9.3.4.2 System reports and graphs as defined above

~~9.3.4.3 Various reporting medias such as: web based reports, paper reports, graphs~~

9.3.4.4 ****Flat file extracts of detail claims, provider, and other data to meet requirements for updating the ODJFS data warehouse environment.****

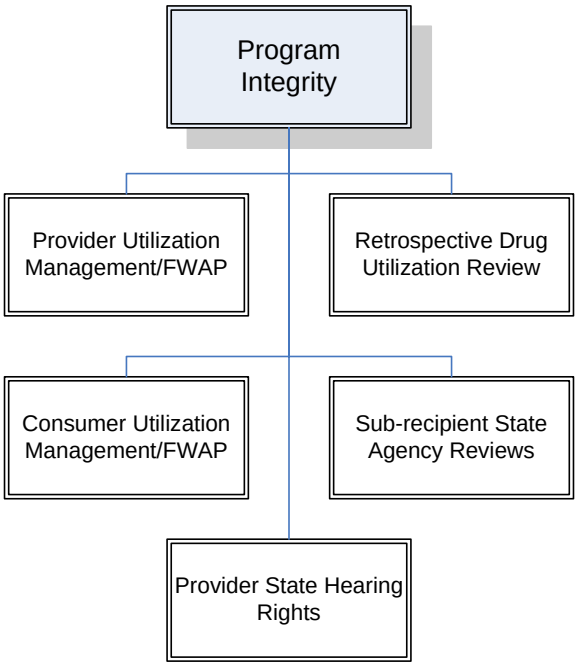
10 Program Integrity

~~JFS requires the delivery of MITS in two (2) phases. Business requirements are considered to be Phase 1 unless otherwise noted. Phase 2 business requirements will be identified with the words "Phase 2" at the beginning of the requirement or should the business requirements for entire sub-process be Phase 2 requirements, it will be noted at the start of the narrative for that sub-process. The labeling of a sub-process or business requirement as Phase 2 does not preclude the Contractor from providing that functionality in Phase 1.~~

The Program Integrity business process encompasses sound mission, consistent practice and accountability in all areas of program management including fiscal, clinical, policy, and administrative compliance. The concept of program integrity refers to a continuum of fraud and abuse oversight activities aimed at ensuring that the various facets of the program function as intended.

MITS must ~~be fully interoperable with equired business intelligence functionality, such as data warehousing and the Decision Support System (DSS) to~~ support the program integrity business needs for health care data analysis and near real-time fraud, waste, and abuse detection.

The Program Integrity business process includes the following sub-processes:



10.1 Provider Utilization Management/Fraud Waste and Abuse Prevention (FWAP)

The provider utilization management sub-process is responsible for monitoring and reviewing a provider's post payment claims history in order to ensure provider compliance; to detect fraud, waste, and abuse; and to implement appropriate corrective action(s). ~~Please note that in addition to the requirements listed below for Program Integrity, additional Program Integrity related requirements are located in the Business Intelligence business requirements in this RFP under the sub-process heading, Business Intelligence Support for Program Integrity.~~ This sub-process also covers support for the CMS Payment Error Rate Measurement program.

****The Program Integrity Reporting requirements outlined below is a summary of standard pre-canned Program Integrity reports within the MITS system that are utilized for the business management of the MITS system. Business Intelligence Analytical functions and applications are in a separate Data Warehouse and Decision Support System RFP and is not included in the MITS RFP. The Data Warehouse and Decision Support system RFP includes the requirements to "pull" data from the MITS system.****

ODJFS envisions the SURS component of the MITS system will utilize both historical and near real-time claims to detect aberrant billing patterns. This sub-process will incorporate an alert system, and both ad hoc and template query, analysis and reporting capabilities, as well as automated advanced analytics to detect aberrant billing patterns, fraud, waste, and abuse.

10.1.1 **Profiling and Claims Analysis**

10.1.1.1 Interface ****with the ODJFS Data Warehouse architecture to provide detail data for profiling and claims analysis**** ~~and interoperate with the data warehouse/DSS~~.

10.1.1.2 Maintain up-to-date clinical summaries for consumers including diagnosis and services information. ~~(Interface with the data warehouse/DSS)~~

10.1.1.3 Analyze, identify, report, and alert on hit-and-run provider schemes and spike billings as defined by ODJFS. For example, these schemes involve a significant or sudden high volume of submitted claims by an individual or group of providers compared to their previous claim activity or to their peers for a given time period. ~~(Interface with the data warehouse/DSS)~~

10.1.1.4 Associate individual providers with their practice affiliation, such as a group practice or MCP. ~~(Interface with the data warehouse/DSS)~~

10.1.1.5 Cross-reference all provider ID numbers, including NPIs as identified by CMS, to a single ID number (e.g., individual provider numbers for their group practice affiliation(s)), track a single provider ID across various sub-recipient State agencies, and report selectively and collectively on provider utilization.

10.1.1.6 Associate services furnished in a clinic setting to both the clinic and servicing provider.

10.1.1.7 Where appropriate, integrate near real-time algorithms into MITS to detect aberrant billing patterns and/or other anomalies while claims are being processed.

10.1.2 **Communication, Tracking, and Alerts**

10.1.2.1 Track report and information request deadlines and generate alerts to appropriate staff when deadlines are past due.

10.1.2.2 Provide role-based access to enter complaints and referrals from outside parties and agencies about consumers or providers into the on-line tracking system for fraud and abuse investigations, and track dispute resolutions and referrals.

10.1.2.3 Link provider enrollment with the payment system to automatically generate a message when an amount is due because of an audit or review finding.

10.1.2.4 Generate an alert to the appropriate staff/business area when it is required to place a provider's claims payment on "hold and review" status.

10.1.2.5 Provide the capability to track and document compliance with the applicable Federal regulations for specific time periods to be defined by ODJFS and produce compliance reports, both summary and detailed, to include the number and percentage of:

- Cases referred and to which agency the referral
- Full scope reviews conducted
- Cases on "hold and review" status
- Other parameters as defined by ODJFS.

10.1.2.6 Develop and maintain an automated case tracking and alert system as defined by ODJFS to accommodate internal and external program integrity audit-related data and activities including:

- Audit time period
- Initiating agency
- Reason for audit

- Providers placed on a hold and review status, the reason for hold and review status, and dates of hold and review.
- Outcomes including monetary recoveries
- Required actions and alerts, such as to re-review alerts, education activities
- Tracking of the repayment activities including the date of overpayment discovery, amount of overpayment, and amount of recovered overpayment.
- Chronology of significant case activity, such as date of opening letter sent to the provider; dates of phone calls to providers; dates of records/information received by the provider
- Significant case documentation, such as case findings and recommendations; exception code key; summary of exceptions; and phone memos
- Listing of case contacts
- Electronic storage of the supporting documents for the case review including significant case documentation as defined by the ODJFS and records received from the providers.

10.1.3 **Support for Payment Error Rate Measurement (PERM)**

10.1.3.1 Comply with Federal (CMS) requirements in support of PERM.

10.1.3.2 In compliance with CMS quarterly claims sample frequency requirements, send the required data to the Statistical Contractor (SC) according to the claims extract approach using CMS-approved formats, media, and security procedures. Only claims that have not been adjusted during the quarter are to be included. The required fields are:

- Unique claim identifier
- Date of payment
- Paid amount ($0 for denied claims)
- Provider type or similar variable
- Strata assignment (1 through 8) or MSIS category.

10.1.3.3 Receive the file of sample claims selected by the SC (including the fields submitted in the claims extract) and send to the SC for each claim (or claim line) in the list of samples, the claim history and all other supporting information including the sample claim itself and any adjustments made within 60 days of the original paid date. For each claim or adjustment, the following information is required:

- Unique claim identifier (Identification Claim Number or other State-assigned number)
- Strata assignment (1 through 8) or MSIS category
- Dates for original payment, adjustments, and for denials, adjudication

- Provider type or similar variable
- Patient information (e.g., name, date of birth, gender, program enrollment indicators impacting claim processing rules, eligibility information including spend-down indicator, if applicable
- Provider number and name for both billing provider and servicing provider
- Provider specialty of both billing provider and servicing provider
- Servicing provider address
- Servicing provider phone number
- Claim type
- All diagnosis codes
- DRG code, if applicable
- Service from date
- Service to date
- Prior authorization
- Place of service
- Number of line items
- Procedure codes (CPT, HCPCS, etc.) and units of service for all line items associated with the claim
- Type of service
- Include at both the line item and claim levels, if applicable:
  - Submitted charge
  - Allowed charge
  - Third party liability information
  - Patient co-payment responsibility
  - Paid amount ($0 for denied claims).

10.1.4 **Performance Expectations**

10.1.4.1 Claims extract data for PERM must be sent to CMS by the 15th of the month following the end of each quarter.

10.1.4.2 ****Ability to meet Federal SUR requirements.****

10.1.5 **Inputs**

10.1.5.1 Complaints and referrals

10.1.5.2 ****Claims and provider data within MITS.****

10.1.6 **Outputs**

10.1.6.1 Data to data Warehouse/DSS

10.1.6.2 Alerts

10.1.6.3 ****Reports, graphs, data files.****

10.2 Consumer Utilization Management/FWAP

The Consumer Utilization Management sub-process is responsible for the identification, management, and monitoring of Medicaid service utilization

by consumers in order to detect and correct inappropriate utilization. The requirements in this sub-process, though specific to the PACT (Primary Alternative Care and Treatment) program, should also be viewed as a model for similar programs that may be legislated or defined in the future. MITS must have the flexibility to support the definition and operation of such programs.

10.2.1 **Requirements**

10.2.1.1 Identify the specific PACT exception criteria for each Medicaid consumer that has been identified for potential PACT participation.

10.2.1.2 Implement and maintain an automated tracking system to accommodate PACT data and activities including:

- PACT category (e.g., physician, drug, etc.)
- Medicaid provider number
- PACT primary care physician name, address and telephone number
- Pact pharmacy, address, and telephone number
- PACT starting and end dates
- Appeals and status
- Hearings, date of hearing, issues and outcomes, and linkage to hearing documents for the PACT program.
- Letters to providers
- Letters to PACT Medicaid consumers
- Note taking functionality.

10.2.1.3 Generate the following PACT related letters to consumers and providers including:

- Notice of enrollment to consumers
- Welcome letter and designated provider form to provider
- State hearing and appeals information to consumer
- Primary care physician name, address, selected pharmacy name and address
- Additional brochures, newsletters, fact sheets, and other PACT related materials.

10.2.1.4 Automate correspondence to the provider and/or consumer via the CRM and EDMS systems.

10.2.1.5 Image documentation and correspondence from consumers and providers regarding the PACT program.

10.2.1.6 Provide on-line role-based access to information including:

- PACT data and imaged documentation
- Consumer information, such as hospitalizations, LTC facility, pharmacy, PA information, State Plan services

- Provider information, such as outpatient services, waiver services by type, waiver services by provider and by consumer
- Waiver services by procedure code
- Waiver services by day.

10.2.1.7 Generate automatic alerts to appropriate PACT staff. Alerts are identified by ODJFS and include:

- Notification of pending review
- State hearings
- 9- and 18-month report due dates for consumer reviews.

10.2.1.8 Identify and view on-line all Medicaid consumers currently restricted to PACT for the month, and new PACT consumers, applying all changes to reflect updates made during the month as directed by ODJFS.

10.2.1.9 Send PACT consumer enrollment information to the eligibility system to drive PACT card issuance.

10.2.1.10 Generate an automatic notification to the appropriate staff when the Medicaid card is issued for consumers identified as PACT consumers. Include in this notification, the name of the consumer and the type of card that was generated.

10.2.1.11 Pay case management fees on a monthly basis to primary care physicians who serve PACT consumers. See the claims adjudication sub-process for managed care payments.

10.2.1.12 Identify conflicting and complementary services by consumer during the same time period (i.e., nursing facility stays and waiver services billed simultaneously).

10.2.1.13 Maintain a history of actions, edits, and changes made to a PACT consumer profile and the staff person who made the changes. Actions, edits, and changes including: re-opening a PACT case; release of a PACT consumer; change in PACT primary care provider or pharmacy.

10.2.2 **Performance Expectations**

10.2.2.1 None.

10.2.3 **Inputs**

10.2.3.1 Complaints

10.2.3.2 Claims data

10.2.3.3 Encounter data

10.2.3.4 Claims adjustment data

10.2.3.5 Letters

10.2.3.6 Documentation and correspondence

10.2.4 **Outputs**

10.2.4.1 Reports

10.2.4.2 Alerts

10.2.4.3 Letters

10.2.4.4 Other correspondence

10.2.4.5 Payments

10.2.4.6 ****Data files or extracts as needed.****

10.3 Retrospective Drug Utilization Review (DUR)

The retrospective Drug Utilization Review (DUR) sub-process is to promote cost effectiveness in the use of drug prescription services, eliminate unnecessary and/or inappropriate use of drugs, identify possible inappropriate drug therapy patterns, develop therapeutic class criteria to reduce the incidence of drug therapy failure and induced illness, establish and maintain drug history profiles, and educate physician and pharmacy providers on the latest standard of care and how their own practice patterns compare to those of their peers.

10.3.1 **Requirements**

10.3.1.1 Generate, track, acknowledge, and archive letters, including responses from providers. Letters should include provider name, date mailed, and findings.

10.3.1.2 Track and notify providers of:

- The need to respond to letters sent according to a time period defined by ODJFS
- Review dates
- Re-review dates.

10.3.1.3 Image, access, archive and maintain incoming correspondence utilizing electronic document management system technology.

10.3.1.4 Refer providers to appropriate licensing board using criteria to be defined by ODJFS.

10.3.1.5 Develop a tickler file with all DUR reviews and alert ODJFS staff when re-views are due. Tickler file criteria and time intervals of re-views will be defined by ODJFS.

10.3.2 **Performance Expectations**

10.3.2.1 None

10.3.3 **Inputs**

10.3.3.1 All paid claims data

10.3.3.2 Incoming correspondence

10.3.4 **Outputs**

10.3.4.1 Reports

10.3.4.2 Letters

10.3.4.3 Alerts

10.3.4.4 Reports in text form and graphical representation of data

10.3.4.5 ****Data files or extracts as needed.****

10.4 Sub-recipient State Agency Reviews

The sub-recipient State agency reviews sub-process includes requirements related to program compliance and financial audits conducted by OHP and Office of Research, Assessment, and Accountability (ORAA) to review Medicaid funds transfer to agencies (e.g., MR/DD, ODH, Ohio Department of Education ODE) that provide services to Medicaid consumers.

10.4.1 **Requirements**

10.4.1.1 Identify the following information for contracts including**:**

- Catalog of Federal Domestic Assistance (CFDA) Number
- Vendor vs. sub-recipient State agency
- Fiscal year for vendor and sub-recipient State agency.

10.4.1.2 Match period expenditures to inter-agency agreement amounts.

10.4.1.3 Generate a report identifying vendor vs. sub-recipient State agency and a report of all sub-recipient State agencies.

10.4.1.4 Generate accounts payable information to track status of sanctions.

10.4.1.5 Track original amount owed, settled amounts and recouped funds, and once paid.

10.4.1.6 Generate reports on expenditures by sub-recipient State agency, by program.

10.4.1.7 Generate and create letters to sub-recipient State agencies.

10.4.1.8 Identify whether an A-133 audit report was required (based upon expenditure information received from MITS, $500,000 or more in known expenditures) and if the report was received.

10.4.1.9 Generate a report that identifies exceptions on single audits and notifies designated staff as defined by ODJFS.

10.4.1.10 Track the status of issues/exceptions (Cost Allocation Plan (CAP), Sanctions) and report to designated ODJFS staff including:

- Audited entity
- Time period audited
- Status of issues/exceptions
- Disposition of issues/exceptions
- Date of and amounts remitted to the State of:
    - Initial finding
    - Adjudicated amount
    - Actual amount collected.

10.4.1.11 Generate a report on services authorized vs. services received.

10.4.1.12 Generate reports based upon ODJFS specified date parameters (e.g., dates needed for audit rather than set time periods).

10.4.1.13 Report on claims that were not paid to utilize in completing a risk assessment for the providers to determine who to audit in a given time period.

10.4.1.14 Capture proposed cost adjustments and alert program staff of proposed cost adjustments.

10.4.1.15 Notify ODJFS of final settlement amount.

10.4.1.16 Generate an A-133 report with Medicaid funding listed by sub-recipient State agencies and potentially by county, by CFDA number, and by discrete entity.

10.4.2 **Performance Expectations**

10.4.2.1 None

10.4.3 **Inputs**

10.4.3.1 Claims data

10.4.3.2 Cost adjustments

10.4.3.3 Audit/review settlement amounts

10.4.3.4 Contract and vendor information

10.4.4 **Outputs**

10.4.4.1 Reports

10.4.4.2 Letters

10.4.4.3 A133 audit report

10.4.4.4 ****Data files or extracts as needed.****

10.5 Provider State Hearing Rights

The Provider State Hearing Rights sub-process includes requirements related to hearings and appeals by which the ODJFS supports and tracks the 119 hearing process for Medicaid providers.

10.5.1 **Requirements**

10.5.1.1 Provide case management tracking capabilities / functionality that tracks case activity related audits and reviews completed by internal and external entities on behalf of Medicaid.

10.5.1.2 Provide complaint identification tracking.

10.5.1.3 Generate Report of Examination (ROE) documentation.

10.5.1.4 Distribute case and ROE documentation in a format that cannot be altered by the notification recipient.

10.5.1.5 Provide flexible status and activity reporting, as defined by ODJFS including:

- Process status
- Adjudication results/amounts
- Date ROE is issued
- Universe dollar amount
- Finding amounts

- Dollars set for recoveries
- Actual recoveries.

10.5.1.6 Generate alerts to ODJFS from the Office of Fiscal Services when a provider defaults on repayment.

10.5.1.7 Update provider history and provider profiles with audit/review findings as defined by ODJFS.

10.5.1.8 Track the collection of repayments by providers, either timed payments or lump sum payments.

10.5.1.9 Accept, retain and track report findings from:

- Auditor of State
- Hospital reviews
- SURS.

10.5.1.10 Track and report on reviews performed by ODJFS and provide results to outside entities as defined by ODJFS.

10.5.1.11 Track cases referred to law enforcement (e.g., Medicaid Fraud Control Unit from the Attorney General, local / State law enforcement, etc.).

10.5.1.12 Accept, retain and track Hospital Submissions for Appeals.

10.5.1.13 Alert ODJFS when appeals are received from peer review organizations.

10.5.1.14 Produce on-line performance reports related to pre-admission review based on ODJFS defined criteria.

10.5.1.15 Track outside legal proceedings and decisions in a format as defined by ODJFS.

10.5.2 **Performance Expectations**

10.5.2.1 None

10.5.3 **Inputs**

10.5.3.1 Claims data

10.5.3.2 Collection of repayment (lump sum and timed payments) data

10.5.3.3 Hospital submissions for appeal rights

10.5.3.4 Requests for chapter 119 provider hearings

10.5.3.5 Outside (e.g., Court of Common Pleas) legal proceedings and information

10.5.4 **Outputs**

10.5.4.1 Reports

10.5.4.2 Alerts

10.5.4.3 Letters

10.5.4.4 Audit findings

10.5.4.5 Provider state hearing rights information

10.5.4.6 Hospital appeal rights

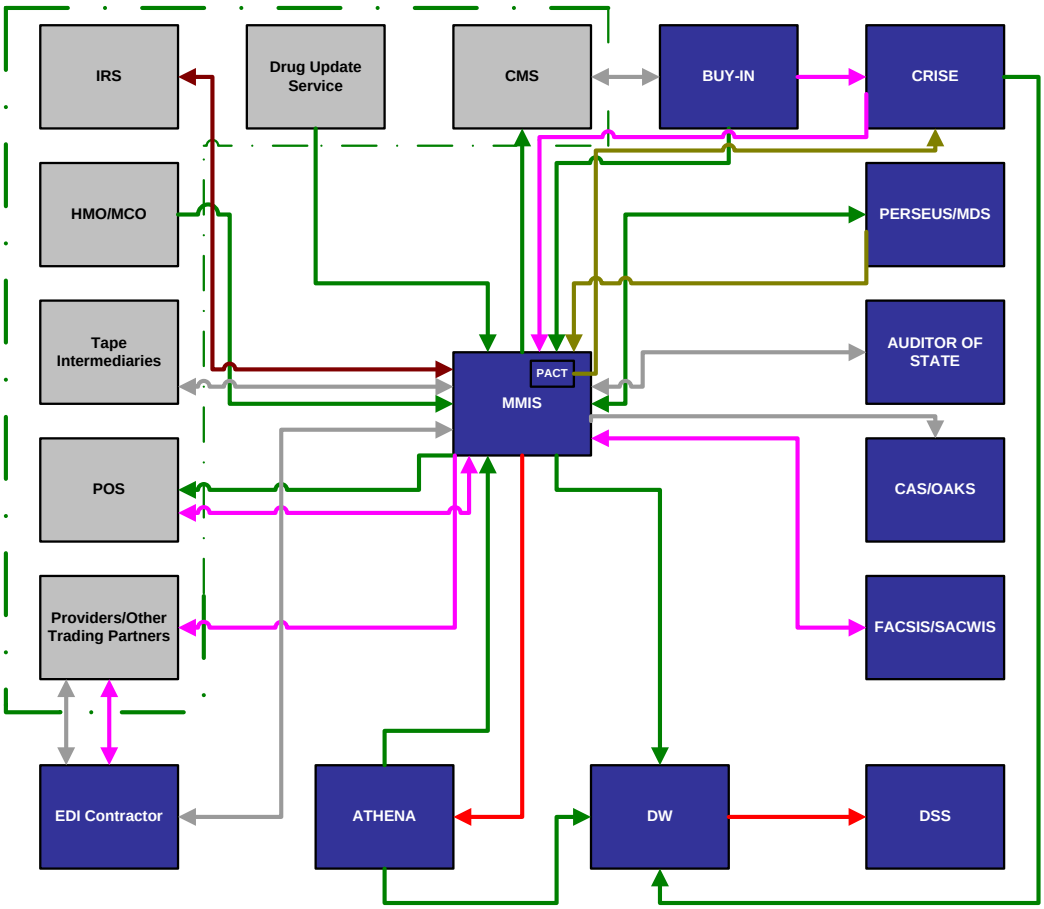
10.5.4.7 ****Data files or extracts as needed.****

Supplement 6

Integration Architecture Requirements Amendment Replacement Pages

Current Integrations with in ODJFS Medicaid Environment

Current Integration Diagram



#	Interface, From – To / or Document Title	Internal \ External	Contents	Frequency	Volume (# of records)	Transfer Protocol	Interface Layout
			format; The future Direction is to use EDI Transaction 837 for this purpose.				
50	Encounter Data - MMIS	Internal	Maternity Payment Claims	Monthly	Approx 2,520	MF Files	Appendix 31
51	Dept. of Aging	External	Claims Data	Weekly	Approx 43,000		See Appendix 1
52	MMIS – Dept. of Aging	External	Payment Information	Weekly		FTP	See Appendix 2
53	Dept Mental Health – MMIS	External	Claims Data	Weekly	Approx 73,000		****See Appendix 38**
54	MMIS – Dept Mental Health	External	Payment information	Weekly	MF Files		**See Appendix 39**
55	MRDD (State Dept) - MMIS	External	Claims Data	Weekly	Approx 19,000		**See Appendix 38**
56	MRDD – MMIS	External	Payment Information	Weekly		Tape	**See Appendix 40**
57	Dept Alcohol & Drug – MMIS	External	Claims Data	Weekly	Approx 24,000		**See Appendix 38****
58	Data Warehaouse – Current Data Marts		System Diagram - ODJFS Enterprise BI Reporting Architecture				Appendix 20
59	Medicaid Decision Support Environment		System Diagram – Medicaid DSE				Appendix 21
****60**	**C-Ports**						**Appendix 41****

Appendix 38: Mental Health – MMIS
MRDD – MMIS
Alcohol & Drug - MMIS

Interface : MH, MRDD, ODADAS - MMIS

Layout :

```
        BLOCK CONTAINS    0
      LABEL RECORDS ARE STANDARD
      RECORDING MODE IS F
      DATA RECORDS ARE
          N1405200-TAPE-BATCH-HDR-REC
          N1405300-TAPE-PHARMCY-REC
          N1405400-TAPE-COMMON-CLM-HDR
          N1405500-TAPE-COMMON-CLM-DET
          N1406000-TAPE-EPSDT-HDR-REC
          N1406100-TAPE-EPSDT-DET-REC
          N1405600-TAPE-COMMON-CLM-DT-2.
   01  N1405200-TAPE-BATCH-HDR-REC.
      05  N1405211-TAPE-RECORD-ID
                          PIC X(1).
      05  N1405221-BATCH-NUMBER
                          PIC 9(3).
      05  N1405211-TAPE-TYPE
                          PIC X(1).
      05  N1405241-NUM-OF-DOCUMENTS
                          PIC 9(2).
      05  FILLER
                          PIC X(018).
      05  FILLER
                          PIC X(002).
      05  N1405221-SUBMISSION-DATE
                          PIC 9(06).
      05  N1405211-SUBMISSION-DATE
                REDEFINES N1405221-SUBMISSION-DATE
                          PIC X(06).
      05  FILLER
                          PIC X(089).
      05  N1405211-TAPE-ID
                          PIC X(6).
      05  N1405221-ASSIGNMENT-NUMBER
                          PIC 9(3).
      05  N1405211-ASSIGNMENT-NUMBER
                REDEFINES N1405221-ASSIGNMENT-NUMBER
                          PIC X(3).
      05  FILLER
                          PIC X(029).
   01  N1405300-TAPE-PHARMCY-REC.
      05  N1405351-DOCUMENT-NUMBER
                          PIC 9(7).
      05  N1405361-DOCUMENT-NUMBER
                REDEFINES N1405351-DOCUMENT-NUMBER
                          PIC X(7).
      05  N1405321-PROV-NUMBER
                          PIC 9(07).
      05  N1405311-PROV-NUMBER
                REDEFINES N1405321-PROV-NUMBER
                          PIC X(07).
      05  N1405311-DATE-BILLED
                          PIC 9(6).
      05  N1405341-DATE-BILLED
                REDEFINES N1405311-DATE-BILLED
                          PIC X(6).
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    05  N1405311-LINE-ITEM-CODE
                    PIC X(2).
    05  N1405391-RECIP-LAST-NAME.
      10  N1405312-LAST-NAME-FIRST-2
                    PIC X(2).
      10  FILLER
                    PIC X(012).
    05  N1405391-RECIP-FIRST-NAME.
      10  N1405312-RECIP-1ST-NAME-INIT
                    PIC X(01).
      10  FILLER
                    PIC X(011).
    05  N1405391-RECIP-IDENT-NUMBER.
      10  N1405312-RECIP-CASE-NUMBER
                    PIC X(10).
      10  N1405312-RECIP-ADC-NUMBER
                    PIC X(02).
    05  FILLER
                    PIC X(012).
    05  N1405311-RECIP-NH-INDIC
                    PIC X(1).
    05  N1405321-PRESC-PHYS-PROV-NUM
                    PIC 9(7).
    05  N1405311-PRESC-PHYS-PROV-NUM
            REDEFINES N1405321-PRESC-PHYS-PROV-NUM
                    PIC X(7).
    05  N1405321-DATE-PRESCRIBED
                    PIC 9(6).
    05  N1405311-DATE-PRESCRIBED
            REDEFINES N1405321-DATE-PRESCRIBED
                    PIC X(6).
    05  N1405311-PRESCRIPTION-NUMBER
                    PIC X(6).
    05  N1405321-DATE-DISPENSED
                    PIC 9(6).
    05  N1405341-DATE-DISPENSED
            REDEFINES N1405321-DATE-DISPENSED
                    PIC X(6).
    05  N1405311-DRUG-CODE
                    PIC X(10).
    05  N1405361-DRUG-QUANTITY
                    PIC 9(5).
    05  N1405381-DRUG-QUANTITY
            REDEFINES N1405361-DRUG-QUANTITY
                    PIC X(5).
    05  N1405341-TAPE-TOTAL-CLM-CHRG
                    PIC 9(7)V99.
    05  N1405381-TAPE-TOTAL-CLM-CHRG
            REDEFINES N1405341-TAPE-TOTAL-CLM-CHRG
                    PIC X(9).
    05  N1405311-OTHER-INSURANCE-IND
                    PIC X(1).
    05  N1405361-THIRD-PARTY-PMT-AMT
                    PIC 9(7)V99.
    05  N1405341-TPL-PAYMENT-AMT
            REDEFINES N1405361-THIRD-PARTY-PMT-AMT
                    PIC X(9).
    05  N1405321-PRIOR-AUTH-NUM
                    PIC 9(6).
    05  N1405311-REFILL-INDICATOR
                    PIC X(1).
    05  N1405311-DAYS-SUPPLIED
                    PIC X(3).
    05  N1405321-OVERRIDE-EXCEP-CODE
                    PIC 9(3).
    05  N1405321-OVERRIDE-LOC-CODE
                    PIC XX.
    05  FILLER
                    PIC X(013).
01  N1405400-TAPE-COMMON-CLM-HDR.
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05  N1405411-TAPE-RECORD-ID
                PIC X(1).
05  N1405451-DOCUMENT-NUMBER
                PIC 9(7).
05  N1405461-DOCUMENT-NUMBER
          REDEFINES N1405451-DOCUMENT-NUMBER
                PIC X(7).
05  N1405421-PROV-NUMBER
                PIC 9(07).
05  N1405411-PROV-NUMBER
          REDEFINES N1405421-PROV-NUMBER
                PIC X(07).
05  N1405421-PAY-TO-PROV-NUM
                PIC 9(7).
05  N1405411-CLM-INPUT-FORM-IND
                PIC X(1).
05  N1405411-MEDICAL-RCD-NUM
                PIC X(9).
05  N1405491-RECIP-LAST-NAME.
 10  N1405412-LAST-NAME-FIRST-2
                PIC X(2).
 10  FILLER
                PIC X(012).
05  N1405491-RECIP-FIRST-NAME.
 10  N1405412-RECIP-1ST-NAME-INIT
                PIC X(01).
 10  FILLER
                PIC X(011).
05  N1405421-PRIOR-AUTH-NUM
                PIC 9(6).
05  N1405441-PRIOR-AUTH-NUM
          REDEFINES N1405421-PRIOR-AUTH-NUM
                PIC X(6).
05  N1405491-RECIP-IDENT-NUMBER.
 10  N1405412-RECIP-CASE-NUMBER
                PIC X(10).
 10  N1405412-RECIP-ADC-NUMBER
                PIC X(02).
05  N1405491-DIAGNOSIS-DATA.
 10  N1405492-DIAGNOSIS-DATA
          OCCURS 0002 TIMES
          INDEXED BY NX1405492-DIAGNOSIS-DATA.
   15  N1405443-DIAG-CODE-ICD-9
                PIC X(5).
05  N1405441-REFERRING-PROV-NUM
                PIC 9(7).
05  N1405451-REFERRING-PROV-NUM
          REDEFINES N1405441-REFERRING-PROV-NUM
                PIC X(7).
05  N1405411-EPSDT-INDICATOR
                PIC X(01).
05  N1405411-FAMILY-PLANNING-CODE
                PIC X(1).
05  N1405411-TRAUMA-REL-IND
                PIC X(1).
05  N1405411-OTHER-INSURANCE-IND
                PIC X(1).
05  N1405411-DATE-BILLED
                PIC 9(6).
05  N1405441-DATE-BILLED
          REDEFINES N1405411-DATE-BILLED
                PIC X(6).
05  N1405441-MCARE-APPROVED-AMT
                PIC 9(7)V99.
05  N1405421-MCARE-DEDUCTIBLE-AMT
                PIC 9(5)V99.
05  N1405421-MCARE-COINS-AMT
                PIC 9(5)V99.
05  N1405441-TAPE-TOTAL-CLM-CHRG
                PIC 9(7)V99.
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    05  N1405481-TAPE-TOTAL-CLM-CHRG
            REDEFINES N1405441-TAPE-TOTAL-CLM-CHRG
                PIC X(9).
    05  N1405461-THIRD-PARTY-PMT-AMT
                PIC 9(7)V99.
    05  N1405441-TPL-PAYMENT-AMT
            REDEFINES N1405461-THIRD-PARTY-PMT-AMT
                PIC X(9).
    05  N1405441-NET-CLAIM-CHARGE
                PIC 9(7)V99.
    05  N1405471-NET-CLAIM-CHARGE
            REDEFINES N1405441-NET-CLAIM-CHARGE
                PIC X(9).
    05  N1405421-DATE-PAID-BY-MCARE
                PIC 9(6).
    05  FILLER
                PIC X(001).
01  N1405500-TAPE-COMMON-CLM-DET.
    05  N1405511-TAPE-RECORD-ID
                PIC X(1).
    05  N1405511-LINE-ITEM-CODE
                PIC X(2).
    05  N1405521-FIRST-DATE-OF-SVC
                PIC 9(6).
    05  N1405511-FIRST-DATE-OF-SVC
            REDEFINES N1405521-FIRST-DATE-OF-SVC
                PIC X(6).
    05  N1405511-PROC-CODE
                PIC X(5).
    05  N1405511-PROC-CODE-MODIFIER
                PIC X(2).
    05  N1405511-PLACE-OF-SERVICE
                PIC X(2).
    05  N1405561-UNITS-OF-SERVICE
                PIC 9(4).
    05  N1405511-UNITS-OF-SERVICE
            REDEFINES N1405561-UNITS-OF-SERVICE
                PIC X(4).
    05  N1405511-TOOTH-NUMBER
                PIC X(2).
    05  N1405591-TOOTH-SURFACE.
     10  N1405592-TOOTH-SURFACE
            OCCURS 0006 TIMES
            INDEXED BY NX1405592-TOOTH-SURFACE.
       15  N1405513-TOOTH-SURFACE
                PIC X(1).
    05  N1405511-PRESCRIPTION-NUMBER
                PIC X(6).
    05  N1405521-PROCEDURE-CHARGE
                PIC 9(5)V99.
    05  N1405571-PROCEDURE-CHARGE
            REDEFINES N1405521-PROCEDURE-CHARGE
                PIC X(7).
    05  N1405521-OVERRIDE-EXCEP-CODE
                PIC 9(3).
    05  FILLER
                PIC X(114).
01  N1406000-TAPE-EPSDT-HDR-REC.
    05  N1406011-TAPE-RECORD-ID
                PIC X(1).
    05  N1406051-DOCUMENT-NUMBER
                PIC 9(7).
    05  N1406021-PROV-NUMBER
                PIC 9(07).
    05  N1406021-PAY-TO-PROV-NUM
                PIC 9(7).
    05  N1406011-MEDICAL-RCD-NUM
                PIC X(9).
    05  N1406011-LAST-NAME-FIRST-2
                PIC X(2).
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    05  N1406011-RECIP-1ST-NAME-INIT
                    PIC X(01).
    05  N1406091-RECIP-IDENT-NUMBER.
     10  N1406012-RECIP-CASE-NUMBER
                    PIC X(10).
     10  N1406012-RECIP-ADC-NUMBER
                    PIC X(02).
    05  N1406041-REFERRING-PROV-NUM
                    PIC 9(7).
    05  N1406011-PLACE-OF-SERVICE
                    PIC X(2).
    05  N1406021-FIRST-DATE-OF-SVC
                    PIC 9(6).
    05  N1406041-TAPE-TOTAL-CLM-CHRG
                    PIC 9(7)V99.
    05  N1406061-THIRD-PARTY-PMT-AMT
                    PIC 9(7)V99.
    05  N1406011-OTHER-INSURANCE-IND
                    PIC X(1).
    05  N1406041-NET-CLAIM-CHARGE
                    PIC 9(7)V99.
    05  N1406011-DATE-BILLED
                    PIC 9(6).
    05  N1406011-IMMUNIZATION-IND
                    PIC X(1).
    05  N1406011-SICKLE-CELL-IND
                    PIC X(1).
    05  N1406011-COMMUN-DISEASE-IND
                    PIC X(1).
    05  N1406011-DENTAL-REFERRAL-IND
                    PIC X(1).
    05  N1406021-OVERRIDE-EXCEP-CODE
                    PIC 9(3).
    05  N1406021-OVERRIDE-LOC-CODE
                    PIC XX.
    05  FILLER
                    PIC X(056).
01  N1406100-TAPE-EPSDT-DET-REC.
    05  N1406111-TAPE-RECORD-ID
                    PIC X(1).
    05  N1406121-LINE-ITEM-CODE
                    PIC 9(2).
    05  N1406111-PROC-CODE
                    PIC X(5).
    05  N1406111-PROC-CODE-MODIFIER
                    PIC X(2).
    05  N1406121-PROCEDURE-CHARGE
                    PIC 9(5)V99.
    05  N1406111-DIAGNOSTIC-STATUS
                    PIC X(1).
    05  N1406141-DIAG-CODE-ICD-9
                    PIC X(5).
    05  N1406111-NO-FOLLOW-UP-CODE
                    PIC X(1).
    05  N1406111-FOLLOW-UP-CODE
                    PIC X(1).
    05  N1406121-OVERRIDE-EXCEP-CODE
                    PIC 9(3).
    05  FILLER
                    PIC X(132).
01  N1405600-TAPE-COMMON-CLM-DT-2.
    05  N1405611-TAPE-RECORD-ID
                    PIC X(1).
    05  N1405621-HR-EST-DATE-DELIVERY
                    PIC 9(06).
    05  N1405611-PRETERM-DELIVERY
                    PIC X(01).
    05  N1405611-DES-EXPOSURE
                    PIC X(01).
    05  N1405611-CONE-BIOPSY
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                PIC X(01).
    05  N1405611-2ND-TRIMESTER-ABORT
                PIC X(01).
    05  N1405611-1ST-TRIMESTER-ABORT
                PIC X(01).
    05  N1405611-UTERNINE-ANOMALY
                PIC X(01).
    05  N1405611-MULTIPLE-GESTATION
                PIC X(01).
    05  N1405611-ABDOMINAL-SURGERY
                PIC X(01).
    05  N1405611-CERVIX-DILATED
                PIC X(01).
    05  N1405611-CERVIX-EFFACED
                PIC X(01).
    05  N1405611-IRRITABLE-UTERUS
                PIC X(01).
    05  N1405611-POLYHYDRAMNIOS
                PIC X(01).
    05  N1405611-BLEEDING
                PIC X(01).
    05  N1405611-PYELONEPHRITIS
                PIC X(01).
    05  N1405611-PRETERM-LABOR
                PIC X(01).
    05  N1405611-SMOKING
                PIC X(01).
    05  N1405611-PROM
                PIC X(01).
    05  N1405611-INFANT-DEATH
                PIC X(01).
    05  N1405611-CONGENITAL-ANOMALY
                PIC X(01).
    05  N1405611-LOW-BIRTH-WEIGHT
                PIC X(01).
    05  N1405611-ECLAMPSIA
                PIC X(01).
    05  N1405611-INCOMPETENT-CERVIX
                PIC X(01).
    05  N1405611-HEART-DISEASE
                PIC X(01).
    05  N1405611-DIABETES-INSULIN
                PIC X(01).
    05  N1405611-SICKLE-CELL-ANEMIA
                PIC X(01).
    05  N1405611-MALIGNANCY
                PIC X(01).
    05  N1405611-THYROID-DISEASE
                PIC X(01).
    05  N1405611-EPILEPSY
                PIC X(01).
    05  N1405611-HEPATITIS
                PIC X(01).
    05  N1405611-ASTHMA
                PIC X(01).
    05  N1405611-TUBERCULOSIS
                PIC X(01).
    05  N1405611-PNEUMONIA
                PIC X(01).
    05  N1405611-HYPERTENSION
                PIC X(01).
    05  N1405611-DEEP-VENOUS-THROMB
                PIC X(01).
    05  N1405611-PLACENTA-PREVIA
                PIC X(01).
    05  N1405611-OLIGOHYDRAMNIOS
                PIC X(01).
    05  N1405611-CURR-ECLAMPSIA
                PIC X(01).
    05  N1405611-ALLOIMMUNIZATION
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                PIC X(01).
    05  N1405611-RUBELLA-EXPOSURE
                PIC X(01).
    05  N1405611-POSITIVE-SEROLOGY
                PIC X(01).
    05  N1405611-ACTIVE-HERPES
                PIC X(01).
    05  N1405611-PRIMIGRAVIDA
                PIC X(01).
    05  N1405611-FAMILIAL-GENETIC
                PIC X(01).
    05  N1405611-PSYCHOSIS
                PIC X(01).
    05  N1405611-MENTAL-RETARDATION
                PIC X(01).
    05  N1405611-DRUG-ALCOHOL-ABUSE
                PIC X(01).
    05  N1405611-OTHER-CODE-47
                PIC X(01).
    05  N1405611-PRIOR-C-SECTION
                PIC X(01).
    05  N1405611-PRENATAL-NON-COMPLI
                PIC X(01).
    05  N1405611-GRAND-MULTIPARA
                PIC X(01).
    05  N1405611-RECENT-DELIVERY
                PIC X(01).
    05  N1405611-LATE-INITIAL-VISIT
                PIC X(01).
    05  N1405611-MISSED-PRENATAL-APPT
                PIC X(01).
    05  N1405611-AGE-LT-17-GT-35
                PIC X(01).
    05  N1405611-HEIGHT-LT-5-FT
                PIC X(01).
    05  N1405611-OBESITY
                PIC X(01).
    05  N1405611-UNDERWEIGHT
                PIC X(01).
    05  N1405611-WEIGHT-LOSS
                PIC X(01).
    05  N1405611-ANEMIA
                PIC X(01).
    05  N1405611-GONORRHEA
                PIC X(01).
    05  N1405611-DIABETES-DIET
                PIC X(01).
    05  N1405611-CHRONIC-BRONCHITIS
                PIC X(01).
    05  N1405611-TRAUMA
                PIC X(01).
    05  N1405611-ILLITERACY
                PIC X(01).
    05  N1405611-DOMESTIC-VIOLENCE
                PIC X(01).
    05  N1405611-OTHER-CODE-66
                PIC X(01).
    05  N1405621-OVERRIDE-EXCEP-CODE
                PIC 9(3).
    05  N1405621-OVERRIDE-LOC-CODE
                PIC XX.
    05  FILLER
                PIC X(082).
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Appendix 39: MMIS – Mental Health

Interface : MMIS – Mental Health

Layout :

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        000010 01  OHIO1-IND-PRAC-CLINIC-CLM-REC.                          00000100
000020     05  OHIO1-CLAIM-TRANS-RCD-CODE            PIC  X(01).     00000200
000030     05  OHIO1-CLAIM-TRANS-SORT-KEY            PIC  X(24).     00000300
000040     05  OHIO1-CLAIM-CTL-NUM.                                   00000400
000050        10  OHIO1-CLAIM-ENTRY-DATE             PIC  9(05).     00000500
000060        10  OHIO1-DOC-CTL-NUM                  PIC  9(07).     00000600
000070        10  OHIO1-DOC-LINE-NUM                 PIC  9(02).     00000700
000080        10  OHIO1-CLM-BATCH-NUM                PIC  9(03).     00000800
000090     05  OHIO1-CLM-PROC-TRANS-CD.                               00000900
000100        10  OHIO1-1ST-DIGIT                   PIC  X(01).     00001000
000110        10  OHIO1-2ND-DIGIT                   PIC  X(01).     00001100
000120     05  OHIO1-SVC-CATEGORY                   PIC  9(02).     00001200
000130     05  OHIO1-RECIP-ID-NUM.                                    00001300
000140        10  OHIO1-CASE-NUM                    PIC  9(10).     00001400
000150        10  OHIO1-ADC-NUM                     PIC  9(02).     00001500
000160     05  OHIO1-RECIP-DATE.                                      00001600
000170        10  OHIO1-RECIP-LAST-NAME             PIC  X(14).     00001700
000180        10  OHIO1-RECIP-FIRST-NAME            PIC  X(12).     00001800
000270     05  OHIO1-PROVIDER-NUM                   PIC  9(07).     00002700
000280     05  OHIO1-PA-CTL-NUM                     PIC  9(06).     00002800
000290     05  OHIO1-DIAGNOSIS-CODES.                                 00002900
000300        10  OHIO1-DIAGNOSIS-CODE  OCCURS 2     PIC  X(05).     00003000
000310     05  OHIO1-3RD-PARTY-CODES.                                 00003100
000320        10  OHIO1-3RD-PARTY-CODE  OCCURS 5     PIC  X(01).     00003200
000330     05  OHIO1-ATT-REF-PRES-PHYS              PIC  9(07).     00003300
000340     05  OHIO1-TOT-CLM-CHG                    PIC S9(05)V99.   00003400
000350     05  OHIO1-3RD-PARTY-AMT                  PIC S9(05)V99.   00003500
000360     05  OHIO1-NET-CLAIM-CHG                  PIC S9(05)V99.   00003600
000370     05  OHIO1-BILLING-DATE                   PIC  9(06).     00003700
000380     05  OHIO1-REIMB-AMT                      PIC S9(05)V99.   00003800
000390     05  OHIO1-ADJUD-DATE                     PIC  9(06).     00003900
000400     05  OHIO1-ADJ-STATUS                     PIC  X(01).     00004000
000410     05  OHIO1-FUND-TYPE                      PIC  X(01).     00004100
000420     05  OHIO1-CC-CASE-TYPE                   PIC  X(01).     00004200
000430     05  OHIO1-CLAIM-ERROR-CODES.                               00004300
000440        10  OHIO1-CLAIM-ERROR-CODE   OCCURS 10  PIC  9(03).     00004400
000450     05  FILLER REDEFINES OHIO1-CLAIM-ERROR-CODES.              00004500
000460        10  FILLER                           PIC  X(24).     00004600
000470        10  OHIO1-WAR-NO            COMP-3     PIC  9(07).     00004700
000480        10 FILLER                            PIC  X(02).     00004800
000490     05  OHIO1-FORCE-DATA-GROUPS.                               00004900
000500        10  OHIO1-FORCE-DATA              OCCURS 3.            00005000
000510           15  OHIO1-FORCE-CODE               PIC  X(03).     00005100
000520           15  OHIO1-FORCE-APP                PIC  X(02).     00005200
        05  OHIO1-OLD-TCN REDEFINES OHIO1-FORCE-DATA-GROUPS.
           10  OHIO1-TAPE-BATCH-NUMBER            PIC 9(3).
           10  OHIO1-TAPE-DOC-NUMBER              PIC 9(7).
           10  FILLER                           PIC X(5).
000550     05  OHIO1-COPAY                 COMP-3     PIC  9(03)V99.   00005500
000560     05  OHIO1-RUN-NUMS.                                        00005600
000570        10 OHIO1-CURR-RUN-NUM.                                  00005700
000580           15 FILLER                         PIC  X(01).     00005800
000590           15 OHIO1-CURR-RUN-NUM-3A.                          00005900
000600              20 OHIO1-CURR-RUN-NUM-3N       PIC  9(03).     00006000
000610           15 FILLER                         PIC  X(01).     00006100
000620        10 OHIO1-PREV-RUN-NUM                PIC  X(05).     00006200
000703     05  OHIO1-NUM-LINE-ITEMS          COMP      PIC S9(02).     00007000
        05  OHIO1-MED-RCD-NUM                   PIC  X(09).
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000730    05  OHIO1-PRAC-LINE-ITEMS.                          00007300
000740      10  OHIO1-PRAC-LINE-ITEM.
000760        15  OHIO1-LINE-ITEM-NUM          PIC  9(02).     00007600
000770        15  OHIO1-PROC-PCS-CODE          PIC  X(01).     00007700
000780        15  OHIO1-PROC-CODE              PIC  X(05).     00007800
000790        15  OHIO1-1ST-PROC-SVC-DATE      PIC  9(06).     00007900
000800        15  OHIO1-LAST-PROC-SVC-DATE     PIC  9(06).     00008000
000810        15  OHIO1-PLC-SVC                PIC  X(01).     00008100
000820        15  OHIO1-TYPE-SVC               PIC  X(01).     00008200
000830        15  OHIO1-TOOTH-NUM              PIC  X(02).     00008300
000840        15  OHIO1-UNITS-SVC              PIC S9(03).     00008400
000850        15  OHIO1-NUM-INJ                PIC S9(01).     00008500
000860        15  OHIO1-GROUP-MEMBER-NUM-A.                    00008600
000870          20  OHIO1-GROUP-MEMBER-NUM     PIC  9(07).     00008610
000880        15  OHIO1-SUBMIT-PROC-CHG        PIC S9(04)V99.  00008700
000890        15  OHIO1-ALLOW-PROC-CHG         PIC S9(04)V99.  00008800
000930        15  OHIO1-LINE-ITEM-ERROR        PIC  X(01).     00009200
000940        15  OHIO1-TOOTH-SURF-NUM         PIC  X(01).     00009300
000730    05  FILLER                           PIC  X(20).     00007300
000950 01  OHIO2-SUP-CLAIM-REC.                                 00009400
000960    05  OHIO2-CLAIM-TRANS-RCD-CODE       PIC  X(01).     00009500
000970    05  OHIO2-CLAIM-TRANS-SORT-KEY       PIC  X(24).     00009600
000980    05  OHIO2-CLAIM-CTL-NUM.                             00009700
000990      10  OHIO2-CLAIM-ENTRY-DATE         PIC  9(05).     00009800
001000      10  OHIO2-DOC-CTL-NUM              PIC  9(07).     00009900
001010      10  OHIO2-DOC-LINE-NUM             PIC  9(02).     00010000
001020      10  OHIO2-CLM-BATCH-NUM            PIC  9(03).     00010100
001030    05  OHIO2-CLM-PROC-TRANS-CD.                         00010200
001040      10  OHIO2-1ST-DIGIT                PIC  X(01).     00010300
001050      10  OHIO2-2ND-DIGIT                PIC  X(01).     00010400
001060    05  OHIO2-SVC-CATEGORY               PIC  9(02).     00010500
001070    05  OHIO2-RECIP-ID-NUM.                              00010600
001080      10  OHIO2-CASE-NUM                 PIC  9(10).     00010700
001090      10  OHIO2-ADC-NUM                  PIC  9(02).     00010800
001100    05  OHIO2-RECIP-DATE.                                00010900
001110      10  OHIO2-RECIP-LAST-NAME          PIC  X(14).     00011000
001120      10  OHIO2-RECIP-FIRST-NAME         PIC  X(12).     00011100
001210    05  OHIO2-PROVIDER-NUM               PIC  9(07).     00012000
001220    05  OHIO2-PA-CTL-NUM                 PIC  9(06).     00012100
001230    05  OHIO2-DIAGNOSIS-CODES.                           00012200
001240      10  OHIO2-DIAGNOSIS-CODE  OCCURS 2 PIC  X(05).     00012300
001250    05  OHIO2-3RD-PARTY-CODES.                           00012400
001260      10  OHIO2-3RD-PARTY-CODE  OCCURS 5 PIC  X(01).     00012500
001270    05  OHIO2-ATT-REF-PRES-PHYS          PIC  9(07).     00012600
001280    05  OHIO2-TOT-CLM-CHG                PIC S9(05)V99.  00012700
001290    05  OHIO2-3RD-PARTY-AMT              PIC S9(05)V99.  00012800
001300    05  OHIO2-NET-CLAIM-CHG              PIC S9(05)V99.  00012900
001310    05  OHIO2-BILLING-DATE               PIC  9(06).     00013000
001320    05  OHIO2-REIMB-AMT                  PIC S9(05)V99.  00013100
001330    05  OHIO2-ADJUD-DATE                 PIC  9(06).     00013200
001340    05  OHIO2-ADJ-STATUS                 PIC  X(01).     00013300
001350    05  OHIO2-FUND-TYPE                  PIC  X(01).     00013400
001360    05  OHIO2-CC-CASE-TYPE               PIC  X(01).     00013500
001370    05  OHIO2-CLAIM-ERROR-CODES.                         00013600
001380      10  OHIO2-CLAIM-ERROR-CODE  OCCURS 10  PIC  9(03). 00013700
001390    05  FILLER REDEFINES OHIO2-CLAIM-ERROR-CODES.        00013800
001400      10  FILLER                         PIC  X(24).     00013900
001410      10  OHIO2-WAR-NO          COMP-3   PIC  9(07).     00014000
001420      10 FILLER                          PIC  X(02).     00014100
001430    05  OHIO2-FORCE-DATA-GROUPS.                         00014200
001440      10  OHIO2-FORCE-DATA               OCCURS 3.       00014300
001450        15  OHIO2-FORCE-CODE             PIC  X(03).     00014400
001460        15  OHIO2-FORCE-APP              PIC  X(02).     00014500
        05  OHIO2-OLD-TCN REDEFINES OHIO2-FORCE-DATA-GROUPS.
          10  OHIO2-TAPE-BATCH-NUMBER          PIC 9(3).
          10  OHIO2-TAPE-DOC-NUMBER            PIC 9(7).
          10  FILLER                       PIC X(5).
001490    05  OHIO2-COPAY           COMP-3   PIC  9(03)V99.  00014800
001500    05  OHIO2-RUN-NUMS.                                  00014900
001510      10 OHIO2-CURR-RUN-NUM.                           00015000
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001520          15 FILLER                    PIC  X(01).     00015100
001530          15 OHIO2-CURR-RUN-NUM-3A.                    00015200
001540             20 OHIO2-CURR-RUN-NUM-3N      PIC  9(03).     00015300
001550          15 FILLER                    PIC  X(01).     00015400
001560       10 OHIO2-PREV-RUN-NUM            PIC  X(05).     00015500
001640    05  OHIO2-NUM-LINE-ITEMS      COMP      PIC S9(02).     00016300
001650    05  OHIO2-SUP-LINE-ITEM.                               00016400
001660       10  OHIO2-SUP-LINE-ITEM.                            00016500
001670          15 OHIO2-SUP-PCS-CODE          PIC  X(01).     00016600
001680          15 OHIO2-DRUG-PCS-CODE.                        00016700
001690             20 FILLER                  PIC  X(03).     00016800
001700             20 OHIO2-DRUG-CODE.                         00016900
001710                25 OHIO2-DRUG-PK    COMP-3  PIC  9(12).     00017000
001720          15 OHIO2-DATE-PRESCRIBE         PIC  9(06).     00017100
001730          15 OHIO2-DATE-DISPENSE          PIC  9(06).     00017200
001740          15 OHIO2-PRESCRIP-NUM           PIC  X(06).     00017300
001760          15 OHIO2-SNH-CODE              PIC  X(01).     00017500
001770          15 OHIO2-DAYS-SUPPLY            PIC  9(02).     00017600
001780          15 OHIO2-SUBMIT-DS-CHG          PIC S9(04)V99.  00017700
001790          15 OHIO2-ALLOW-DS-CHG           PIC S9(04)V99.  00017800
001800          15 OHIO2-PROF-FEE              PIC S9(01)V99.  00017900
001810          15 OHIO2-DS-QTY                PIC S9(03).     00018000
001830          15 OHIO2-LINE-ITEM-ERROR        PIC  X(01).     00018200
000730    05  FILLER                     PIC  X(27).     00007300
001840 01  OHIO3-INST-CLAIM-REC.                              00018300
001850    05  OHIO3-CLAIM-TRANS-RCD-CODE          PIC  X(01).     00018400
001860    05  OHIO3-CLAIM-TRANS-SORT-KEY          PIC  X(24).     00018500
001870    05  OHIO3-CLAIM-CTL-NUM.                               00018600
001880       10  OHIO3-CLAIM-ENTRY-DATE          PIC  9(05).     00018700
001890       10  OHIO3-DOC-CTL-NUM               PIC  9(07).     00018800
001900       10  OHIO3-DOC-LINE-NUM              PIC  9(02).     00018900
001910       10  OHIO3-CLM-BATCH-NUM             PIC  9(03).     00019000
001920    05  OHIO3-CLM-PROC-TRANS-CD.                           00019100
001930       10  OHIO3-1ST-DIGIT                PIC  X(01).     00019200
001940       10  OHIO3-2ND-DIGIT                PIC  X(01).     00019300
001950    05  OHIO3-SVC-CATEGORY                 PIC  9(02).     00019400
001960    05  OHIO3-RECIP-ID-NUM.                               00019500
001970       10  OHIO3-CASE-NUM                 PIC  9(10).     00019600
001980       10  OHIO3-ADC-NUM                  PIC  9(02).     00019700
001990    05  OHIO3-RECIP-DATA.                                 00019800
002000       10  OHIO3-RECIP-LAST-NAME           PIC  X(14).     00019900
002010       10  OHIO3-RECIP-FIRST-NAME          PIC  X(12).     00020000
002100    05  OHIO3-PROVIDER-NUM                 PIC  9(07).     00020900
002110    05  OHIO3-PA-CTL-NUM                  PIC  9(06).     00021000
002120    05  OHIO3-DIAGNOSIS-CODES.                            00021100
002130       10  OHIO3-DIAGNOSIS-CODE  OCCURS 2     PIC  X(05).     00021200
002140    05  OHIO3-3RD-PARTY-CODES.                            00021300
002150       10  OHIO3-3RD-PARTY-CODE  OCCURS 5     PIC  X(01).     00021400
002160    05  OHIO3-ATT-REF-PRES-PHYS            PIC  9(07).     00021500
002170    05  OHIO3-TOT-CLM-CHG                 PIC S9(05)V99.  00021600
002180    05  OHIO3-3RD-PARTY-AMT                PIC S9(05)V99.  00021700
002190    05  OHIO3-NET-CLAIM-CHG                PIC S9(05)V99.  00021800
002200    05  OHIO3-BILLING-DATE                 PIC  9(06).     00021900
002210    05  OHIO3-REIMB-AMT                    PIC S9(05)V99.  00022000
002220    05  OHIO3-ADJUD-DATE                   PIC  9(06).     00022100
002230    05  OHIO3-ADJ-STATUS                   PIC  X(01).     00022200
002240    05  OHIO3-FUND-TYPE                    PIC  X(01).     00022300
002250    05  OHIO3-CC-CASE-TYPE                  PIC  X(01).     00022400
002260    05  OHIO3-CLAIM-ERROR-CODES.                          00022500
002270       10  OHIO3-CLAIM-ERROR-CODE   OCCURS 10  PIC  9(03).     00022600
002280    05  FILLER REDEFINES OHIO3-CLAIM-ERROR-CODES.          00022700
002290       10  FILLER                     PIC  X(24).     00022800
002300       10  OHIO3-WAR-NO           COMP-3     PIC  9(07).     00022900
002310       10 FILLER                     PIC  X(02).     00023000
002320    05  OHIO3-FORCE-DATA-GROUPS.                          00023100
002330       10  OHIO3-FORCE-DATA              OCCURS 3.        00023200
002340          15  OHIO3-FORCE-CODE             PIC  X(03).     00023300
002350          15  OHIO3-FORCE-APP              PIC  X(02).     00023400
        05  OHIO3-OLD-TCN REDEFINES OHIO3-FORCE-DATA-GROUPS.
          10  OHIO3-TAPE-BATCH-NUMBER           PIC 9(3).
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           10  OHIO3-TAPE-DOC-NUMBER            PIC 9(7).
           10  FILLER                          PIC X(5).
002380     05  OHIO3-PRE-ADMISSION               PIC  X(01).     00023700
002390     05  FILLER                          PIC  9(02).     00023800
002400     05  OHIO3-RUN-NUMS.                                   00023900
002410        10 OHIO3-CURR-RUN-NUM.                           00024000
002420           15 FILLER                      PIC  X(01).     00024100
002430           15 OHIO3-CURR-RUN-NUM-3A.                     00024200
002440              20 OHIO3-CURR-RUN-NUM-3N       PIC  9(03).     00024300
002450           15 FILLER                      PIC  X(01).     00024400
002460        10 OHIO3-PREV-RUN-NUM               PIC  X(05).     00024500
002540     05  OHIO3-NUM-LINE-ITEMS        COMP      PIC S9(02).     00025300
002550     05  OHIO3-BEGIN-SVC-DATE              PIC  9(06).     00025400
002560     05  OHIO3-END-SVC-DATE                PIC  9(06).     00025500
002570     05  OHIO3-ADMIT-DATE                  PIC  9(06).     00025600
002580     05  OHIO3-MED-RCD-NUM                 PIC  X(09).     00025700
002590     05  OHIO3-TYPE-BILL-PAT-STAT            PIC  X(01).     00025800
002600     05  OHIO3-FINAL-BILL-RSN              PIC  X(01).     00025900
002610     05  OHIO3-PREV-STAY                   PIC  X(01).     00026000
002620     05  OHIO3-DISCH-DEST-CODE               PIC  X(01).     00026100
002630     05  OHIO3-DISCH-DEST-PROV               PIC  9(07).     00026200
002640     05  OHIO3-NON-COV-CLM-CHG               PIC S9(05)V99.   00026300
002650     05  OHIO3-BLOOD-FORM                  PIC  9(02).     00026400
002660     05  OHIO3-BLOOD-REPL                  PIC  9(02).     00026500
002670     05  OHIO3-UNITS-SVC                 PIC S9(02).     00026600
002680     05  OHIO3-LEAVE-DAYS                  PIC S9(02).     00026700
002690     05  OHIO3-ADMIT-HR                  PIC  X(02).     00026800
002700     05  OHIO3-INST-LINE-ITEMS.                            00026900
002710        10  OHIO3-INST-LINE-ITEM.
002730           15  OHIO3-INST-UB16-LI-CODE.                    00027200
002740              20  OHIO3-COST-CENTER          PIC  X(02).     00027300
002750              20  OHIO3-INST-LI-CODE         PIC  X(01).     00027400
002760           15  OHIO3-DAYS-BLOOD-VIS          PIC S9(02).     00027500
002770           15  OHIO3-ACC-VIS-CHG             PIC S9(03)V99.   00027600
002780           15  OHIO3-SURG-CODE REDEFINES OHIO3-ACC-VIS-CHG     00027700
002790                                       PIC  X(05).     00027800
002800           15  OHIO3-TOT-CHG-DATE            PIC S9(04)V99.   00027900
002810           15  OHIO3-SURG-DATE REDEFINES OHIO3-TOT-CHG-DATE    00028000
002820                                       PIC  9(06).     00028100
002830           15  OHIO3-LINE-ITEM-NON-COV-CHG    PIC S9(04)V99.   00028200
002840           15  OHIO3-LINE-ITEM-ERROR          PIC  X(01).     00028300
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Appendix 40: MRDD – MMIS

Interface : MRDD - MMIS

Layout :

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       000010 01  OHIO1-IND-PRAC-CLINIC-CLM-REC.                          00000100
000020     05  OHIO1-CLAIM-TRANS-RCD-CODE           PIC  X(01).     00000200
000030     05  OHIO1-CLAIM-TRANS-SORT-KEY           PIC  X(24).     00000300
000040     05  OHIO1-CLAIM-CTL-NUM.                                  00000400
000050        10  OHIO1-CLAIM-ENTRY-DATE           PIC  9(05).     00000500
000060        10  OHIO1-DOC-CTL-NUM                PIC  9(07).     00000600
000070        10  OHIO1-DOC-LINE-NUM               PIC  9(02).     00000700
000080        10  OHIO1-CLM-BATCH-NUM              PIC  9(03).     00000800
000090     05  OHIO1-CLM-PROC-TRANS-CD.                              00000900
000100        10  OHIO1-1ST-DIGIT                  PIC  X(01).     00001000
000110        10  OHIO1-2ND-DIGIT                  PIC  X(01).     00001100
000120     05  OHIO1-SVC-CATEGORY                  PIC  9(02).     00001200
000130     05  OHIO1-RECIP-ID-NUM.                                   00001300
000140        10  OHIO1-CASE-NUM                   PIC  9(10).     00001400
000150        10  OHIO1-ADC-NUM                    PIC  9(02).     00001500
000160     05  OHIO1-RECIP-DATE.                                     00001600
000170        10  OHIO1-RECIP-LAST-NAME            PIC  X(14).     00001700
000180        10  OHIO1-RECIP-FIRST-NAME           PIC  X(12).     00001800
000190        10  OHIO1-RECIP-SEX-CD               PIC  9(01).     00001900
000200        10  OHIO1-RECIP-RACE-CD              PIC  9(01).     00002000
000210        10  OHIO1-RECIP-AGE                  PIC  9(03).     00002100
000220        10  OHIO1-RECIP-AID-CATG             PIC  X(01).     00002200
000230        10  OHIO1-RECIP-COUNTY               PIC  9(02).     00002300
000240        10  OHIO1-RECIP-A-CASE-TYPE.                         00002400
000250          15  OHIO1-RECIP-CASE-TYPE          PIC  9(01).     00002500
000260        10  OHIO1-RECIP-PYMT-IND             PIC  9(01).     00002600
000270     05  OHIO1-PROVIDER-NUM                  PIC  9(07).     00002700
000280     05  OHIO1-PA-CTL-NUM                    PIC  9(06).     00002800
000290     05  OHIO1-DIAGNOSIS-CODES.                                00002900
000300        10  OHIO1-DIAGNOSIS-CODE  OCCURS 2     PIC  X(05).     00003000
000310     05  OHIO1-3RD-PARTY-CODES.                                00003100
000320        10  OHIO1-3RD-PARTY-CODE  OCCURS 5     PIC  X(01).     00003200
000330     05  OHIO1-ATT-REF-PRES-PHYS             PIC  9(07).     00003300
000340     05  OHIO1-TOT-CLM-CHG                   PIC S9(05)V99.   00003400
000350     05  OHIO1-3RD-PARTY-AMT                 PIC S9(05)V99.   00003500
000360     05  OHIO1-NET-CLAIM-CHG                 PIC S9(05)V99.   00003600
000370     05  OHIO1-BILLING-DATE                  PIC  9(06).     00003700
000380     05  OHIO1-REIMB-AMT                     PIC S9(05)V99.   00003800
000390     05  OHIO1-ADJUD-DATE                    PIC  9(06).     00003900
000400     05  OHIO1-ADJ-STATUS                    PIC  X(01).     00004000
000410     05  OHIO1-FUND-TYPE                     PIC  X(01).     00004100
000420     05  OHIO1-CC-CASE-TYPE                  PIC  X(01).     00004200
000430     05  OHIO1-CLAIM-ERROR-CODES.                              00004300
000440        10  OHIO1-CLAIM-ERROR-CODE   OCCURS 10  PIC  9(03).     00004400
000450     05  FILLER REDEFINES OHIO1-CLAIM-ERROR-CODES.             00004500
000460        10  FILLER                           PIC  X(24).     00004600
000470        10  OHIO1-WAR-NO            COMP-3   PIC  9(07).     00004700
000480        10 FILLER                           PIC  X(02).     00004800
000490     05  OHIO1-FORCE-DATA-GROUPS.                              00004900
000500        10  OHIO1-FORCE-DATA              OCCURS 3.           00005000
000510          15  OHIO1-FORCE-CODE               PIC  X(03).     00005100
000520          15  OHIO1-FORCE-APP                PIC  X(02).     00005200
       05  OHIO1-OLD-TCN REDEFINES OHIO1-FORCE-DATA-GROUPS.
          10  OHIO1-TAPE-BATCH-NUMBER            PIC 9(3).
          10  OHIO1-TAPE-DOC-NUMBER              PIC 9(7).
          10  FILLER                          PIC X(5).
000530     05  OHIO1-SPECIAL-PROC-FLAGS.                             00005300
000540        10 OHIO1-SPEC-PROC          OCCURS 4   PIC  X(01).     00005400
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000550    05  OHIO1-COPAY              COMP-3     PIC  9(03)V99.   00005500
000560    05  OHIO1-RUN-NUMS.                                      00005600
000570       10 OHIO1-CURR-RUN-NUM.                                 00005700
000580          15 FILLER                    PIC  X(01).      00005800
000590          15 OHIO1-CURR-RUN-NUM-3A.                       00005900
000600             20 OHIO1-CURR-RUN-NUM-3N       PIC  9(03).      00006000
000610          15 FILLER                    PIC  X(01).      00006100
000620       10 OHIO1-PREV-RUN-NUM              PIC  X(05).      00006200
000630    05  OHIO1-DE-NO                    PIC  X(02).      00006300
000640    05  OHIO1-BIRTH-DATE                  PIC  9(06).      00006400
000650    05  OHIO1-ER-IND                   PIC  X(01).      00006500
000660    05  OHIO1-OCC-CODE                    PIC  X(01).      00006600
000670    05  OHIO1-PAT-LAST-NAME               PIC  X(14).      00006700
000680    05  OHIO1-PAT-FRST-NAME               PIC  X(12).      00006800
000703    05  OHIO1-NUM-LINE-ITEMS         COMP      PIC S9(02).      00007000
000710    05  OHIO1-FP-IND                   PIC  X(01).      00007100
000720    05  OHIO1-MED-RCD-NUM                 PIC  X(09).      00007200
000730    05  OHIO1-PRAC-LINE-ITEMS.                               00007300
000740       10  OHIO1-PRAC-LINE-ITEM    OCCURS 0 TO 19 TIMES       00007400
000750           DEPENDING ON OHIO1-NUM-LINE-ITEMS.              00007500
000760          15  OHIO1-LINE-ITEM-NUM           PIC  9(02).      00007600
000770          15  OHIO1-PROC-PCS-CODE           PIC  X(01).      00007700
000780          15  OHIO1-PROC-CODE              PIC  X(05).      00007800
000790          15  OHIO1-1ST-PROC-SVC-DATE        PIC  9(06).      00007900
000800          15  OHIO1-LAST-PROC-SVC-DATE       PIC  9(06).      00008000
000810          15  OHIO1-PLC-SVC                PIC  X(01).      00008100
000820          15  OHIO1-TYPE-SVC               PIC  X(01).      00008200
000830          15  OHIO1-TOOTH-NUM              PIC  X(02).      00008300
000840          15  OHIO1-UNITS-SVC              PIC S9(03).      00008400
000850          15  OHIO1-NUM-INJ                PIC S9(01).      00008500
000860          15  OHIO1-GROUP-MEMBER-NUM-A.                    00008600
000870             20  OHIO1-GROUP-MEMBER-NUM     PIC  9(07).      00008610
000880          15  OHIO1-SUBMIT-PROC-CHG          PIC S9(04)V99.   00008700
000890          15  OHIO1-ALLOW-PROC-CHG           PIC S9(04)V99.   00008800
000900          15  OHIO1-PROC-PAY-AMT           PIC S9(04)V99.   00008900
000910          15  OHIO1-PROC-CHARS REDEFINES OHIO1-PROC-PAY-AMT.   00009000
000920             20  OHIO1-PROC-CHAR   OCCURS 6  PIC  X(01).      00009100
000930          15  OHIO1-LINE-ITEM-ERROR          PIC  X(01).      00009200
000940          15  OHIO1-TOOTH-SURF-NUM          PIC  X(01).      00009300
000950 01  OHIO2-SUP-CLAIM-REC.                                     00009400
000960    05  OHIO2-CLAIM-TRANS-RCD-CODE            PIC  X(01).      00009500
000970    05  OHIO2-CLAIM-TRANS-SORT-KEY            PIC  X(24).      00009600
000980    05  OHIO2-CLAIM-CTL-NUM.                                 00009700
000990       10  OHIO2-CLAIM-ENTRY-DATE            PIC  9(05).      00009800
001000       10  OHIO2-DOC-CTL-NUM               PIC  9(07).      00009900
001010       10  OHIO2-DOC-LINE-NUM              PIC  9(02).      00010000
001020       10  OHIO2-CLM-BATCH-NUM              PIC  9(03).      00010100
001030    05  OHIO2-CLM-PROC-TRANS-CD.                             00010200
001040       10  OHIO2-1ST-DIGIT                 PIC  X(01).      00010300
001050       10  OHIO2-2ND-DIGIT                 PIC  X(01).      00010400
001060    05  OHIO2-SVC-CATEGORY                   PIC  9(02).      00010500
001070    05  OHIO2-RECIP-ID-NUM.                                  00010600
001080       10  OHIO2-CASE-NUM                 PIC  9(10).      00010700
001090       10  OHIO2-ADC-NUM                  PIC  9(02).      00010800
001100    05  OHIO2-RECIP-DATE.                                    00010900
001110       10  OHIO2-RECIP-LAST-NAME            PIC  X(14).      00011000
001120       10  OHIO2-RECIP-FIRST-NAME           PIC  X(12).      00011100
001130       10  OHIO2-RECIP-SEX-CD               PIC  9(01).      00011200
001140       10  OHIO2-RECIP-RACE-CD              PIC  9(01).      00011300
001150       10  OHIO2-RECIP-AGE                 PIC  9(03).      00011400
001160       10  OHIO2-RECIP-AID-CATG             PIC  X(01).      00011500
001170       10  OHIO2-RECIP-COUNTY               PIC  9(02).      00011600
001180       10  OHIO2-RECIP-A-CASE-TYPE.                         00011700
001190          15  OHIO2-RECIP-CASE-TYPE          PIC  9(01).      00011800
001200       10  OHIO2-RECIP-PYMT-IND             PIC  9(01).      00011900
001210    05  OHIO2-PROVIDER-NUM                  PIC  9(07).      00012000
001220    05  OHIO2-PA-CTL-NUM                   PIC  9(06).      00012100
001230    05  OHIO2-DIAGNOSIS-CODES.                               00012200
001240       10  OHIO2-DIAGNOSIS-CODE  OCCURS 2      PIC  X(05).      00012300
001250    05  OHIO2-3RD-PARTY-CODES.                               00012400
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001260       10  OHIO2-3RD-PARTY-CODE  OCCURS 5      PIC  X(01).      00012500
001270     05  OHIO2-ATT-REF-PRES-PHYS              PIC  9(07).      00012600
001280     05  OHIO2-TOT-CLM-CHG                  PIC S9(05)V99.   00012700
001290     05  OHIO2-3RD-PARTY-AMT                 PIC S9(05)V99.   00012800
001300     05  OHIO2-NET-CLAIM-CHG                 PIC S9(05)V99.   00012900
001310     05  OHIO2-BILLING-DATE                  PIC  9(06).      00013000
001320     05  OHIO2-REIMB-AMT                    PIC S9(05)V99.   00013100
001330     05  OHIO2-ADJUD-DATE                    PIC  9(06).      00013200
001340     05  OHIO2-ADJ-STATUS                    PIC  X(01).      00013300
001350     05  OHIO2-FUND-TYPE                     PIC  X(01).      00013400
001360     05  OHIO2-CC-CASE-TYPE                  PIC  X(01).      00013500
001370     05  OHIO2-CLAIM-ERROR-CODES.                             00013600
001380       10  OHIO2-CLAIM-ERROR-CODE   OCCURS 10  PIC  9(03).      00013700
001390     05  FILLER REDEFINES OHIO2-CLAIM-ERROR-CODES.            00013800
001400       10  FILLER                          PIC  X(24).      00013900
001410       10  OHIO2-WAR-NO              COMP-3     PIC  9(07).      00014000
001420       10 FILLER                           PIC  X(02).      00014100
001430     05  OHIO2-FORCE-DATA-GROUPS.                             00014200
001440       10  OHIO2-FORCE-DATA              OCCURS 3.          00014300
001450         15  OHIO2-FORCE-CODE              PIC  X(03).      00014400
001460         15  OHIO2-FORCE-APP               PIC  X(02).      00014500
          05  OHIO2-OLD-TCN REDEFINES OHIO2-FORCE-DATA-GROUPS.
            10  OHIO2-TAPE-BATCH-NUMBER           PIC 9(3).
            10  OHIO2-TAPE-DOC-NUMBER             PIC 9(7).
            10  FILLER                        PIC X(5).
001470     05  OHIO2-SPECIAL-PROC-FLAGS.                            00014600
001480       10 OHIO2-SPEC-PROC          OCCURS 4   PIC  X(01).      00014700
001490     05  OHIO2-COPAY                COMP-3     PIC  9(03)V99.   00014800
001500     05  OHIO2-RUN-NUMS.                                      00014900
001510       10 OHIO2-CURR-RUN-NUM.                                 00015000
001520         15 FILLER                         PIC  X(01).      00015100
001530         15 OHIO2-CURR-RUN-NUM-3A.                          00015200
001540           20 OHIO2-CURR-RUN-NUM-3N        PIC  9(03).      00015300
001550         15 FILLER                         PIC  X(01).      00015400
001560       10 OHIO2-PREV-RUN-NUM                 PIC  X(05).      00015500
001570     05  OHIO2-DE-NO                       PIC  X(02).      00015600
001580     05  OHIO2-BIRTH-DATE                    PIC  9(06).      00015700
001590     05  OHIO2-ER-IND                      PIC  X(01).      00015800
001600     05  OHIO2-OCC-CODE                      PIC  X(01).      00015900
001610     05  OHIO2-PAT-LAST-NAME                 PIC  X(14).      00016000
001620     05  OHIO2-PAT-FRST-NAME                 PIC  X(12).      00016100
001640     05  OHIO2-NUM-LINE-ITEMS       COMP       PIC S9(02).      00016300
001650     05  OHIO2-SUP-LINE-ITEM.                                 00016400
001660       10  OHIO2-SUP-LINE-ITEM.                               00016500
001670         15 OHIO2-SUP-PCS-CODE             PIC  X(01).      00016600
001680         15 OHIO2-DRUG-PCS-CODE.                            00016700
001690           20 FILLER                       PIC  X(03).      00016800
001700           20 OHIO2-DRUG-CODE.                              00016900
001710             25 OHIO2-DRUG-PK    COMP-3  PIC  9(12).      00017000
001720         15 OHIO2-DATE-PRESCRIBE           PIC  9(06).      00017100
001730         15 OHIO2-DATE-DISPENSE            PIC  9(06).      00017200
001740         15 OHIO2-PRESCRIP-NUM             PIC  X(06).      00017300
001750         15 OHIO2-REFILL-CODE              PIC  9(01).      00017400
001760         15 OHIO2-SNH-CODE                 PIC  X(01).      00017500
001770         15 OHIO2-DAYS-SUPPLY              PIC  9(02).      00017600
001780         15 OHIO2-SUBMIT-DS-CHG            PIC S9(04)V99.   00017700
001790         15 OHIO2-ALLOW-DS-CHG             PIC S9(04)V99.   00017800
001800         15 OHIO2-PROF-FEE                PIC S9(01)V99.   00017900
001810         15 OHIO2-DS-QTY                  PIC S9(03).      00018000
001820         15 OHIO2-DRUG-CLASS               PIC  9(02).      00018100
001830         15 OHIO2-LINE-ITEM-ERROR          PIC  X(01).      00018200
001840 01  OHIO3-INST-CLAIM-REC.                                    00018300
001850   03  OHIO3-FIXED.                                         00018400
001850     05  OHIO3-CLAIM-TRANS-RCD-CODE          PIC  X(01).      00018400
001860     05  OHIO3-CLAIM-TRANS-SORT-KEY          PIC  X(24).      00018500
001870     05  OHIO3-CLAIM-CTL-NUM.                                 00018600
001880       10  OHIO3-CLAIM-ENTRY-DATE          PIC  9(05).      00018700
001890       10  OHIO3-DOC-CTL-NUM               PIC  9(07).      00018800
001900       10  OHIO3-DOC-LINE-NUM              PIC  9(02).      00018900
001910       10  OHIO3-CLM-BATCH-NUM             PIC  9(03).      00019000
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001920    05  OHIO3-CLM-PROC-TRANS-CD.                          00019100
001930        10  OHIO3-1ST-DIGIT              PIC  X(01).      00019200
001940        10  OHIO3-2ND-DIGIT              PIC  X(01).      00019300
001950    05  OHIO3-SVC-CATEGORY               PIC  9(02).      00019400
001960    05  OHIO3-RECIP-ID-NUM.                               00019500
001970        10  OHIO3-CASE-NUM               PIC  9(10).      00019600
001980        10  OHIO3-ADC-NUM                PIC  9(02).      00019700
001990    05  OHIO3-RECIP-DATA.                                 00019800
002000        10  OHIO3-RECIP-LAST-NAME        PIC  X(14).      00019900
002010        10  OHIO3-RECIP-FIRST-NAME       PIC  X(12).      00020000
002020        10  OHIO3-RECIP-SEX-CD           PIC  9(01).      00020100
002030        10  OHIO3-RECIP-RACE-CD          PIC  9(01).      00020200
002040        10  OHIO3-RECIP-AGE              PIC  9(03).      00020300
002050        10  OHIO3-RECIP-AID-CATG         PIC  X(01).      00020400
002060        10  OHIO3-RECIP-COUNTY           PIC  9(02).      00020500
002070        10  OHIO3-RECIP-A-CASE-TYPE.                      00020600
002080          15  OHIO3-RECIP-CASE-TYPE      PIC  9(01).      00020700
002090        10  OHIO3-RECIP-PYMT-IND         PIC  9(01).      00020800
002100    05  OHIO3-PROVIDER-NUM               PIC  9(07).      00020900
002110    05  OHIO3-PA-CTL-NUM                 PIC  9(06).      00021000
002120    05  OHIO3-DIAGNOSIS-CODES.                            00021100
002130        10  OHIO3-DIAGNOSIS-CODE  OCCURS 2   PIC  X(05).  00021200
002140    05  OHIO3-3RD-PARTY-CODES.                            00021300
002150        10  OHIO3-3RD-PARTY-CODE  OCCURS 5   PIC  X(01).  00021400
002160    05  OHIO3-ATT-REF-PRES-PHYS          PIC  9(07).      00021500
002170    05  OHIO3-TOT-CLM-CHG                PIC S9(05)V99.   00021600
002180    05  OHIO3-3RD-PARTY-AMT              PIC S9(05)V99.   00021700
002190    05  OHIO3-NET-CLAIM-CHG              PIC S9(05)V99.   00021800
002200    05  OHIO3-BILLING-DATE               PIC  9(06).      00021900
002210    05  OHIO3-REIMB-AMT                  PIC S9(05)V99.   00022000
002220    05  OHIO3-ADJUD-DATE                 PIC  9(06).      00022100
002230    05  OHIO3-ADJ-STATUS                 PIC  X(01).      00022200
002240    05  OHIO3-FUND-TYPE                  PIC  X(01).      00022300
002250    05  OHIO3-CC-CASE-TYPE               PIC  X(01).      00022400
002260    05  OHIO3-CLAIM-ERROR-CODES.                          00022500
002270        10  OHIO3-CLAIM-ERROR-CODE   OCCURS 10  PIC  9(03).  00022600
002280    05  FILLER REDEFINES OHIO3-CLAIM-ERROR-CODES.         00022700
002290        10  FILLER                       PIC  X(24).      00022800
002300        10  OHIO3-WAR-NO           COMP-3    PIC  9(07).  00022900
002310        10 FILLER                        PIC  X(02).      00023000
002320    05  OHIO3-FORCE-DATA-GROUPS.                          00023100
002330        10  OHIO3-FORCE-DATA             OCCURS 3.        00023200
002340          15  OHIO3-FORCE-CODE           PIC  X(03).      00023300
002350          15  OHIO3-FORCE-APP            PIC  X(02).      00023400
          05  OHIO3-OLD-TCN REDEFINES OHIO3-FORCE-DATA-GROUPS.
            10  OHIO3-TAPE-BATCH-NUMBER        PIC 9(3).
            10  OHIO3-TAPE-DOC-NUMBER          PIC 9(7).
            10  FILLER                     PIC X(5).
002360    05  OHIO3-SPECIAL-PROC-FLAGS.                         00023500
002370        10 OHIO3-SPEC-PROC          OCCURS 4   PIC  X(01).  00023600
002380    05  OHIO3-PRE-ADMISSION              PIC  X(01).      00023700
002390    05  FILLER                           PIC  9(02).      00023800
002400    05  OHIO3-RUN-NUMS.                                   00023900
002410        10 OHIO3-CURR-RUN-NUM.                            00024000
002420          15 FILLER                      PIC  X(01).      00024100
002430          15 OHIO3-CURR-RUN-NUM-3A.                     00024200
002440            20 OHIO3-CURR-RUN-NUM-3N     PIC  9(03).      00024300
002450          15 FILLER                      PIC  X(01).      00024400
002460        10 OHIO3-PREV-RUN-NUM            PIC  X(05).      00024500
002470    05  OHIO3-DE-NO                      PIC  X(02).      00024600
002480    05  OHIO3-BIRTH-DATE                 PIC  9(06).      00024700
002490    05  OHIO3-ER-IND                     PIC  X(01).      00024800
002500    05  OHIO3-OCC-CODE                   PIC  X(01).      00024900
002510    05  OHIO3-PAT-LAST-NAME              PIC  X(14).      00025000
002520    05  OHIO3-PAT-FRST-NAME              PIC  X(12).      00025100
002540    05  OHIO3-NUM-LINE-ITEMS      COMP   PIC S9(02).      00025300
002550    05  OHIO3-BEGIN-SVC-DATE             PIC  9(06).      00025400
002560    05  OHIO3-END-SVC-DATE               PIC  9(06).      00025500
002570    05  OHIO3-ADMIT-DATE                 PIC  9(06).      00025600
002580    05  OHIO3-MED-RCD-NUM                PIC  X(09).      00025700
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002590    05  OHIO3-TYPE-BILL-PAT-STAT              PIC  X(01).      00025800
002600    05  OHIO3-FINAL-BILL-RSN                  PIC  X(01).      00025900
002610    05  OHIO3-PREV-STAY                       PIC  X(01).      00026000
002620    05  OHIO3-DISCH-DEST-CODE                 PIC  X(01).      00026100
002630    05  OHIO3-DISCH-DEST-PROV                 PIC  9(07).      00026200
002640    05  OHIO3-NON-COV-CLM-CHG                 PIC S9(05)V99.   00026300
002650    05  OHIO3-BLOOD-FORM                      PIC  9(02).      00026400
002660    05  OHIO3-BLOOD-REPL                      PIC  9(02).      00026500
002670    05  OHIO3-UNITS-SVC                       PIC S9(02).      00026600
002680    05  OHIO3-LEAVE-DAYS                      PIC S9(02).      00026700
002690    05  OHIO3-ADMIT-HR                        PIC  X(02).      00026800
001850  03  OHIO3-VARIABLE.                                          00018400
002700    05  OHIO3-INST-LINE-ITEMS.                                 00026900
002710       10  OHIO3-INST-LINE-ITEM  OCCURS 0 TO 25 TIMES          00027000
002720             DEPENDING ON OHIO3-NUM-LINE-ITEMS.               00027100
002730          15  OHIO3-INST-UB16-LI-CODE.                        00027200
002740            20  OHIO3-COST-CENTER          PIC  X(02).       00027300
002750            20  OHIO3-INST-LI-CODE         PIC  X(01).       00027400
002760          15  OHIO3-DAYS-BLOOD-VIS          PIC S9(02).       00027500
002770          15  OHIO3-ACC-VIS-CHG             PIC S9(03)V99.    00027600
002780          15  OHIO3-SURG-CODE REDEFINES OHIO3-ACC-VIS-CHG     00027700
002790                                  PIC  X(05).                 00027800
002800          15  OHIO3-TOT-CHG-DATE            PIC S9(04)V99.    00027900
002810          15  OHIO3-SURG-DATE REDEFINES OHIO3-TOT-CHG-DATE    00028000
002820                                  PIC  9(06).                 00028100
002830          15  OHIO3-LINE-ITEM-NON-COV-CHG   PIC S9(04)V99.    00028200
002840          15  OHIO3-LINE-ITEM-ERROR         PIC  X(01).       00028300
002850          15  OHIO3-SLACK-BYTE              PIC  X(01).       00028400
002860 01  OHIO4-AMB-SVC-CLAIM-REC.                                 00028500
002870   03  OHIO4-FIXED.                                           00028600
002870    05  OHIO4-CLAIM-TRANS-RCD-CODE            PIC  X(01).      00028600
002880    05  OHIO4-CLAIM-TRANS-SORT-KEY            PIC  X(24).      00028700
002890    05  OHIO4-CLAIM-CTL-NUM.                                   00028800
002900       10  OHIO4-CLAIM-ENTRY-DATE             PIC  9(05).      00028900
002910       10  OHIO4-DOC-CTL-NUM                  PIC  9(07).      00029000
002920       10  OHIO4-DOC-LINE-NUM                 PIC  9(02).      00029100
002930       10  OHIO4-CLM-BATCH-NUM                PIC  9(03).      00029200
002940    05  OHIO4-CLM-PROC-TRANS-CD.                               00029300
002950       10  OHIO4-1ST-DIGIT                    PIC  X(01).      00029400
002960       10  OHIO4-2ND-DIGIT                    PIC  X(01).      00029500
002970    05  OHIO4-SVC-CATEGORY                    PIC  9(02).      00029600
002980    05  OHIO4-RECIP-ID-NUM.                                    00029700
002990       10  OHIO4-CASE-NUM                     PIC  9(10).      00029800
003000       10  OHIO4-ADC-NUM                      PIC  9(02).      00029900
003010    05  OHIO4-RECIP-DATE.                                      00030000
003020       10  OHIO4-RECIP-LAST-NAME              PIC  X(14).      00030100
003030       10  OHIO4-RECIP-FIRST-NAME             PIC  X(12).      00030200
003040       10  OHIO4-RECIP-SEX-CD                 PIC  9(01).      00030300
003050       10  OHIO4-RECIP-RACE-CD                PIC  9(01).      00030400
003060       10  OHIO4-RECIP-AGE                    PIC  9(03).      00030500
003070       10  OHIO4-RECIP-AID-CATG               PIC  X(01).      00030600
003080       10  OHIO4-RECIP-COUNTY                 PIC  9(02).      00030700
003090       10  OHIO4-RECIP-A-CASE-TYPE.                           00030800
003100         15  OHIO4-RECIP-CASE-TYPE            PIC  9(01).      00030900
003110       10  OHIO4-RECIP-PYMT-IND               PIC  9(01).      00031000
003120    05  OHIO4-PROVIDER-NUM                    PIC  9(07).      00031100
003130    05  OHIO4-PA-CTL-NUM                      PIC  9(06).      00031200
003140    05  OHIO4-DIAGNOSIS-CODES.                                 00031300
003150       10  OHIO4-DIAGNOSIS-CODE  OCCURS 2     PIC  X(05).      00031400
003160    05  OHIO4-3RD-PARTY-CODES.                                 00031500
003170       10  OHIO4-3RD-PARTY-CODE  OCCURS 5     PIC  X(01).      00031600
003180    05  OHIO4-ATT-REF-PRES-PHYS               PIC  9(07).      00031700
003190    05  OHIO4-TOT-CLM-CHG                     PIC S9(05)V99.   00031800
003200    05  OHIO4-3RD-PARTY-AMT                   PIC S9(05)V99.   00031900
003210    05  OHIO4-NET-CLAIM-CHG                   PIC S9(05)V99.   00032000
003220    05  OHIO4-BILLING-DATE                    PIC  9(06).      00032100
003230    05  OHIO4-REIMB-AMT                       PIC S9(05)V99.   00032200
003240    05  OHIO4-ADJUD-DATE                      PIC  9(06).      00032300
003250    05  OHIO4-ADJ-STATUS                      PIC  X(01).      00032400
003260    05  OHIO4-FUND-TYPE                       PIC  X(01).      00032500
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003270    05  OHIO4-CC-CASE-TYPE                  PIC  X(01).     00032600
003280    05  OHIO4-CLAIM-ERROR-CODES.                           00032700
003290       10  OHIO4-CLAIM-ERROR-CODE   OCCURS 10  PIC  9(03).     00032800
003300    05  FILLER REDEFINES OHIO4-CLAIM-ERROR-CODES.          00032900
003310       10  FILLER                      PIC  X(24).     00033000
003320       10  OHIO4-WAR-NO           COMP-3     PIC  9(07).     00033100
003330       10 FILLER                      PIC  X(02).     00033200
003340    05  OHIO4-FORCE-DATA-GROUPS.                           00033300
003350       10  OHIO4-FORCE-DATA            OCCURS 3.          00033400
003360          15  OHIO4-FORCE-CODE            PIC  X(03).     00033500
003370          15  OHIO4-FORCE-APP             PIC  X(02).     00033600
         05  OHIO4-OLD-TCN REDEFINES OHIO4-FORCE-DATA-GROUPS.
            10  OHIO4-TAPE-BATCH-NUMBER          PIC 9(3).
            10  OHIO4-TAPE-DOC-NUMBER            PIC 9(7).
            10  FILLER                      PIC X(5).
003380    05  OHIO4-SPECIAL-PROC-FLAGS.                          00033700
003390       10 OHIO4-SPEC-PROC          OCCURS 4   PIC  X(01).     00033800
003400    05  OHIO4-NUM-CYCLES                 PIC  9(03).     00033900
003410    05  OHIO4-RUN-NUMS.                                    00034000
003420       10 OHIO4-CURR-RUN-NUM.                            00034100
003430          15 FILLER                      PIC  X(01).     00034200
003440          15 OHIO4-CURR-RUN-NUM-3A.                      00034300
003450             20 OHIO4-CURR-RUN-NUM-3N       PIC  9(03).     00034400
003460          15 FILLER                      PIC  X(01).     00034500
003470       10 OHIO4-PREV-RUN-NUM             PIC  X(05).     00034600
003480    05  OHIO4-DE-NO                   PIC  X(02).     00034700
003490    05  OHIO4-BIRTH-DATE                 PIC  9(06).     00034800
003500    05  OHIO4-ER-IND                  PIC  X(01).     00034900
003510    05  OHIO4-OCC-CODE                   PIC  X(01).     00035000
003520    05  OHIO4-PAT-LAST-NAME              PIC  X(14).     00035100
003530    05  OHIO4-PAT-FRST-NAME              PIC  X(12).     00035200
003550    05  OHIO4-NUM-LINE-ITEMS         COMP      PIC S9(02).     00035400
003560    05  OHIO4-PICKUP-DATE                PIC  9(06).     00035500
003570    05  OHIO4-NUM-RIDERS                 PIC  9(02).     00035600
003580    05  OHIO4-MED-RCD-NUM                PIC  X(09).     00035700
002870   03  OHIO4-VARIABLE.                                    00028600
003590    05  OHIO4-AMB-LINE-ITEMS.                              00035800
003600       10  OHIO4-AMB-LINT-ITEM  OCCURS 0 TO 5 TIMES           00035900
003610             DEPENDING ON OHIO4-NUM-LINE-ITEMS.             00036000
003620          15  OHIO4-AMB-LI-CODE            PIC  X(01).     00036100
003630          15  OHIO4-MILES-HOURS            PIC  9(03).     00036200
003640          15  OHIO4-RATE-HR-CHG            PIC S9(04)V99.   00036300
003650          15  OHIO4-AMB-LI-CHG             PIC S9(04)V99.   00036400
003660          15  OHIO4-LINE-ITEM-ERROR        PIC  X(01).     00036500
003670          15  OHIO4-SLACK-BYTE             PIC  X(01).     00036600
003680 01  OHIO5-MCARD-XOVER-CLM-REC.                             00036700
003690    05  OHIO5-CLAIM-TRANS-RCD-CODE           PIC  X(01).     00036800
003700    05  OHIO5-CLAIM-TRANS-SORT-KEY           PIC  X(24).     00036900
003710    05  OHIO5-CLAIM-CTL-NUM.                               00037000
003720       10  OHIO5-CLAIM-ENTRY-DATE          PIC  9(05).     00037100
003730       10  OHIO5-DOC-CTL-NUM               PIC  9(07).     00037200
003740       10  OHIO5-DOC-LINE-NUM              PIC  9(02).     00037300
003750       10  OHIO5-CLM-BATCH-NUM             PIC  9(03).     00037400
003760    05  OHIO5-CLM-PROC-TRANS-CD.                           00037500
003770       10  OHIO5-1ST-DIGIT                 PIC  X(01).     00037600
003780       10  OHIO5-2ND-DIGIT                 PIC  X(01).     00037700
003790    05  OHIO5-SVC-CATEGORY                  PIC  9(02).     00037800
003800    05  OHIO5-RECIP-ID-NUM.                                00037900
003810       10  OHIO5-CASE-NUM                  PIC  9(10).     00038000
003820       10  OHIO5-ADC-NUM                   PIC  9(02).     00038100
003830    05  OHIO5-RECIP-DATE.                                  00038200
003840       10  OHIO5-RECIP-LAST-NAME           PIC  X(14).     00038300
003850       10  OHIO5-RECIP-FIRST-NAME          PIC  X(12).     00038400
003860       10  OHIO5-RECIP-SEX-CD              PIC  9(01).     00038500
003870       10  OHIO5-RECIP-RACE-CD             PIC  9(01).     00038600
003880       10  OHIO5-RECIP-AGE                 PIC  9(03).     00038700
003890       10  OHIO5-RECIP-AID-CATG            PIC  X(01).     00038800
003900       10  OHIO5-RECIP-COUNTY              PIC  9(02).     00038900
003910       10  OHIO5-RECIP-A-CASE-TYPE.                       00039000
003920          15  OHIO5-RECIP-CASE-TYPE        PIC  9(01).     00039100
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003930       10  OHIO5-RECIP-PYMT-IND              PIC  9(01).     00039200
003940    05  OHIO5-PROVIDER-NUM                   PIC  9(07).     00039300
003950    05  OHIO5-PA-CTL-NUM                  PIC  9(06).     00039400
003960    05  OHIO5-DIAGNOSIS-CODES.                            00039500
003970       10  OHIO5-DIAGNOSIS-CODE  OCCURS 2     PIC  X(05).     00039600
003980    05  OHIO5-3RD-PARTY-CODES.                            00039700
003990       10  OHIO5-3RD-PARTY-CODE  OCCURS 5     PIC  X(01).     00039800
004000    05  OHIO5-ATT-REF-PRES-PHYS              PIC  9(07).     00039900
004010    05  OHIO5-TOT-CLM-CHG                 PIC S9(05)V99.   00040000
004020    05  OHIO5-3RD-PARTY-AMT                  PIC S9(05)V99.   00040100
004030    05  OHIO5-NET-CLAIM-CHG                  PIC S9(05)V99.   00040200
004040    05  OHIO5-BILLING-DATE                PIC  9(06).     00040300
004050    05  OHIO5-REIMB-AMT                   PIC S9(05)V99.   00040400
004060    05  OHIO5-ADJUD-DATE                  PIC  9(06).     00040500
004070    05  OHIO5-ADJ-STATUS                  PIC  X(01).     00040600
004080    05  OHIO5-FUND-TYPE                   PIC  X(01).     00040700
004090    05  OHIO5-CC-CASE-TYPE                   PIC  X(01).     00040800
004100    05  OHIO5-CLAIM-ERROR-CODES.                          00040900
004110       10  OHIO5-CLAIM-ERROR-CODE   OCCURS 10  PIC  9(03).     00041000
004120    05  FILLER REDEFINES OHIO5-CLAIM-ERROR-CODES.             00041100
004130       10  FILLER                        PIC  X(24).     00041200
004140       10  OHIO5-WAR-NO            COMP-3     PIC  9(07).     00041300
004150       10 FILLER                         PIC  X(02).     00041400
004160    05  OHIO5-FORCE-DATA-GROUPS.                          00041500
004170       10  OHIO5-FORCE-DATA              OCCURS 3.          00041600
004180          15  OHIO5-FORCE-CODE              PIC  X(03).     00041700
004190          15  OHIO5-FORCE-APP               PIC  X(02).     00041800
        05  OHIO5-OLD-TCN REDEFINES OHIO5-FORCE-DATA-GROUPS.
          10  OHIO5-TAPE-BATCH-NUMBER            PIC 9(3).
          10  OHIO5-TAPE-DOC-NUMBER              PIC 9(7).
          10  FILLER                          PIC X(5).
004200    05  OHIO5-SPECIAL-PROC-FLAGS.                         00041900
004210       10 OHIO5-SPECIAL-PROC       OCCURS 4   PIC  X(01).     00042000
004220    05  OHIO5-NUM-CYCLES                     PIC  9(03).     00042100
004230    05  OHIO5-RUN-NUMS.                                   00042200
004240       10 OHIO5-CURR-RUN-NUM.                           00042300
004250          15 FILLER                         PIC  X(01).     00042400
004260          15 OHIO5-CURR-RUN-NUM-3A.                        00042500
004270             20 OHIO5-CURR-RUN-NUM-3N       PIC  9(03).     00042600
004280          15 FILLER                         PIC  X(01).     00042700
004290       10 OHIO5-PREV-RUN-NUM                  PIC  X(05).     00042800
004300    05  OHIO5-DE-NO                       PIC  X(02).     00042900
004310    05  OHIO5-BIRTH-DATE                     PIC  9(06).     00043000
004320    05  OHIO5-ER-IND                      PIC  X(01).     00043100
004330    05  OHIO5-OCC-CODE                       PIC  X(01).     00043200
004340    05  OHIO5-PAT-LAST-NAME                  PIC  X(14).     00043300
004350    05  OHIO5-PAT-FRST-NAME                  PIC  X(12).     00043400
004370    05  OHIO5-MED-RCD-NUM                    PIC  X(09).     00043600
004380    05  OHIO5-BEGIN-SVC-DATE                 PIC  9(06).     00043700
004390    05  OHIO5-END-SVC-DATE                   PIC  9(06).     00043800
004400    05  OHIO5-COINS-DAYS                  PIC  9(02).     00043900
004410    05  OHIO5-CASH-DEDUCT                    PIC  9(03)V99.   00044000
004420    05  OHIO5-BLOOD-DEDUCT                   PIC  9(03)V99.   00044100
004430    05  OHIO5-COINS-AMT                   PIC  9(04)V99.   00044200
004440    05  OHIO5-OTHER-CHGS                     PIC  9(04)V99.   00044300
004450    05  OHIO5-MCARE-COV-CODE                 PIC  X(01).     00044400
004460 01  OHIO7-DRUG-CLM-DIAG-REC.                          00044500
004470    05  OHIO7-CLAIM-TRANS-RCD-CODE           PIC  X(01).     00044600
004480    05  OHIO7-CLAIM-TRANS-SORT-KEY           PIC  X(24).     00044700
004490    05  OHIO7-CLAIM-CTL-NUM.                              00044800
004500       10  OHIO7-CLAIM-ENTRY-DATE           PIC  9(05).     00044900
004510       10  OHIO7-DOC-CTL-NUM                PIC  9(07).     00045000
004520       10  OHIO7-DOC-LINE-NUM               PIC  9(02).     00045100
004530       10  OHIO7-CLM-BATCH-NUM              PIC  9(03).     00045200
004540    05  FILLER                            PIC  X(02).     00045300
004550    05  OHIO7-SVC-CATEGORY                   PIC  9(02).     00045400
004560    05  OHIO7-RECIP-ID-NUM                PIC  X(12).     00045500
004570    05  OHIO7-PROVIDER-NUM                   PIC  9(07).     00045600
004580    05  OHIO7-DATE-DESPENSE                  PIC  9(06).     00045700
004590    05  OHIO7-DIAGNOSIS-CODE                 PIC  X(05).     00045800
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004600 01  OHIO8-MAX-REC.                                    00045900
004610     05  FILLER                      PIC  X(2143).    00046000
004620 01  OHIO9-INST-CLAIM-REC-UB82.                        00046100
004630   03  OHIO9-FIXED.                                    00046200
004630     05  OHIO9-CLAIM-TRANS-RCD-CODE      PIC  X(01).    00046200
004640     05  OHIO9-CLAIM-TRANS-SORT-KEY      PIC  X(24).    00046300
004650     05  OHIO9-CLAIM-CTL-NUM.                          00046400
004660        10  OHIO9-CLAIM-ENTRY-DATE      PIC  9(05).    00046500
004670        10  OHIO9-DOC-CTL-NUM           PIC  9(07).    00046600
004680        10  OHIO9-DOC-LINE-NUM          PIC  9(02).    00046700
004690        10  OHIO9-CLM-BATCH-NUM         PIC  9(03).    00046800
004700     05  OHIO9-CLM-PROC-TRANS-CD.                      00046900
004710        10  OHIO9-1ST-DIGIT             PIC  X(01).    00047000
004720        10  OHIO9-2ND-DIGIT             PIC  X(01).    00047100
004730     05  OHIO9-SVC-CATEGORY             PIC  9(02).    00047200
004740     05  OHIO9-RECIP-ID-NUM.                           00047300
004750        10  OHIO9-CASE-NUM              PIC  9(10).    00047400
004760        10  OHIO9-ADC-NUM               PIC  9(02).    00047500
004770     05  OHIO9-RECIP-DATE.                             00047600
004780        10  OHIO9-RECIP-LAST-NAME       PIC  X(14).    00047700
004790        10  OHIO9-RECIP-FIRST-NAME      PIC  X(12).    00047800
004800        10  OHIO9-RECIP-SEX-CD          PIC  9(01).    00047900
004810        10  OHIO9-RECIP-RACE-CD         PIC  9(01).    00048000
004820        10  OHIO9-RECIP-AGE             PIC  9(03).    00048100
004830        10  OHIO9-RECIP-AID-CATG        PIC  X(01).    00048200
004840        10  OHIO9-RECIP-COUNTY          PIC  9(02).    00048300
004850        10  OHIO9-RECIP-A-CASE-TYPE.                   00048400
004860          15  OHIO9-RECIP-CASE-TYPE     PIC  9(01).    00048500
004870        10  OHIO9-RECIP-PYMT-IND        PIC  9(01).    00048600
004880     05  OHIO9-PROVIDER-NUM             PIC  9(07).    00048700
004890     05  OHIO9-PA-CTL-NUM               PIC  9(06).    00048800
004900     05  OHIO9-DIAGNOSIS-CODES.                        00048900
004910        10  OHIO9-DIAGNOSIS-CODE  OCCURS 5   PIC  X(05).    00049000
004920     05  FILLER                      PIC  X(01).    00049100
004930     05  OHIO9-ATT-PRACTITIONER          PIC  9(07).    00049200
004940     05  OHIO9-OPERATING-PROVIDER        PIC  9(07).    00049300
004950     05  OHIO9-TOT-CLM-CHG               PIC S9(06)V99.   00049400
004960     05  OHIO9-TOT-NON-COV               PIC S9(06)V99.   00049500
004970     05  OHIO9-ADJUD-DATE                PIC  9(06).    00049600
004980     05  OHIO9-ADJ-STATUS                PIC  X(01).    00049700
004990     05  OHIO9-FUND-TYPE                 PIC  X(01).    00049800
005000     05  OHIO9-CC-CASE-TYPE              PIC  X(01).    00049900
005010     05  OHIO9-CLAIM-ERROR-CODES.                      00050000
005020        10  OHIO9-CLAIM-ERROR-CODE   OCCURS 10  PIC  9(03).    00050100
005030     05  OHIO9-FORCE-DATA-GROUPS.                      00050200
005040        10  OHIO9-FORCE-DATA        OCCURS 3.         00050300
005050          15  OHIO9-FORCE-CODE          PIC  X(03).    00050400
005060          15  OHIO9-FORCE-APP           PIC  X(02).    00050500
         05  OHIO9-OLD-TCN REDEFINES OHIO9-FORCE-DATA-GROUPS.
            10  OHIO9-TAPE-BATCH-NUMBER          PIC 9(3).
            10  OHIO9-TAPE-DOC-NUMBER            PIC 9(7).
            10  FILLER                      PIC X(5).
005070     05  OHIO9-SPECIAL-PROC-FLAGS.                     00050600
005080        10  OHIO9-SPEC-PROC         OCCURS 4   PIC  X(01).    00050700
005090     05  FILLER                      PIC  X(03).    00050800
005100     05  OHIO9-RUN-NUMS.                               00050900
005110        10  OHIO9-CURR-RUN-NUM.                        00051000
005120          15 FILLER                   PIC  X(01).    00051100
005130          15 OHIO9-CURR-RUN-NUM-3A.                   00051200
005140            20 OHIO9-CURR-RUN-NUM-3N       PIC  9(03).    00051300
005150          15 FILLER                   PIC  X(01).    00051400
005160        10  OHIO9-PREV-RUN-NUM          PIC  X(05).    00051500
005170     05  OHIO9-DE-NO                     PIC  X(02).    00051600
005180     05  OHIO9-BIRTH-DATE                PIC  9(06).    00051700
005190     05  OHIO9-ER-IND                    PIC  X(01).    00051800
005200     05  OHIO9-OCC-CODE                  PIC  X(01).    00051900
005210     05  OHIO9-PAT-LAST-NAME             PIC  X(14).    00052000
005220     05  OHIO9-PAT-FRST-NAME             PIC  X(12).    00052100
005240     05  OHIO9-NUM-LINE-ITEMS     COMP       PIC S9(02).    00052300
005250     05  OHIO9-FP-IND                    PIC  X(01).    00052400
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005260    05  OHIO9-MED-RCD-NUM                  PIC  X(17).     00052500
005270    05  OHIO9-MEDICARE-NUM                 PIC  X(08).     00052600
005280    05  OHIO9-WAR-NO                     PIC  9(07).     00052700
005290    05  OHIO9-HOSPITAL-WARD                PIC  X(01).     00052800
005300    05  OHIO9-BILLING-DATE               PIC  9(06).     00052900
005310    05  OHIO9-REIMB-AMT                  PIC S9(06)V99.  00053000
005320    05  OHIO9-ALLOWED-CLM-AMT              PIC S9(06)V99.  00053100
005330    05  OHIO9-BEGIN-SVC-DATE             PIC  9(06).     00053200
005340    05  OHIO9-END-SVC-DATE               PIC  9(06).     00053300
005350    05  OHIO9-ADMIT-DATE                 PIC  9(06).     00053400
005360    05  OHIO9-ADMIT-HR                   PIC  9(02).     00053500
005370    05  OHIO9-DISCHARGE-HOUR               PIC  9(02).     00053600
005380    05  OHIO9-ADMISSION-TYPE               PIC  X(01).     00053700
005390       88  OHIO9-EMER                  VALUE '1'.          00053800
005400       88  OHIO9-URGENT                VALUE '2'.          00053900
005410       88  OHIO9-ELECTIVE              VALUE '3'.          00054000
005420       88  OHIO9-NEWBORN               VALUE '4'.          00054100
005430       88  OHIO9-PENDIND-WELF          VALUE '5'.          00054200
005440       88  OHIO9-DENY-AFT-ADM          VALUE '6'.          00054300
005450       88  OHIO9-CERT-TRANSFER         VALUE '7'.          00054400
005460       88  OHIO9-REHAB-ADM             VALUE '8'.          00054500
005470       88  OHIO9-NOINFO                VALUE '9'.          00054600
005480       88  OHIO9-XXXXXX                VALUE 'T'.          00054700
005490       88  OHIO9-VALID-ADM-TYPE        VALUE '1'           00054800
                                THRU '9' 'T'.
005500    05  OHIO9-ADMISSION-SOURCE             PIC  9(01).     00054900
005510    05  FILLER                           PIC  X(03).     00055000
005520    05  OHIO9-PATIENT-STATUS               PIC  9(02).     00055100
005530       88  OHIO9-HOME                  VALUE 01.           00055200
005540       88  OHIO9-HOSP                  VALUE 02.           00055300
005550       88  OHIO9-SNF                   VALUE 03.           00055400
005560       88  OHIO9-ICF                   VALUE 04.           00055500
005570       88  OHIO9-INSTIT                VALUE 05.           00055600
005580       88  OHIO9-HOMECARE              VALUE 06.           00055700
005590       88  OHIO9-LEFT                  VALUE 07.           00055800
005600       88  OHIO9-DIEDCSP               VALUE 20.           00055900
005610       88  OHIO9-STILLPAT              VALUE 30.           00056000
005620       88  OHIO9-DIEDHOME              VALUE 40.           00056100
005630       88  OHIO9-DIEDHOSP              VALUE 41.           00056200
005640       88  OHIO9-DIED                  VALUE 42.           00056300
005650       88  OHIO9-REHAB                 VALUE 98.           00056400
005660       88  OHIO9-TRANS-WITH-DRG        VALUE 99.           00056500
005670       88  OHIO9-VALID-PAT-STATUS VALUES 1 THRU 7 20 30 40    00056600
005680                                  41 42 98 99.       00056700
005690    05  OHIO9-DISCH-TO-PROV                PIC  9(07).     00056800
005700    05  OHIO9-CO-INSURANCE-DAYS              PIC  9(02).     00056900
005710    05  OHIO9-RESERVE-DAYS                 PIC  9(02).     00057000
005720    05  OHIO9-BLOOD-FRUN                 PIC  9(02).     00057100
005730    05  OHIO9-BLOOD-REPL                 PIC  9(02).     00057200
005740    05  OHIO9-BLOOD-NOT-REPL               PIC  9(02).     00057300
005750    05  OHIO9-UNITS-SVC-COV-DAYS    COMP-3     PIC S9(03).     00057400
005760    05  OHIO9-OLD-UNITS-G677 REDEFINES OHIO9-UNITS-SVC-COV-DAYS  00057500
005770                                  PIC S9(02).     00057600
005780    05  OHIO9-NON-COVERED-DAYS      COMP-3     PIC S9(03).     00057700
005790    05  OHIO9-OLD-NC-G677 REDEFINES OHIO9-NON-COVERED-DAYS       00057800
005800                                  PIC S9(02).     00057900
005810    05  OHIO9-BILL-TYPE                  PIC  9(03).     00058000
005820       88  OHIO9-NO-PAY                VALUE 110.          00058100
005830       88  OHIO9-REGINPAT              VALUE 111.          00058200
005840       88  OHIO9-INPATFSTINTM          VALUE 112.          00058300
005850       88  OHIO9-INPATINTM             VALUE 113.          00058400
005860       88  OHIO9-INPATLSTINTM          VALUE 114.          00058500
005870       88  OHIO9-INPATLATE             VALUE 115.          00058600
005880       88  OHIO9-INPATADJ              VALUE 116.          00058700
005890       88  OHIO9-INPATREPL             VALUE 117.          00058800
005900       88  OHIO9-INPATCAN              VALUE 118.          00058900
005910       88  OHIO9-COMPOSITE-REHAB       VALUE 119.          00059000
005920       88  OHIO9-INPATPARTB            VALUE 121.          00059100
005930       88  OHIO9-PARTBFSTINTM          VALUE 122.          00059200
005940       88  OHIO9-PARTBINTM             VALUE 123.          00059300
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005950        88  OHIO9-PARTBLSTINTM            VALUE 124.          00059400
005960        88  OHIO9-PARTBLATE               VALUE 125.          00059500
005970        88  OHIO9-MEDADJ                  VALUE 126.          00059600
005980        88  OHIO9-MEDREPL                 VALUE 127.          00059700
005990        88  OHIO9-MEDCAN                  VALUE 128.          00059800
006000        88  OHIO9-REGOUTPAT               VALUE 131.          00059900
006010        88  OHIO9-OUTPTLATELIER           VALUE 135.          00060000
006020        88  OHIO9-OUTADJ                  VALUE 136.          00060100
006030        88  OHIO9-OUTREPL                 VALUE 137.          00060200
006040        88  OHIO9-OUTCAN                  VALUE 138.          00060300
006050        88  OHIO9-VALID-BILL-TYPE VALUES 110 THRU 119         00060400
006060                                 121 THRU 128              00060500
006070                                 131                       00060600
006080                                 135 THRU 138.             00060700
006090    05  OHIO9-OCCURRENCE-CODES  OCCURS 5.                    00060800
006100******** 10  OHIO9-OCCUR-CODE                PIC  9(02).     93057-23
           10  OHIO9-OCCUR-CODE                PIC  X(02).     93057-23
006110          88  OHIO9-AUTOACCDNT            VALUE '01'.         00061000
006120          88  OHIO9-AUTOACCNF             VALUE '02'.         00061100
006130          88  OHIO9-ACCDNTTORT            VALUE '03'.         00061200
006140          88  OHIO9-ACCDNTER              VALUE '04'.         00061300
006150          88  OHIO9-ACCDNTOTHR            VALUE '05'.         00061400
006160          88  OHIO9-CRIME                 VALUE '06'.         00061500
006170          88  OHIO9-BENEOVER              VALUE '23'.         00061600
006180          88  OHIO9-DTEINSDENY            VALUE '24'.         00061700
006190          88  OHIO9-DTEBENEOVR            VALUE '25'.         00061800
006200          88  OHIO9-DTEDISCHG             VALUE '42'.         00061900
006210          88  OHIO9-DTEWELFEXH            VALUE '50'.         00062000
006220          88  OHIO9-NR90DAYS              VALUE '51'.         00062100
006230          88  OHIO9-WELFNC                VALUE '52'.         00062200
006240          88  OHIO9-NONCOVER              VALUE '53'.         00062300
006250          88  OHIO9-DISPUTED              VALUE '54'.         00062400
006260          88  OHIO9-DENIES                VALUE '55'.         00062500
006270          88  OHIO9-NONCOOP               VALUE '56'.         00062600
006280          88  OHIO9-VALID-OCCUR-CODE VALUES '1' THRU '6'      00062700
006290                                 '23' THRU '25'            00062800
006300                                 '42'                      00062900
006310                                 '50' THRU '56'.           00063000
006320        10  OHIO9-OCCUR-DATE                PIC  9(06).     00063100
006330**** 05  OHIO9-CONDITION-CODES   OCCURS 5       PIC  9(02).     93057-23
         05  OHIO9-CONDITION-CODES   OCCURS 5       PIC  X(02).     93057-23
006340        88  OHIO9-EMPREL                VALUE '02'.         00063300
006350        88  OHIO9-PATCVRD               VALUE '03'.         00063400
006360        88  OHIO9-OVER100               VALUE '17'.         00063500
006370        88  OHIO9-PRREQD                VALUE '39'.         00063600
006380        88  OHIO9-DAYOUTLIER            VALUE '60'.         00063700
006390        88  OHIO9-COSTOUTLIER           VALUE '61'.         00063800
006400        88  OHIO9-FULLDIALYSIS          VALUE '71'.         00063900
006410        88  OHIO9-SELFDIALYSIS          VALUE '72'.         00064000
006420        88  OHIO9-SELFTRAIN             VALUE '73'.         00064100
006430        88  OHIO9-HOMEDIALYSIS          VALUE '74'.         00064200
006440        88  OHIO9-HOME100PERCENT        VALUE '75'.         00064300
006450        88  OHIO9-BACKUPDIALYSIS        VALUE '76'.         00064400
006460        88  OHIO9-PAT-PAY-PR            VALUE '81'.         00064500
006470        88  OHIO9-PART-ELIG             VALUE '97'.         00064600
006480        88  OHIO9-ALLOWDRG468           VALUE '98'.         00064700
006490        88  OHIO9-HAS-CONSENT           VALUE '99'.         00064800
006500*       88  OHIO9-VALID-CONDITN-CODE VALUES 2 3 17 39 60 61     00064900
006500        88  OHIO9-VALID-CONDITN-CODE VALUES                    00064900
006500                                 '2'  '3'  '17'          00064900
006500                                 '39' '60' '61'          00064900
006510                                 '71' THRU '76' '81'     00065000
006520                                 '97' THRU '99'.         00065100
006530    05  OHIO9-SPECIAL-PGM-IND           PIC  9(02).     00065200
006540        88  OHIO9-EPSDT                 VALUE 01.           00065300
006550        88  OHIO9-CRIPCHILD             VALUE 02.           00065400
006560        88  OHIO9-FAMPLAN               VALUE 04.           00065500
006570        88  OHIO9-ABORTION              VALUE 07.           00065600
006580        88  OHIO9-PRETEST               VALUE 80.           00065700
006590        88  OHIO9-POSTTEST              VALUE 81.           00065800
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006600       88  OHIO9-PREPOSTTEST              VALUE 82.           00065900
006610       88  OHIO9-HYSTERECTOMY             VALUE 83.           00066000
006620       88  OHIO9-STERILIZATION            VALUE 84.           00066100
006630       88  OHIO9-VALID-SPEC-PGM-IND VALUES 1 2 4 7            00066200
006640                                  80 THRU 84.           00066300
006650    05  OHIO9-MONETARY-DATA    OCCURS 8.                      00066400
006660******** 10  OHIO9-VALUE-CODE                 PIC  9(02).      93057-23
           10  OHIO9-VALUE-CODE                 PIC  X(02).      93057-23
006670          88  OHIO9-NOSEMIRMS            VALUE '02'.         00066600
006680          88  OHIO9-SPENDOWN             VALUE '23'.         00066700
006690       10  OHIO9-AMOUNT                   PIC  9(06)V99.   00066800
006700    05  FILLER      OCCURS 3.                                 00066900
006710       10  OHIO9-PAYOR                    PIC  9(03).      00067000
006720          88  OHIO9-MEDICAID             VALUE 100.          00067100
006730          88  OHIO9-PRIVATE              VALUE 200.          00067200
006740          88  OHIO9-BLUE                 VALUE 300.          00067300
006750          88  OHIO9-EMPLOYEER            VALUE 400.          00067400
006760          88  OHIO9-PARTB                VALUE 500.          00067500
006770          88  OHIO9-SPENDDOWN            VALUE 800.          00067600
006780          88  OHIO9-OTHERPAY             VALUE 900.          00067700
006790          88  OHIO9-VALID-PAYOR VALUES 100 200 300 400       00067800
006800                                  500 800 900.              00067900
006810       10  OHIO9-PAYOR-PAID                PIC S9(06)V99.   00068000
006820    05  OHIO9-DEDUCTIBLE                   PIC  9(06)V99.   00068100
006830    05  OHIO9-COINSURANCE                  PIC  9(06)V99.   00068200
006840    05  OHIO9-CASE-REL-TO-PATIENT          PIC  9(02).      00068300
006850       88  OHIO9-ORGANDNR                 VALUE 11.           00068400
006860       88  OHIO9-CADAVDNR                 VALUE 12.           00068500
006870    05  OHIO9-PRIOR-INSURED-DATA  OCCURS 2.                   00068600
006880       10  OHIO9-INSURED-NAME             PIC  X(26).      00068700
006890       10  OHIO9-INSURED-REL              PIC  9(02).      00068800
006900       10  OHIO9-INSURED-ID-NUM           PIC  X(12).      00068900
006910    05  OHIO9-SURGERY-PROCEDURES  OCCURS 3.                   00069000
006920       10  OHIO9-PROC-CODE                PIC  X(05).      00069100
006930       10  OHIO9-PROCEDURE-DATE.                           00069200
006940         15  OHIO9-PROC-DATE              PIC  9(06).      00069300
006950    05  OHIO9-PSRO-DATA.                                    00069400
006960       10  OHIO9-PSRO-CODE                PIC  9(01).      00069500
006970       10  OHIO9-PSRO-FROM-DATE           PIC  9(06).      00069600
006980       10  OHIO9-PSRO-TO-DATE             PIC  9(06).      00069700
006990       10  OHIO9-PSRO-GRACE-DAYS          PIC  9(01).      00069800
007000    05  OHIO9-PAYMENT-PERCENT             PIC  9(01)V99.   00069900
007010    05  OHIO9-DRG                    PIC  9(03).      00070000
007020    05  OHIO9-PROVIDER-PEER-GRP           PIC  X(03).      00070100
007030    05  OHIO9-DRG-OUTLIER-DAYS            PIC  9(03).      00070200
007040    05  OHIO9-DRG-OUTLIER-AMT             PIC S9(06)V99.   00070300
007050    05  OHIO9-DRG-AMT                  PIC S9(06)V99.   00070400
007060    05  OHIO9-DRG-PAY-TYPE                PIC  X(02).      00070500
007070       88  OHIO9-DRG-NORMAL               VALUE '01'.         00070600
007080       88  OHIO9-HIGH-OUT-DAYS            VALUE '02'.         00070700
007090       88  OHIO9-LOW-OUT-DAYS             VALUE '03'.         00070800
007100       88  OHIO9-HIGH-OUT-AMT             VALUE '04'.         00070900
007110       88  OHIO9-LOW-OUT-AMT              VALUE '05'.         00071000
007120       88  OHIO9-PER-DIEM                 VALUE '06'.         00071100
007130       88  OHIO9-EXEMPT                   VALUE '99'.         00071200
007140    05  OHIO9-PROC-CHARS      OCCURS 6         PIC  X(01).      00071300
007150    05  OHIO9-MDC-CODE                    PIC  X(02).      00071400
007160    05  OHIO9-OUT-OF-STATE                PIC  9(01).      00071500
007170       88  OHIO9-OHIO                     VALUE 0.            00071600
007180       88  OHIO9-OFS                      VALUE 1.            00071700
007190    05  FILLER                           PIC  X(13).      00071800
004630  03  OHIO9-VARIABLE.                                       00046200
007200    05  OHIO9-INST-LINE-ITEMS.                              00071900
007210       10  OHIO9-ACCOM-LINE OCCURS 0 TO 50 TIMES              00072000
007220             DEPENDING ON OHIO9-NUM-LINE-ITEMS.             00072100
007230         15  OHIO9-ACCOM-RATE             PIC  9(04)V99.   00072200
007240         15  OHIO9-ANCIL-DATE REDEFINES OHIO9-ACCOM-RATE     00072300
007250                                  PIC  9(06).      00072400
007260         15  OHIO9-CPT-CODE REDEFINES OHIO9-ACCOM-RATE.      00072500
007270           20  OHIO9-CPT-FIL              PIC  X(01).      00072600
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007280             20  OHIO9-CPT               PIC  X(05).     00072700
007290          15  OHIO9-RCC-CODE.                            00072800
007300             20  OHIO9-COST-CENTER        PIC  X(02).     00072900
007310             20  OHIO9-INST-LI-CODE       PIC  X(01).     00073000
007320          15  OHIO9-RCC-CODE-NUM REDEFINES OHIO9-RCC-CODE     00073100
007330                                  PIC  9(03).     00073200
007340          15  OHIO9-ACCOM-DAYS            PIC  9(03).     00073300
007350          15  OHIO9-UNITS-SVC REDEFINES OHIO9-ACCOM-DAYS      00073400
007360                                  PIC  9(03).     00073500
007370          15  OHIO9-TOT-CHG              PIC  9(06)V99.  00073600
007380          15  OHIO9-NON-COV-CHG          PIC  9(06)V99.  00073700
007390 01  OHIOB-CLM-PROC-CREDIT-REC.                          00073800
007400     05  OHIOB-CLAIM-TRANS-RCD-CODE          PIC  X(01).     00073900
007410     05  OHIOB-CLAIM-TRANS-SORT-KEY          PIC  X(24).     00074000
007420     05  OHIOB-CLAIM-CTL-NUM.                           00074100
007430        10  OHIOB-CLAIM-ENTRY-DATE          PIC  9(05).     00074200
007440        10  OHIOB-DOC-CTL-NUM               PIC  9(07).     00074300
007450        10  OHIOB-DOC-LINE-NUM              PIC  9(02).     00074400
007460        10  OHIOB-CLM-BATCH-NUM             PIC  9(03).     00074500
007470     05  OHIOB-CLM-PROC-TRANS-CD.                       00074600
007480        10  OHIOB-1ST-DIGIT                 PIC  X(01).     00074700
007490        10  OHIOB-2ND-DIGIT                 PIC  X(01).     00074800
007500     05  OHIOB-SVC-CATEGORY                 PIC  9(02).     00074900
007510     05  OHIOB-RECIP-ID-NUM.                            00075000
007520        10  OHIOB-CASE-NUM                  PIC  9(10).     00075100
007530        10  OHIOB-ADC-NUM                   PIC  9(02).     00075200
007540     05  OHIOB-RECIP-DATE.                              00075300
007550        10  OHIOB-RECIP-LAST-NAME           PIC  X(14).     00075400
007560        10  OHIOB-RECIP-FIRST-NAME          PIC  X(12).     00075500
007570        10  OHIOB-RECIP-SEX-CD              PIC  9(01).     00075600
007580        10  OHIOB-RECIP-RACE-CD             PIC  9(01).     00075700
007590        10  OHIOB-RECIP-AGE                 PIC  9(03).     00075800
007600        10  OHIOB-RECIP-AID-CATG            PIC  X(01).     00075900
007610        10  OHIOB-RECIP-COUNTY              PIC  9(02).     00076000
007620        10  OHIOB-RECIP-A-CASE-TYPE.                   00076100
007630          15  OHIOB-RECIP-CASE-TYPE         PIC  9(01).     00076200
007640        10  OHIOB-RECIP-PYMT-IND            PIC  9(01).     00076300
007650     05  OHIOB-BIRTH-DATE                   PIC  9(06).     00076400
007660     05  FILLER                             PIC  X(62).     00076500
007670     05  OHIOB-NUM-CYCLES                   PIC  9(03).     00076600
007680     05  OHIOB-CLAIM-ERROR-CODES.                       00076700
007690        10  OHIOB-CLAIM-ERROR-CODE OCCURS 10    PIC  9(03).     00076800
007700     05  FILLER       REDEFINES  OHIOB-CLAIM-ERROR-CODES.     00076900
007710        10  FILLER                          PIC  X(24).     00077000
007720        10  OHIOB-WAR-NO          COMP-3    PIC  9(07).     00077100
007730        10  FILLER                          PIC  X(02).     00077200
007740     05  OHIOB-FORCE-DATA-GROUPS.                       00077300
007750        10  OHIOB-FORC-DATA      OCCURS 2.             00077400
007760          15  OHIOB-FORCE-CODE              PIC  X(03).     00077500
007770          15  OHIOB-FORCE-APP               PIC  X(02).     00077600
007780        10 OHIOB-CURR-RUN-NUM.                         00077700
007790          15 FILLER                         PIC  X(01).     00077800
007800          15 OHIOB-CURR-RUN-NUM-3A.                  00077900
007810             20 OHIOB-CURR-RUN-NUM-3N       PIC  9(03).     00078000
007820          15 FILLER                         PIC  X(01).     00078100
         05  OHIOB-OLD-TCN REDEFINES OHIOB-FORCE-DATA-GROUPS.
            10  OHIOB-TAPE-BATCH-NUMBER          PIC 9(3).
            10  OHIOB-TAPE-DOC-NUMBER            PIC 9(7).
            10  FILLER                      PIC X(5).
007830     05  OHIOB-CR-OR-ADJ-CLAIM-NUM          PIC  9(17).     00078200
007840     05  OHIOB-PROVIDER-NUM                 PIC  9(07).     00078300
007850     05  OHIOB-CREDIT-AMT                   PIC S9(05)V99.  00078400
007860     05  OHIOB-CREDIT-APP                   PIC  X(02).     00078500
007870     05  OHIOB-FUND-TYPE                    PIC  X(01).     00078600
007880     05  OHIOB-CC-CASE-TYPE                 PIC  X(01).     00078700
007890     05  OHIOB-1ST-SERVICE-DATE             PIC  9(06).     00078800
007900     05  OHIOB-LAST-SERVICE-DATE            PIC  9(06).     00078900
007910     05  OHIOB-ADJUD-DATE                   PIC  9(06).     00079000
007920     05  OHIOB-ADJ-STATUS                   PIC  X(01).     00079100
007930 01  OHIOC-CLM-PROC-ADJ-REC.                            00079200
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007940    05  OHIOC-CLAIM-TRANS-RCD-CODE            PIC  X(01).     00079300
007950    05  OHIOC-CLAIM-TRANS-SORT-KEY            PIC  X(24).     00079400
007960    05  OHIOC-CLAIM-CTL-NUM.                                  00079500
007970       10  OHIOC-CLAIM-ENTRY-DATE             PIC  9(05).     00079600
007980       10  OHIOC-DOC-CTL-NUM                  PIC  9(07).     00079700
007990       10  OHIOC-DOC-LINE-NUM                 PIC  9(02).     00079800
008000       10  OHIOC-CLM-BATCH-NUM                PIC  9(03).     00079900
008010    05  OHIOC-CLM-PROC-TRANS-CD.                              00080000
008020       10  OHIOC-1ST-DIGIT                    PIC  X(01).     00080100
008030       10  OHIOC-2ND-DIGIT                    PIC  X(01).     00080200
008040    05  OHIOC-SVC-CATEGORY                    PIC  9(02).     00080300
008050    05  OHIOC-RECIP-ID-NUM.                                   00080400
008060       10  OHIOC-CASE-NUM                     PIC  9(10).     00080500
008070       10  OHIOC-ADC-NUM                      PIC  9(02).     00080600
008080    05  OHIOC-RECIP-DATE.                                     00080700
008090       10  OHIOC-RECIP-LAST-NAME              PIC  X(14).     00080800
008100       10  OHIOC-RECIP-FIRST-NAME             PIC  X(12).     00080900
008110       10  OHIOC-RECIP-SEX-CD                 PIC  9(01).     00081000
008120       10  OHIOC-RECIP-RACE-CD                PIC  9(01).     00081100
008130       10  OHIOC-RECIP-AGE                    PIC  9(03).     00081200
008140       10  OHIOC-RECIP-AID-CATG               PIC  X(01).     00081300
008150       10  OHIOC-RECIP-COUNTY                 PIC  9(02).     00081400
008160       10  OHIOC-RECIP-A-CASE-TYPE.                          00081500
008170          15  OHIOC-RECIP-CASE-TYPE           PIC  9(01).     00081600
008180       10  OHIOC-RECIP-PYMT-IND               PIC  9(01).     00081700
008190    05  OHIOC-BIRTH-DATE                      PIC  9(06).     00081800
008200    05  FILLER                          PIC  X(62).           00081900
008210    05  OHIOC-NUM-CYCLES                      PIC  9(03).     00082000
008220    05  OHIOC-CLAIM-ERROR-CODES.                              00082100
008230       10  OHIOC-CLAIM-ERROR-CODE OCCURS 10    PIC  9(03).   00082200
008240    05  FILLER       REDEFINES  OHIOC-CLAIM-ERROR-CODES.      00082300
008250       10  FILLER                          PIC  X(24).       00082400
008260       10  OHIOC-WAR-NO          COMP-3    PIC  9(07).       00082500
008270       10  FILLER                          PIC  X(02).       00082600
008280    05  OHIOC-FORCE-DATA-GROUPS.                              00082700
008290       10  OHIOC-FORC-DATA      OCCURS 2.                    00082800
008300          15  OHIOC-FORCE-CODE              PIC  X(03).       00082900
008310          15  OHIOC-FORCE-APP               PIC  X(02).       00083000
008320       10 OHIOC-CURR-RUN-NUM.                                00083100
008330          15 FILLER                         PIC  X(01).       00083200
008340          15 OHIOC-CURR-RUN-NUM-3A.                          00083300
008350             20 OHIOC-CURR-RUN-NUM-3N       PIC  9(03).       00083400
008360          15 FILLER                         PIC  X(01).       00083500
        05  OHIOC-OLD-TCN REDEFINES OHIOC-FORCE-DATA-GROUPS.
           10  OHIOC-TAPE-BATCH-NUMBER            PIC 9(3).
           10  OHIOC-TAPE-DOC-NUMBER              PIC 9(7).
           10  FILLER                        PIC X(5).
008370    05  OHIOC-CR-OR-ADJ-CLAIM-NUM             PIC  9(17).     00083600
008380    05  OHIOC-PROVIDER-NUM                    PIC  9(07).     00083700
008390    05  OHIOC-CREDIT-AMT                   PIC S9(05)V99.   00083800
008400    05  OHIOC-CREDIT-APP                      PIC  X(02).     00083900
008410    05  OHIOC-FUND-TYPE                       PIC  X(01).     00084000
008420    05  OHIOC-CC-CASE-TYPE                    PIC  X(01).     00084100
008430    05  OHIOC-1ST-SERVICE-DATE                PIC  9(06).     00084200
008440    05  OHIOC-LAST-SERVICE-DATE               PIC  9(06).     00084300
008450    05  OHIOC-ADJUD-DATE                      PIC  9(06).     00084400
008460    05  OHIOC-ADJ-STATUS                      PIC  X(01).     00084500
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Appendix 41: C-PORTS

Table: tbl_ACTION

Columns

Name	Type	Size
V_VId	Text	15
A_VoluntaryWithdraw	Yes/No	1
A_VoluntaryWithdraw_Date	Date/Time	8
A_WithdrawLetter	Yes/No	1
A_WithdrawLetter_Date	Date/Time	8
A_ToAG	Yes/No	1
A_ToAG_Date	Date/Time	8
A_OverPayLetter	Yes/No	1
A_OverPayLetter_Date	Date/Time	8
A_OverPayLetter_Amount	Currency	8
A_OverPayLetter_DateDue	Date/Time	8
A_ToSURS	Yes/No	1
A_ToSURS_Date	Date/Time	8
A_ToSURS_Amount	Currency	8
A_HoldAction	Yes/No	1
A_HoldAction_Date	Date/Time	8
A_HoldandReview	Yes/No	1
A_Indictment	Text	8
A_IndictmentResult	Text	9
A_IndictmentResult_Date	Date/Time	8

Relationships

tbl_VIOLATIONtbl_ACTION
tbl_VIOLATION tbl_ACTION

1 1 V_VId V_VId

Attributes: Unique, Enforced, Cascade Updates, Cascade Deletes, Left Join

RelationshipType: One-To-One

Table: tbl_ALLEGED_VIOLATOR

Columns

Name	Type	Size
AV_AVId	Long Integer	4
AV_FName	Text	15
AV_MI	Text	1
AV_LName	Text	50
AV_Add	Text	50
AV_City	Text	25
AV_ST	Text	2
AV_ZIP	Text	5
AV_Ph1	Text	12
AV_Ph2	Text	12
AV_ProvNum	Text	7
AV_ProvType1	Text	50
AV_ProvType2	Text	35

Relationships

tbl_ALLEGED_VIOLATORtbl_ORF
tbl_ALLEGED_VIOLATOR tbl_ORF

1 AV_AVId AV_AVId

Attributes: Enforced, Cascade Updates, Cascade Deletes

RelationshipType: One-To-Many

Table: tbl_BHCS_STAFF

Columns

Name	Type	Size
BHCS_Staff	Text	50
BHCS_Staff_LName	Text	20
BHCS_StaffNum	Long Integer	4
BHCS_StaffInitials	Text	2

Relationships

tbl_BHCS_STAFFtbl_ORF
tbl_BHCS_STAFF tbl_ORF

1 BHCS_Staff ORF_Assign

Attributes: Enforced, Cascade Updates, Cascade Deletes

RelationshipType: One-To-Many

Table: tbl_CONSUMER

Columns

Name	Type	Size
C_CId	Long Integer	4
C_MMIS	Text	12
C_FName	Text	15
C_MI	Text	1
C_LName	Text	25
C_Add	Text	50
C_City	Text	25
C_ST	Text	2
C_ZIP	Text	5
C_Phone	Text	12
C_DOB	Date/Time	8
C_SSN	Text	11

Relationships

tbl_CONSUMERtbl_ORF
tbl_CONSUMER tbl_ORF

1 C_MMIS C_MMIS

Attributes: Enforced, Cascade Updates, Cascade Deletes

RelationshipType: One-To-Many

Table: tbl_INFORMATION

Columns

Name	Type	Size
I_IId	Long Integer	4
V_VID	Text	15
I_Info	Text	50
I_Info_Time	Text	3
I_Info_Date	Date/Time	8
I_Info_DateDue	Date/Time	8
I_Info_Extend	Yes/No	1
I_Info_Rcvd	Yes/No	1
I_Info_RcvdDate	Date/Time	8

Relationships

tbl_VIOLATIONtbl_INFORMATION
tbl_VIOLATION tbl_INFORMATION

1 V_VId V_VID

Attributes: Enforced, Cascade Updates, Cascade Deletes, Left Join

RelationshipType: One-To-Many

Table: tbl_INTERNAL_REFERRAL

Columns

Name	Type	Size
IR_IRId	Long Integer	4
V_VId	Text	15
IR_ToSection	Text	35
IR_ToSection_Date	Date/Time	8

Relationships

tbl_VIOLATIONtbl_INTERNAL_REFERRAL
tbl_VIOLATION tbl_INTERNAL_REFERRAL

1 V_VId V_VId

Attributes: Enforced, Cascade Updates, Cascade Deletes, Left Join

RelationshipType: One-To-Many

Table: tbl_LOCATION_List

Columns

Name	Type	Size
LOCID	Text	2
Location	Text	10

Relationships

tbl_LOCATION_Listtbl_ORF
tbl_LOCATION_List tbl_ORF

1 LOCID ORF_SubLoc

Attributes: Enforced

RelationshipType: One-To-Many

Table: tbl_NOD

Columns

Name	Type	Size
V_VId	Text	15
NOD_NODNum	Long Integer	4
NOD_NOD	Yes/No	1
NOD_NODId	Text	50
NOD_NODDate	Date/Time	8
NOD_NODTime	Text	2
NOD_NODDue	Date/Time	8
NOD_NODAppeal	Yes/No	1
NOD_L1	Yes/No	1
NOD_L1Date	Date/Time	8
NOD_L1Time	Text	2
NOD_L1Due	Date/Time	8
NOD_L1Appeal	Yes/No	1
NOD_L2	Yes/No	1
NOD_L2Date	Date/Time	8
NOD_L2Time	Text	2
NOD_L2Due	Date/Time	8
NOD_L2Appeal	Yes/No	1
NOD_L3	Yes/No	1
NOD_L3Date	Date/Time	8
NOD_L3Time	Text	2
NOD_L3Due	Date/Time	8
NOD_L3Appeal	Yes/No	1
NOD_L4	Yes/No	1
NOD_L4Date	Date/Time	8
NOD_L4Appeal	Yes/No	1
NOD_Monitor	Yes/No	1
NOD_MonitorComplete	Yes/No	1
NOD_NODClosed	Date/Time	8

Relationships

tbl_VIOLATIONtbl_NOD
tbl_VIOLATION tbl_NOD

1 1 V_VId V_VId

Attributes: Unique, Enforced, Cascade Updates, Cascade Deletes, Left Join

RelationshipType: One-To-One

Table: tbl_ORF

Columns

Name	Type	Size
ORF_ORFNum	Long Integer	4
C_MMIS	Text	50
R_RId	Long Integer	4
AV_AVId	Long Integer	4
ORF_EntryDate	Date/Time	8
ORF_Assign	Text	15
ORF_AssignDate	Date/Time	8
ORF_HSFADisc	Date/Time	8
ORF_HSFADue	Date/Time	8
ORF_HSFAExtend	Yes/No	1
ORF_RepDisc	Date/Time	8
ORF_SubDate	Date/Time	8
ORF_SubFName	Text	15
ORF_SubLName	Text	25
ORF_SubTitle	Text	50
ORF_SubLoc	Text	1
ORF_SubLocOther	Text	50
ORF_IntMedical	Yes/No	1
ORF_IntHHA	Yes/No	1
ORF_IntNewProv	Yes/No	1
ORF_IntLaw	Yes/No	1
ORF_IntBoardHealth	Yes/No	1
ORF_IntBoardNursing	Yes/No	1
ORF_IntAPS	Yes/No	1
ORF_IntCPS	Yes/No	1
ORF_IntMRDD	Yes/No	1
ORF_IntMUI	Yes/No	1
ORF_IntPASSPORT	Yes/No	1
ORF_IntMental	Yes/No	1
ORF_IntOLRS	Yes/No	1
ORF_IntOther	Yes/No	1
ORF_IntOther_specify	Text	50
ORF_ReferralViolation	Text	15
ORF_AVRel	Text	16
ORF_AVRelOther	Text	50
ORF_RRel	Text	16
ORF_RRelOther	Text	50
ORF_RcvdDate	Date/Time	8
ORF_AgencyEmployee	Text	50
ORF_AgencyEmpType	Text	10

Relationships

tbl_REPORTERtbl_ORF
tbl_REPORTER tbl_ORF

1 R_RId R_RId

Attributes: Enforced, Cascade Updates, Cascade Deletes

RelationshipType: One-To-Many

Table: tbl_ORF (Continued)

tbl_CONSUMERtbl_ORF
tbl_CONSUMER tbl_ORF

1 C_MMIS C_MMIS

Attributes: Enforced, Cascade Updates, Cascade Deletes

RelationshipType: One-To-Many

tbl_LOCATION_Listtbl_ORF
tbl_LOCATION_List tbl_ORF

1 LOCID ORF_SubLoc

Attributes: Enforced

RelationshipType: One-To-Many

tbl_ALLEGED_VIOLATORtbl_ORF
tbl_ALLEGED_VIOLATOR tbl_ORF

1 AV_AVId AV_AVId

Attributes: Enforced, Cascade Updates, Cascade Deletes

RelationshipType: One-To-Many

tbl_ORFtbl_VIOLATION
tbl_ORF tbl_VIOLATION

1 ORF_ORFNum ORF_ORFNum

Attributes: Enforced, Cascade Updates, Cascade Deletes, Left Join

RelationshipType: One-To-Many

tbl_BHCS_STAFFtbl_ORF
tbl_BHCS_STAFF tbl_ORF

1 BHCS_Staff ORF_Assign

Attributes: Enforced, Cascade Updates, Cascade Deletes

RelationshipType: One-To-Many

Table: tbl_PREVENTION

Columns

Name	Type	Size
PR_PRId	Long Integer	4
V_VId	Text	15
PR_Prevent	Text	50

Relationships

tbl_VIOLATIONtbl_PREVENTION
tbl_VIOLATION tbl_PREVENTION

1 V_VId V_VId

Attributes: Enforced, Cascade Updates, Cascade Deletes, Left Join

RelationshipType: One-To-Many

Table: tbl_REFERRAL

Columns

Name	Type	Size
RE_REId	Long Integer	4
V_VId	Text	15
RE_Referral	Text	50
RE_Referral_Date	Date/Time	8
RE_Referral_HSFANotify	Yes/No	1
RE_Referral_HSFANotify_Date	Date/Time	8
RE_Referral_MUI	Text	50

Relationships

tbl_VIOLATIONtbl_REFERRAL
tbl_VIOLATION tbl_REFERRAL

1 V_VId V_VId

Attributes: Enforced, Cascade Updates, Cascade Deletes, Left Join

RelationshipType: One-To-Many

Table: tbl_REPORTER

Columns

Name	Type	Size
R_RId	Long Integer	4
R_FName	Text	15
R_MI	Text	1
R_LName	Text	50
R_Add	Text	50
R_City	Text	25
R_ST	Text	2
R_ZIP	Text	5
R_Ph1	Text	12
R_Ph2	Text	12

Relationships

tbl_REPORTERtbl_ORF
tbl_REPORTER tbl_ORF

1 R_RId R_RId

Attributes: Enforced, Cascade Updates, Cascade Deletes

RelationshipType: One-To-Many

Table: tbl_VIOLATION

Columns

Name	Type	Size
V_VId	Text	15
ORF_ORFNum	Long Integer	4
V_VNum	Long Integer	4
V_Type	Text	60
V_FromDate	Date/Time	8
V_ToDate	Date/Time	8
V_HSFASubstantiate	Text	2
V_Lead	Text	2
V_FromMMIS	Yes/No	1
V_ToClaimsDetail	Yes/No	1
V_ToClaimsDetail_Date	Date/Time	8
V_FromClaimsDetail_DateDue	Date/Time	8
V_FromClaimsDetail	Yes/No	1
V_FromClaimsDetail_Date	Date/Time	8
V_Substantiation	Text	3
V_Substantiation_Date	Date/Time	8
V_Substantiation_Close	Date/Time	8
V_Suspicious	Yes/No	1
V_FinalResolution	Date/Time	8
V_Memo	Memo	-
V_HSFAVisit	Yes/No	1
V_HSFAVisit_Date	Date/Time	8
V_ConsumerVisit	Yes/No	1
V_ConsumerVisit_Date	Date/Time	8
V_PrimaryProviderVisit	Yes/No	1
V_PrimaryProviderVisit_Date	Date/Time	8
V_PrimaryProviderNumber	Text	50

Relationships

tbl_VIOLATIONtbl_PREVENTION
tbl_VIOLATION tbl_PREVENTION

1 V_VId V_VId

Attributes: Enforced, Cascade Updates, Cascade Deletes, Left Join

RelationshipType: One-To-Many

tbl_VIOLATION_Listtbl_VIOLATION
tbl_VIOLATION_List tbl_VIOLATION

1 Code V_Type

Attributes: Enforced

RelationshipType: One-To-Many

Table: tbl_VIOLATION (continued)

tbl_VIOLATIONtbl_REFERRAL
tbl_VIOLATION tbl_REFERRAL

1 V_VId V_VId

Attributes: Enforced, Cascade Updates, Cascade Deletes, Left Join

RelationshipType: One-To-Many

tbl_VIOLATIONtbl_INFORMATION
tbl_VIOLATION tbl_INFORMATION

1 V_VId V_VID

Attributes: Enforced, Cascade Updates, Cascade Deletes, Left Join

RelationshipType: One-To-Many

tbl_ORFtbl_VIOLATION
tbl_ORF tbl_VIOLATION

1 ORF_ORFNum ORF_ORFNum

Attributes: Enforced, Cascade Updates, Cascade Deletes, Left Join

RelationshipType: One-To-Many

tbl_VIOLATIONtbl_NOD
tbl_VIOLATION tbl_NOD

1 1 V_VId V_VId

Attributes: Unique, Enforced, Cascade Updates, Cascade Deletes, Left Join

RelationshipType: One-To-One

tbl_VIOLATIONtbl_ACTION
tbl_VIOLATION tbl_ACTION

1 1 V_VId V_VId

Attributes: Unique, Enforced, Cascade Updates, Cascade Deletes, Left Join

RelationshipType: One-To-One

tbl_VIOLATIONtbl_INTERNAL_REFERRAL
tbl_VIOLATION tbl_INTERNAL_REFERRAL

1 V_VId V_VId

Attributes: Enforced, Cascade Updates, Cascade Deletes, Left Join

RelationshipType: One-To-Many

Table: tbl_VIOLATION_List

Columns

Name	Type	Size
Code	Text	5
Violation	Text	75
ID	Long Integer	4

Relationships

tbl_VIOLATION_Listtbl_VIOLATION
tbl_VIOLATION_List tbl_VIOLATION

1 Code V_Type

Attributes: Enforced

Supplement 9

Business Requirements Matrix Amendment

Instructions for Completing the Function Self-Scoring Worksheets

1. The Contractor must self-score each MITS Business Requirement in the "Response Code" column using Only the values that appear in the drop-down list.

2. The "Response Code" values are:

F - Requirement will be fully met in the delivered transfer system software (without configuration, code extensions, or modification)

P - Requirement will be partially met with the delivered transfer system (without configuration, code extensions, or modification). ****When "P" is used in responding to a requirement, the offeror must provide a description explaining the extent to which the requirement is met and not met. A row may be added below the requirement in the Supplement 9 spreadsheet that contains the description or the offeror may use the Proposal Reference column to point back to that description in the Proposal.****

C - Requirement will be via configurable parameters (e.g., tables, rules)

E - Requirement will be met via code extensions (without changing base application code)

M - Requirement will be met via significant modification of the software solution (e.g., via new functional modules). ****When "M" is used in responding to a requirement, the offeror must provide a description explaining the modification needed to meet the requirement. A row may be added below the requirement in the Supplement 9 spreadsheet that contains the description or the offeror may use the Proposal Reference column to point back to that description in the Proposal. ****

N - Requirement will not be met

****NA – Not Applicable - functions would still be preformed in the other system(s).****

~~3. All requirements must contain one of the scoring values identified in Item #2 above. Any requirement without a scoring value will be considered to be "Not Met" ("N").~~

~~4. Comments **must** be included in the required narrative section of the Contractor's RFP response and the applicable narrative reference page number **must** be inserted in the Page Reference ("Page Ref") column for all requirements that are coded "P" (Requirement will be partially met in the delivered transfer system without configuration, code extensions, or modification). These narrative comments must explain how the requirement will be partially met and which areas will not be met.~~

~~5. Comments **must** be included in the required narrative section of the Contractor's RFP response and the applicable narrative reference page number **must** be inserted in the Page Reference ("Page Ref") column for all requirements that are coded "N" (Requirement will not be met) These narrative comments must explain why the requirement will not or cannot be met.~~

MITS Business Requirement "Functional Fit" Survey				
Business Infrastructure				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
1.1	**Medicaid Portal**			
1.1.1	General Requirements			
1.1.1.1	Provide the information and content currently available on the ODJFS website.			
1.1.1.2	Ensure Medicaid Portal design, development, implementation and operations are in accordance with State and Federal regulations and guidelines related to security, confidentiality, and auditing.			
1.1.1.3	Provide a single gateway to general and specific information and defined links for internal and external entities such as Medicaid consumers and providers and sub-recipient State agencies.			
1.1.1.4	Include secure and non-secure tabs.			
1.1.1.5	Provide public information without requiring authentication.			
1.1.1.6	Provide links to secure and non-secure ODJFS applications such as: • ODJFS website • Provider Locator • Net Effect • Evaluate • Advanced Case Tracking System (ACTS) • Cognos • Quality Information.			
1.1.1.7	Provide online, real time access to MITS provider, claims, prior authorization, and reference file information.			
1.1.1.8	Include static and easily updated web pages.			
1.1.1.9	Provide the ability to handle lockouts, timeouts.			
1.1.1.10	Support multiple communication lines and provide fail-over capability.			
1.1.1.11	Provide growth capacity for high volumes of activity.			
1.1.1.12	Develop and create specific search and drill-down capability for pages and applications.			
1.1.1.13	Ability to interface, receive, send, and download specified content and reporting information directly to entities such as provider associations, Ohio Council for Home Care, county agencies and sub-recipient State agencies.			
1.1.1.14	Provide users with the flexibility to select the frequency, format, source, and destination of secure transmissions.			
1.1.1.15	Provide flexible web based reporting that meets external reporting needs and requirements defined by ODJFS.			
1.1.1.16	Allow ODJFS staff to generate customized messages.			
1.1.1.17	Provide the capability to display confirmation messages for requestor transactions.			
1.1.1.18	Provide help screens and tutorials for Medicaid Portal application.			
1.1.1.19	Include a desktop windows environment with browser capability for easy navigation.			
1.1.1.20	Provide a Graphical User Interface (GUI) that allows all users to move easily throughout the system.			
1.1.1.21	Support a graphical menu and control system with highly flexible, mouse-driven tab-like navigation.			
1.1.1.22	Provide GUI features and capabilities including:			

MITS Business Requirement "Functional Fit" Survey				
Business Infrastructure				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
	• Transfer of information from one screen to all related screens to reduce re-entry • Drag and drop, “point and click”, and “copy, cut, and paste” functionality • Pull down menus and window tabs • Scalable true type screen and printing fonts • Upper and lower case alphabetic characters • Multi-tasking and multi-windowing including split screen capability • Simultaneous closing of all windows relating to a single inquiry • Sophisticated form-based queries • Ability to tab and mouse-click through data fields and screens • Full use of mnemonics to aid keyboard navigation • Extensive file search and save capabilities, including ability for users to search by file name, date, and other characteristics.			
1.1.1.23	Provide a user-friendly menu system that is easily navigable by the non-technical user while not restricting direct access to any screen to experienced users.			
1.1.1.24	Use the following standards for all screens, windows, and reports: • Maintain a consistent theme throughout the site and standardize all headings and footers with index tabs as identified by ODJFS • Display current date and time in a system-wide consistent format • Utilize data labels and definitions in a system-wide consistent manner and as defined in user manuals and data element dictionaries • Generated messages must be available in both mixed font and mixed case formats • Screens should distinguish between production and test environments • Comply with the American Disabilities Act (ADA) development standards for user screens • Comply with the Older Americans Act development standards for user screens • All generated messages must be clear and sufficiently descriptive to provide enough information for problem correction and be written in full English text.			
1.1.1.25	Ability to display and accept web site terms of agreement when entering the Medicaid Portal.			
1.1.1.26	Provide a site map that includes all areas of the Medicaid Portal.			
1.1.1.27	The site must allow authorized users to perform Electronic Data Interchange (EDI) transactions such as, but not limited: • Interactive Eligibility Verification (270/271 – Direct Data Entry (DDE) compliant with an option for additional non-HIPAA-required information) • Interactive Claims Inquiry (276/277 – DDE compliant with an option for additional non-HIPAA-required information) • Interactive Claim Submission (DDE compliant) to allow a provider to submit a claim, including HIPAA/EDI compliant responses • Remittance Advice (RA) (835).			
1.1.1.28	Utilize software that can automatically and proactively discover, report, and fix broken links.			

MITS Business Requirement "Functional Fit" Survey				
Business Infrastructure				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
1.1.1.29	Provide on-line option for end users to report any technical problems with the web application and web pages.			
1.1.1.30	Provide multiple access points for main topics.			
1.1.1.31	Allow for provider and consumer web survey submissions.			
1.1.1.32	Allow for Email submission by user initiated from a link on the website.			
1.1.1.33	Allow for direct mail services bulk outgoing email to registered users.			
1.1.1.34	Ensure that information taken into the Medicaid Portal is in a format that can be processed by MITS.			
1.1.1.35	Require qualifying information such as provider number, prior authorization number, consumer number, date of service, or claim number to access various information via the Medicaid Portal.			
1.1.1.36	Provide inquiry capabilities for categories including: • Consumer eligibility • Claim status • Payment status • PA • Reference information • RA • Provider tax program information.			
1.1.1.37	Implement audit trails to provide reporting and audit information regarding web usage. Audit trail functionality must include listings, transactions reports, update reports, transaction logs, and error logs.			
1.1.2	Security/Authentication			
1.1.2.1	Provide a secure web site with authentication standards to handle PHI as identified in State and Federal privacy and security standards.			
1.1.2.2	Utilize an authentication process to handle multiple layers of security levels as defined by ODJFS.			
1.1.2.3	Include email address in the authorization table. The confidentiality of email addresses must be protected and only used for official State business.			
1.1.2.4	Provide Internet security functionality to include firewalls, intrusion detection, and encrypted network/secure socket layer.			
1.1.2.5	Handle PHI through authentication, along with encryption methods to secure PHI.			
1.1.2.6	Establish user access to predefined ODJFS levels such as page level, field and data element level.			
1.1.2.7	Develop a protected web site with secure passwords and log-ons to include: • Instructions on how to use the secure site • Site map • Contact information.			
1.1.2.8	Provide a secure web site for MCPs, and the Selection Services Contractor that is customizable by ODJFS and includes functions for the interchange of data, both submission and receipt of reports, such as: • Encounter data, grievance and complaint, and case management submissions • Membership and premium payment inquiries and reports			

MITS Business Requirement "Functional Fit" Survey				
Business Infrastructure				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
	• Hospital deferment and just cause requests • Newborn verification.			
1.1.2.9	Send users their initial password via email and require that they change their password at next sign-on.			
1.1.2.10	Provide password protection.			
1.1.2.11	Provide the ability to expire a password in a given number of days according to ODJFS standards.			
1.1.2.12	Provide self-service password resets.			
1.1.2.13	Prohibit the display of passwords at the sign-on screen when entered by the user.			
1.1.2.14	Allow providers to be authorized to access only their own claim information.			
1.1.2.15	Allow providers to establish access for billing entities for which they have a contractual agreement. An “Agree” button with a disclaimer stating the provider’s responsibility for granting billing entity access will be added to the site’s design.			
1.1.2.16	Notify providers at regular intervals defined by ODJFS that security access tables will be cleared unless otherwise directed.			
1.1.2.17	Delete account profiles after a period of inactivity as defined by ODJFS.			
1.1.2.18	Do not delete an inactive user from history.			
1.1.2.19	Delete accounts with initial passwords that are not changed within a specified amount of time as defined by ODJFS.			
1.1.2.20	Provide ODJFS/county staff with secured access to information such as: • County reports • Managed care programs monthly enrollment reports • Performance measures by county • Administrative information • Email mailing list • Quality Information.			
1.1.2.21	Provide the capability to receive and send on-line, near real-time confidential information, as directed and managed by the State and Federal government.			
1.1.3	Medicaid Program			
1.1.3.1	Provide the ability for stakeholders such as providers and billing entities (as per direction of the provider) to access information about program policies and processes and be able to communicate readily with ODJFS.			
1.1.3.2	Provide general and program specific information and links to other programs, related agencies, and resources.			
1.1.3.3	Contain information such as: • Frequently Asked Questions (FAQs) • Provider workshop information • Managed care plan information • Program information for both the Medicaid consumer and provider. • Provide access to the following documents and files: o Bulletins (in formats including Portable Document Format (PDF)) o Banners (in formats including PDF) o Provider manuals (in formats including PDF)			

MITS Business Requirement "Functional Fit" Survey				
Business Infrastructure				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
	o Forms (in formats including PDF, Word, and Excel) o State Plan (in digitized format as appropriate).			
1.1.3.4	Allow access to program reference information such as procedure, drug, and diagnosis code information to be viewed without requiring authentication.			
1.1.3.5	Provide access to non-claim related program information such as transportation and pregnancy services.			
1.1.3.6	Provide non-claim related program reports to county staff as identified by ODJFS.			
1.1.3.7	Allow for easy upload and update of Medicaid program/general website content.			
1.1.3.8	Allow for the ability to search various program reports by options such as name, number, and/or date.			
1.1.3.9	Display program training information.			
1.1.4	Claim Submission			
1.1.4.1	Accept claim data that is compliant with EDI transactions 837P, 837I, and 837D and also supports claim information submitted on the following claim forms: • UB92 • Center for Medicare and Medicaid Services (CMS)1500 • 6780 • ADA forms • NCPDP (Durable Medical Equipment) claim.			
1.1.4.2	Accept attachments and supporting documentation in EDI formats such as: • Remittance advice for an adjustment • County letters supporting eligibility • Inquiry forms • Operative reports • Adjustment forms 6766, 6767 • Medical review form 6653 • Phase 2 - Digital X-rays.			
1.1.4.3	Reject those attachments that require an original signature, based on Federal regulations.			
1.1.4.4	Provide downloadable formats of forms to include: • Medical review form 6653 • UB92 form • CMS1500 form • ADA form • 6780 form • NCPDP (Durable Medical Equipment) claim • 3197 Abortion form • 3198 Sterilization form • 3199 Hysterectomy form • Adjustment forms 6766, 6767, 6768.			
1.1.4.5	Assign reference/transaction control number to submitted claim and/or attachment claims that can be used in the translator process and through adjudication.			

MITS Business Requirement "Functional Fit" Survey				
Business Infrastructure				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
1.1.4.6	Capture fields on current claims submission forms on-line in a HIPAA compliant manner and in a format that allows them to be processed by a translator.			
1.1.4.7	Allow for growth, capacity, and scalability to respond to high volumes of claim submissions.			
1.1.4.8	Track and report web submission errors.			
1.1.4.9	Provide on-line access to claims/adjustments status for a rolling 24-month period.			
1.1.4.10	Accept third party submitted control numbers (e.g., Medicare Internal Control Number (ICN)) for crossover claims.			
1.1.4.11	Provide field level and relationship edit capability such as: • Length of fields • Character type • Presence of data.			
1.1.4.12	Validate fields such as: • Provider number • Consumer billing number • Procedure code/modifier • Prior authorization • Consumer eligibility • Third party coverage • Date of service.			
1.1.4.13	Accept 999 lines on an institutional claim.			
1.1.4.14	Provide the capability to limit the number of submissions per day per submitter.			
1.1.4.15	Track and report submissions per submitter per day.			
1.1.4.16	Ensure that claims and attachments submitted via the Medicaid Portal are in a format that can be processed by MITS.			
1.1.4.17	Provide the capability for providers to correct and resubmit claims immediately.			
1.1.4.18	Retrieve claims information directly from MITS.			
1.1.4.19	Provide the ability to display information from multiple sources such as paper, tape, and EDI transactions 837 I, 837 P, and 837 D.			
1.1.4.20	Provide quick links to related claim information including eligibility, status, payment status, prior authorization, and remittance advice.			
1.1.5	Claim Inquiry			
1.1.5.1	Provide search option fields (required unless otherwise noted) for claim status inquiries to include: • Ohio Medicaid provider number • Consumer billing number • Claim status • Claim type • Date of service (optional field) • Total claim charge submitted (optional field) • Prescription number (optional field) • Claim transaction control number • Provider information • Consumer information			

MITS Business Requirement "Functional Fit" Survey				
Business Infrastructure				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
	• Billing code information • Claim/service information • Medicare information • Payment information • Third party information • Third party coordination of benefits.			
1.1.5.2	Run a set of edits upon submission of an inquiry to include: • Relationship edits • Field length • Character type • Presence of data.			
1.1.5.3	Display multiple claims if search results in more than one claim.			
1.1.5.4	Provide claim status for all claim input media.			
1.1.5.5	Display high level information for multiple claims match to include: • Remittance advice date • Claim type • Claim status • Claim line information.			
1.1.5.6	Provide capability to select and drill down to line level information.			
1.1.5.7	Provide search capability for payment status by Medicaid provider number.			
1.1.5.8	Display information for a claim payment match to include: • Medicaid provider name • Number of claims paid in current month • Amount paid in current month • Number of claims paid in past 12 months • Amount paid in past 12 months • Number of claims denied in current month • Number of claims denied in past 12 months • Number of claims in final disposition • Date, amount, and type of most recent payments • Number of suspended claims.			
1.1.5.9	Provide search options for Remittance Advice claim information to include: • Medicaid provider number • Provider name • Payment date • RA number • Transaction Control Number (TCN) • Check or Electronic Funds Transfer (EFT) Trace number.			
1.1.6	Consumer Eligibility Inquiry			
1.1.6.1	Ability to search for consumer eligibility with options such as: • Consumer billing number AND date of service OR month/year of service OR range of service • Consumer Social Security Number (SSN) AND date of birth AND date of service OR month/year of service OR range of service.			

MITS Business Requirement "Functional Fit" Survey				
Business Infrastructure				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
1.1.6.2	Ability to search for consumer eligibility for a range of up to six months of service.			
1.1.6.3	Display information for a consumer eligibility match such as: • Eligibility for those services that have limits during specific time frames, e.g., vision exams and glasses, physical therapy, chiropractic • Consumer Information o Billing number o Name o Gender o Date of birth o Patient liability (full and partial month) o Level of care information with date spans • Case worker Information o Name/identifier o Number o County name • Medicare Part A, Part B, Part C, and Part D information o Health care ID numbers o Coverage spans o Prescription Drug Plan o Medicare Advantage Plan • Managed care Information o Coverage spans o MCP name and address • Primary Alternative Care and Treatment Program information o Primary care provider o Pharmacy coverage spans o Pharmacy name and address • Waivers and Special Programs Information o Coverage spans o Provider name and address • Covered/Non-covered LTC leave days • Third party information o National Association of Insurance Carriers (NAIC) numbers o Carrier names o Third party coverage periods o Policy number o Policy holder o Group number o Benefit package.			
1.1.7	Prior Authorization (PA) Submission			
1.1.7.1	Accept on-line, real-time entry and update of PA requests through the Medicaid Portal, including initial entry of PA requests pending determination.			
1.1.7.2	Allow prior authorization request entries through the Medicaid Portal to be limited to those provider types and services which are covered by Medicaid policy.			
1.1.7.3	Send alert to ODJFS staff for PA submissions.			

MITS Business Requirement "Functional Fit" Survey				
Business Infrastructure				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
1.1.7.4	Provide role-based authorization/access of identified ODJFS staff to the PA module of the Medicaid Portal.			
1.1.7.5	Generate a tracking number for Medicaid Portal PA requests.			
1.1.7.6	Use tracking number to link attachments submitted by mail to electronic PA request.			
1.1.7.7	Notify submitter of successful submission and display the tracking number.			
1.1.7.8	Assign a PA number as soon as the submitted request passes edits.			
1.1.7.9	Reject PA request if it does not pass all edits.			
1.1.7.10	Notify the submitter of invalid web PA entries and which field(s) caused the edit to fail.			
1.1.7.11	Run edits such as the following on all submitted PA requests: • Relationship edits • Field length • Character type • Presence of data.			
1.1.7.12	Accept electronic attachments and link to PA request with tracking number.			
1.1.7.13	Allow users to submit PA's for multiple providers, but only for those providers that have authorized the user.			
1.1.7.14	Allow users to submit a PA request on the provider's behalf.			
1.1.7.15	Screen for duplicate PA requests for exact service and for related or similar type service requests (e.g., services bundled into other prior authorized service codes).			
1.1.7.16	Ensure that attachments submitted electronically meet PHI security policy.			
1.1.7.17	Interface with MITS to identify procedure codes that require PA (medical utilization requirements).			
1.1.7.18	Provide an on-line Medicaid Portal Tutorial for PA application to guide users through the screens they must complete to request a PA.			
1.1.7.19	Interface with MITS and populate PA sub-system screens with PA information to be determined during design.			
1.1.7.20	Phase 2 - Accept PA submissions using the 278, 275, eXtensive Markup Language (XML), Health Level 7 (HL7) Health Care Services Review standard and the National Council for Prescription Drug Programs (NCPDP) standard for retail pharmacy.			
1.1.7.21	Include data fields such as the following to be used for submission of web PA requests: • Consumer billing number • Service • Provider name and ID • Dates of service • Authorized services (units, effective dates) • Miscellaneous codes with notes field (for contractors) • Rates • Dollar cap • Local provider information • Provider demographic and rate data			

Req Number	Requirement	Phase (1 or 2)	Response Code	Page Ref
	• Limits • Certification information • Room and board • Health costs • Waiver start date • Waiver program (benefit package) • Waiver wait list data • Cost share data ~~• For miscellaneous codes, descriptions must be available on the PA request form.~~			
1.1.7.22	Allow for expansion and addition of fields to the on-line PA request form.			
1.1.7.23	Allow providers the ability to view alerts and notifications generated by ODJFS staff via MITS to include: • The need for additional information on an already submitted PA request • Reminders of missing information • Approval or denial of the PA • System updates/policy changes • Duplicate or possible duplicate requests.			
1.1.7.24	Generate approval or denial notices as soon as the determination has been made.			
1.1.7.25	Provide the ability to automatically approve certain PA requests based on information entered as identified by ODJFS.			
1.1.7.26	Retain incomplete PA request submissions for a minimum number of days, to be defined by ODJFS, before deleting the record.			
1.1.7.27	Maintain a rolling thirteen-month period of on-line PA history.			
1.1.7.28	Allow PA request forms to be available on the Medicaid Portal for download by users.			
1.1.7.29	Link to Ohio administrative rules/program information.			
1.1.7.30	Provide an on-line PA submission tutorial.			
1.1.7.31	Reflect updates to MITS (e.g., when procedure codes and/or modifiers which require prior authorization have been deleted and/or replaced with new or revised HIPAA-compliant codes) without interruption to service.			
1.1.7.32	Support PA entries for medical services such as: • Vision • Dental • Durable Medical Equipment (DME) • Surgical procedures.			
1.1.7.33	Report and maintain Medicaid Portal PA activity statistics such as: • Number of PA submissions • Number of times application was selected • Number of PA requests pended for review.			
1.1.8	PA Inquiry			
1.1.8.1	Provide PA search options such as: • Consumer billing number AND Medicaid provider number, OR • PA number.			
1.1.8.2	Display PA status information for the previous 12 month period.			
1.1.8.3	Return multiple PAs if more than one match is found.			

MITS Business Requirement "Functional Fit" Survey				
Business Infrastructure				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
1.1.8.4	Display information for a PA match to include: • PA numbers • PA status • Procedure codes • Line item status • Reasons • Process dates • Service dates • Coverage types • Amounts approved • Amounts used.			
1.1.9	Provider Enrollment/Maintenance			
1.1.9.1	Allow providers on-line entry, update, and access to screens that are designed to capture the enrollment and change information as defined by ODJFS requirements.			
1.1.9.2	Allow providers to complete and submit applications and update provider demographic data via the Medicaid Portal.			
1.1.9.3	Allow Medicaid Portal to accept electronic attachments and match them with enrollment application in the system.			
1.1.9.4	Require applicants to state whether they are a current or new provider before starting the enrollment application.			
1.1.9.5	Require applicants to state that they meet the State-defined provider eligibility rules.			
1.1.9.6	Provide help screens and tutorial to guide provider through the necessary steps to complete application.			
1.1.9.7	Identify provider applications and updates by provider types that are assigned by ODJFS.			
1.1.9.8	Generate tracking numbers for Medicaid Portal submitted provider enrollment applications and updates.			
1.1.9.9	Provide role-based access to ODJFS staff to provider application, supporting documentation, and other enrollment updates submitted through the Medicaid Portal.			
1.1.9.10	Send notification to ODJFS staff regarding new enrollment entries.			
1.1.9.11	Route applications and updates to the appropriate ODJFS staff to work.			
1.1.9.12	Incorporate relationship editing, as defined by ODJFS, into the interactive application process.			
1.1.9.13	Edit to ensure that all required fields, as defined by ODJFS, must be completed before the application is accepted.			
1.1.9.14	Provide web links to entities such as: • Drug Enforcement Agency (DEA) • On-line Survey Certification and Reporting (OSCAR) • Clinical Laboratory Improvement Act (CLIA) • Automated Survey Process Environment (ASPEN) • Office of Inspector General (OIG) sanction list • National Provider System (NPS) • National practitioner • Board of nursing • Databank.			

MITS Business Requirement "Functional Fit" Survey				
Business Infrastructure				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
1.1.9.15	Incorporate electronic signatures that comply with Ohio Administrative Rule 123:3-1-0, with provider enrollment applications and updates.			
1.1.9.16	Use a single provider enrollment application with required fields being driven by provider and program type as identified by ODJFS.			
1.1.9.17	Assign provider number prior to the completion of the credentialing process, but provider numbers must remain inactive until all the verification, accreditation, and credentialing are complete.			
1.1.9.18	Generate to the submitter a receipt notification with an inactive provider number when the application and/or update are submitted for review.			
1.1.9.19	Allow access, with appropriate level of security, to providers to retrieve the status of applications assigned to them.			
1.1.9.20	Make provider demographic information as defined by ODJFS available through the Medicaid Portal.			
1.1.9.21	Give providers the ability to view alerts and notifications generated by ODJFS staff.			
1.1.9.22	Provide the ability to terminate providers.			
1.1.9.23	Allow providers to request termination of their provider agreement on-line.			
1.1.9.24	Provide structured on-line templates and documents regarding enrollment and maintenance to providers.			
1.1.9.25	Maintain history and audit trails for all changes and updates made on-line.			
1.1.9.26	Restrict data elements that providers can change on-line to those permitted by ODJFS. Other changes will require approval by ODJFS staff.			
1.1.9.27	Include in the enrollment process and in notification to the provider links for accessing provider manuals and other important documentation, as defined by ODJFS.			
1.1.9.28	Check for duplicate providers when accepting an enrollment application and/or update via the Medicaid Portal.			
1.1.9.29	Provide help screens to define enrollment data requirements for providers and users.			
1.1.9.30	Alert appropriate ODJFS staff that an enrollment application has pended on for a certain amount of days as defined by ODJFS.			
1.1.9.31	Notify applicants of partially submitted applications.			
1.1.9.32	Save partially completed provider enrollments for a given number of days to be defined by ODJFS.			
1.1.9.33	Automatically notify providers via the Medicaid Portal of acceptance/rejection as a Medicaid provider and send enrolled providers an electronic notice for web site locations regarding policy and billing information.			
1.1.9.34	Update provider enrollments via the Medicaid Portal in the provider subsystem in near real-time, except when prevented by batch or other activities. If updates cannot be made immediately, they should be made at the next available time.			
1.1.9.35	Accommodate the 10 digit National Provider Identifier.			
1.1.9.36	Provide notes functionality for web applications.			

MITS Business Requirement "Functional Fit" Survey				
Business Infrastructure				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
1.1.9.37	Provide on-line statistics of provider enrollments/updates and audit trail reports to include the number of enrollments submitted per day by provider type and the number that are approved, denied, or pending.			
1.1.9.38	Provide links from the Medicaid Portal to trading partner websites.			
1.1.9.39	Allow the Medicaid Portal to interface with contractors for waiver provider enrollment.			
1.1.9.40	Send email notification to appropriate agency when an application is submitted or ready for their review.			
1.1.9.41	Hold application in pending status until pre-approving entity gives authorization to proceed.			
1.1.9.42	Allow certain changes to provider demographic data, as defined by ODJFS, must be pre-approved depending on provider type.			
1.1.9.43	Provide on-line applications, addendums, and provider agreements. • Provider agreement • Provider enrollment application (individual, group, organization).			
1.1.9.44	Provide a link to downloadable W-9 form.			
1.1.9.45	Ensure that Medicaid Portal field definitions comply with system field definitions.			
1.1.9.46	Allow provider enrollment and update transaction information including status to be viewed for a rolling 13-month period.			
1.1.9.47	Allow providers to access to their own information and group owners to access information for all providers in the group.			
1.1.9.48	Provide ODJFS staff the ability to view on-line the details enrollment and update activities for the past seven (7) years.			
1.1.9.49	Report and maintain Medicaid Portal provider enrollment and update activity statistics such as the number of enrollment applications/updates received hourly, daily, etc, number of applications/updates pending.			
1.1.9.50	Provide forms on-line and in downloadable format to include: • EFT • Change of address forms • Medicare information • CLIA • Adding individuals to a group practice • Change of ownership.			
1.1.10	Long Term Care (LTC) Rate Submission and Inquiry			
1.1.10.1	Provide an interface between Perseus and MITS.			
1.1.10.2	Restrict LTC provider enrollment information from public viewing.			
1.1.10.3	Allow authenticated providers/users access to only their own information.			
1.1.10.4	Allow providers/users to submit/upload information in formats to include PDF and text files.			
1.1.10.5	Provide the capability for near real-time file transfers from providers to Medicaid Portal to Perseus and visa versa (for 1500 LTC providers and 65,000 consumers).			
1.1.10.6	Send cost report verification to user if no errors are found during edits and supply providers with a method to agree to the verification.			
1.1.10.7	Send automated notifications/alerts from LTC site to provider.			

MITS Business Requirement "Functional Fit" Survey				
Business Infrastructure				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
1.1.10.8	Provide non-secured access via links to public information to include: • Provider specific information • Rate setting information • Statistical Analysis Software (SAS)/ Pregnancy Related Services (PRS) datasets • Cost report datasets • Rate setting ceiling data • Inflation data • Trend reporting information • Average monthly rates • Rule filing process • Public notices • Proposed rules • Public comments • Transmittal letters • Listing of providers.			
1.1.10.9	Provide inquiry capabilities for public information with search options to include: • County • Peer group • Date or date ranges • Keyword in provider name field.			
1.1.10.10	Link to documents to include: • Procedure code for LTC facility therapy • Bureau of LTC Facility (BLTCF) newsletters/bulletins • Center for Medicare and Medicaid Services (CMS) website • Resident's rights document • Definition of cost report • Companion guide • Automated Cost Report (ACR) website • Ohio Revised Code (ORC) administrative code • Multiple links containing LTC data • Form 9402 & Form 9405.			
1.1.10.11	Provide link to Bureau of Long Term Care.			
1.1.10.12	Provide a private document page that will display a list of the available documents for each logged-in provider.			
1.1.10.13	Provide the ability to search for corporate facilities by provider-specific user ID and password.			
1.1.10.14	Provide the ability to upload rate information in batch or in bulk.			
1.1.10.15	Provide the ability to archive various documents after a specified period of time.			
1.1.10.16	Provide the ability to submit, inquiry, update, and publish information.			
1.1.10.17	Support file transfer on an hourly, daily, weekly, monthly, and yearly basis.			
1.1.10.18	Provide inquiry provider-specific access to secured information such as: • Provider correspondence • Automated Cost Report (ACR) (data and reports) • Error reports as part of the cost verification process			

MITS Business Requirement "Functional Fit" Survey				
Business Infrastructure				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
	• Rate setting package report • Cost verification report • Provider acceptance of the Verification report • Minimum Data Set (MDS) scores • MDS error reports • Individual Assessment Form (IAF) scores • IAF error reports • Rate reconsideration requests • Non-extensive renovations request • Civil Monetary Penalties (CMP) notice • Provider acceptance of civil monetary penalties • Status of fiscal year adjudication by provider • Paid monthly MITS days report • Franchise fee assessment notices.			
1.1.10.19	Allow providers to submit and upload via the Medicaid Portal to BLTCF the following: • Cost reports • Provider acceptance of the verification report • MDS scores • Rate reconsideration requests • Provider correspondence • Non-extensive renovations request • Provider acceptance of civil monetary penalties.			
1.1.11	Disability Determination (DD)			
1.1.11.1	Provide a gateway for ODJFS and county staff to: • Review DD cases • Perform processing functions on DD case information.			
1.1.11.2	Provide role-based access for both ODJFS and county staff to query, view, and update DD case information.			
1.1.11.3	Support web application by ODJFS and county database servers that will house DD case information.			
1.2	**Electronic Document Management System (EDMS)**			
1.2.1	General EDMS Requirements			
1.2.1.1	Integrate an EDMS sub-system into MITS that supports, at a minimum, the following capabilities: • Document management • Content management • Records management • Document capture and imaging • Document-centric collaboration • Workflow management including document workflow.			
1.2.1.2	Utilize open architecture standards and scalability to promote integration throughout all MITS business processes and sub-processes.			
1.2.1.3	Align with MITA standards.			
1.2.1.4	Employ a security approach that integrates with other MITS components to provide role-based access with a single log-on.			
1.2.1.5	Integrate with and provide support to various MITS components such as:			

MITS Business Requirement "Functional Fit" Survey				
Business Infrastructure				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
	• Customer Relationship Management (CRM) • Medicaid Portal • Security system.			
1.2.1.6	Accept documents through various input methods such as: • Medicaid Portal • E-mail • Facsimile • Internal creation from Personal Computers (PCs) • Imaging • Mailroom.			
1.2.1.7	Store both electronic and imaged paper documents and make them available on-line through a single user interface to promote a total view of current and historical information.			
1.2.1.8	Provide for on-line retrieval and access to documents and files for up to seven (7) years rolling.			
1.2.1.9	~~Provide backup and storage of documents as defined by ODJFS.~~			
1.2.2	Document Management			
1.2.2.1	Associate with all documents parameters such as: • Document type • Document format • Storage location • Barcode formats • Security levels • Size • Field validation.			
1.2.2.2	Provide multiple search options (e.g., Structured Query Language (SQL), various index search options, content-based searches, etc.) to view contents.			
1.2.2.3	Track all versions of each document.			
1.2.2.4	Phase 2 - Present users with the latest revision of a document with the option to view previous versions.			
1.2.2.5	Phase 2 - Manage document content and configuration across the ODJFS enterprise and, with suitable role-based permissions.			
1.2.2.6	Support the management of documents created in the following applications. • Microsoft Word • Microsoft Excel • Microsoft PowerPoint • Microsoft Publisher • Microsoft Project.			
1.2.2.7	Allow drag-and-drop functionality to be used when creating or editing a document.			
1.2.2.8	Include at a minimum the following document management capabilities: • Access letter templates and forms • Concurrent retrieval functions to publications and other stored documents • On-line, updateable letter templates with the ability to add free-form text			

MITS Business Requirement "Functional Fit" Survey				
Business Infrastructure				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
	• Automated inventory control for all forms, letter templates, publications and other ODJFS-designated documents • Store documents and files • Generate materials in both hard copy and electronic format including forms and letters.			
1.2.2.9	Create letter templates, and forms, for the following areas such as: • Provider certification materials • General correspondence/notices for providers and consumers • Financial letters • Coordination Of Benefits (COB) letters • Managed Care Plan/Care Management Plan (MCP) letters • PA letters • Temporary ID cards • Premium coupons • State (Social Security Income) SSI benefit checks.			
1.2.2.10	Letter templates and forms should be stored within the document management system and contain the following attributes assigned to each letter template to include: • Letter template/form name • ODJFS letter template/form number • Letter template/form unit owner (e.g., provider services) • Contact name for updates • Last revision date • Letterhead type used (not applicable to forms) • Whether ODJFS administrator signature is contained on the letter template (not applicable to forms).			
1.2.2.11	Allow for specific Information on the letter templates such as: • Signature block • Electronic signature capability • Revision date • Phone number • Department letterhead.			
1.2.2.12	Print letter templates to networked and individual printers.			
1.2.2.13	Convert letters to PDF format.			
1.2.2.14	Update letter templates and forms as requested by ODJFS.			
1.2.2.15	Retain letter templates and forms for a time period defined by State and Federal guidelines.			
1.2.2.16	Generate pre-populated forms.			
1.2.2.17	Utilize document management capabilities, standard for all counties, for scanning and routing documents between County Department of Job and Family Services (CDJFS) offices and the Disability Determination Unit.			
1.2.2.18	Provide the ability to easily match up related documents such as claims and supporting attachments in a many to one relationship.			
1.2.2.19	Allow for storage and retrieval of all documents (e.g., fax, letters, reports, and claims).			
1.2.3	Document Imaging			
1.2.3.1	Support cataloging/indexing of all imaged documents.			

MITS Business Requirement "Functional Fit" Survey				
Business Infrastructure				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
1.2.3.2	Include Optical Character Recognition (OCR) technology that minimizes manual indexing and automates the retrieval of scanned documents.			
1.2.3.3	Utilize bar code technology that minimizes manual indexing and automates the retrieval of scanned documents.			
1.2.3.4	Provide backup capability for manually indexed scanned documents.			
1.2.3.5	Provide the capability to adjust scan preferences for each document type to include: • Resolution • File numbering • Storage location.			
1.2.3.6	Include at a minimum the following imaging and document management capabilities: • Scan both single and dual sided documents • Scan complete or scrapped documents • Scan color, black and white, and grayscale images • Provide capability to handle special characters • Support a wide range of compression methods • Retrieve images through the use of key word searches.			
1.2.3.7	Provide the capability to manipulate images to include: • Rotation • Inversion • Zoom • Brightness/contrast.			
1.2.3.8	Use imaging/document management technology that handles multiple types of letters, forms, publications, and other State designated documents, files and automates workflow processing to include: • Provider certification materials • Claim forms and attachments • PA forms and attachments • COB (including casualty) • Estate recovery • Employer verification of earnings and health insurance • Provider correspondence • Consumer correspondence • Medicaid Portal correspondence • ~~Consumer enrollment materials~~ • Notices • Letters • Audit materials.			
1.2.3.9	Automate batch scanning with user-defined document separators to expedite the imaging and validation process.			
1.2.3.10	Provide the capability for documents to be scanned and batched based on date of receipt.			
1.2.3.11	Allow manual data entry from scanned documents if they cannot be read and transmitted electronically from an image to MITS.			
1.2.3.12	Transmit scanned document data to MITS.			
1.2.4	Workflow Management (Phase 2)			

MITS Business Requirement "Functional Fit" Survey				
Business Infrastructure				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
1.2.4.1	Include in the EDMS a comprehensive workflow management system that supports: • Definition, and possibly modeling, of workflow processes and their constituent activities • Run-time control functions concerned with managing the workflow process in the MITS operational environment and sequencing the various activities to be handled as part of each process • Run-time interactions with users and Information Technology (IT) application tools for processing the various activity steps.			
1.2.4.2	Provide a user-friendly GUI for process definition, execution, monitoring, and management.			
1.2.4.3	Support a role-based interface for process definition that leads the user through the steps of defining the workflow associated with a business process, and that captures all the information needed by the workflow engine to execute that process to include: • Start and completion conditions • Activities and rules for navigation between them • Tasks to be undertaken by ODJFS staff involved in the process • Authorized approvers • References to applications which may need to be invoked • Definition of other workflow-relevant data.			
1.2.4.4	Allow the process definition to be specified in terms of organizations and roles with later linkage to specific participants.			
1.2.4.5	Provide a rules-based workflow engine that supports workflow access, assignments, and execution.			
1.2.4.6	Coordinate interactions between the workflow engine and participating ODJFS staff to manage the work required to execute a process including: • Work queues for each participating staff member • Alerts to the presence of work • Other triggers, timers, and alerts to support workflow • Status indicators to mark work in progress or completed.			
1.2.4.7	Support workflow management for multiple simultaneous processes, each with multiple simultaneous instances of execution.			
1.2.4.8	Provide the ability to incorporate simple low-level workflow processes into more complex higher-level workflow processes.			
1.2.4.9	Log all instances of workflows that are executed throughout the ODJFS enterprise.			
1.2.4.10	Expose key interfaces to support integration with a variety of best-in-class applications to support process execution.			
1.2.4.11	Support supervisory operations for the management of workflow including: • Assignments/re-assignments and priorities • Status querying and monitoring of individual documents and other work steps or products • Work allocation and load balancing • Approval for work assignments and work deliverables via a tiered approach			

MITS Business Requirement "Functional Fit" Survey				
Business Infrastructure				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
	• Ability to take necessary action or provide notification when corrective action is needed, including the ability to modify or abort a workflow process • Monitoring of key information regarding a process in execution, including: o Estimated time to completion o Staff assigned to various process activities o Any error conditions • Overall monitoring of workflow indicators and statistics by sub-process, organization, or individual staff members including: o Work in queue by priority o Throughput o Individual and organizational productivity o Current activity by individual staff member.			
1.2.4.12	Support ODJFS in mapping all business processes and sub-processes to the workflow application and in transitioning from manual to automated process execution.			
1.2.4.13	Utilize automated workflow to transfer documents to ODJFS for review, editing, and approval, and back to external stakeholders for re-writes and production.			
1.2.4.14	Use workflow management functionality to route and assign cases to the appropriate State and county staff and offices.			
1.3	**MITS User Screens**			
1.3.1	Overall Requirements			
1.3.1.1	Incorporate systems navigation technology and a graphical user interface (GUI) that allows all users to move freely throughout the system.			
1.3.1.2	Provide a graphical menu and control system with highly flexible, mouse-driven, and tab navigation.			
1.3.1.3	Emphasize plain English commands, controls, menus, and files.			
1.3.1.4	Include at minimum the following GUI features and capabilities: • Ability to transfer information from one screen to all related screens to reduce re-entry of information • Drag and drop, "point and click", and "copy, cut, and paste" functionality • Pull down menus and window tabs • Scalable true type screen and printing fonts • Use both upper and lower case alphabetic characters • Multi-tasking and multiple window capability including split screens • Ability to simultaneously close all windows relating to a single inquiry • Sophisticated form-based queries • Full use of mnemonics to aid keyboard navigation • Extensive file search and save capabilities, including ability for users to search by file name, date, and other characteristics • Ability to tab and mouse through data fields and screens.			
1.3.1.5	Include a menu system, understandable by non-technical users, that provides access to all functional areas. This menu system must be hierarchical and provide submenus for all functional area.			

MITS Business Requirement "Functional Fit" Survey				
Business Infrastructure				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
1.3.1.6	Incorporates a non-restrictive environment for experienced users to directly access a screen or to move from one screen to another without reverting to the menu structure.			
1.3.1.7	Utilize standard log-in; display and navigation requirements must be standard for all authorized users.			
1.3.1.8	Include “Help” screens with context-sensitive in order to provide for ease of use.			
1.3.1.9	Require help facility to be available from any screen and any screen field, must provide a description of and the processing performed by a screen or window, data entry format and restrictions, explanation of error messages and other information helpful to the user.			
1.3.1.10	Generate drop-down lists to identify options available, valid values, and code descriptions, by screen field.			
1.3.1.11	Omit screen scrape function from the GUI of the transferred system.			
1.3.1.12	Utilize the following standards for all screens, windows, and reports: • All headings and footers must be standardized • Current date and time must be displayed • All references to dates must be displayed consistently throughout the system • All data labels and definitions used must be consistent throughout the system and clearly defined in user manuals and data element dictionaries • All MITS generated messages must be clear and sufficiently descriptive to provide enough information for problem correction and be written in full English text • Generated messages must be available in both mixed font and mixed case formats • All screens must display the generating program identification name and/or number.			
1.3.1.13	Display of data will be consistent from screen to screen.			
1.3.1.14	Require screens to distinguish between production and test environments.			
1.3.1.15	Comply with the American Disabilities Act (ADA) development standards for user screens.			
1.3.1.16	Comply with the Older Americans Act development standards for user screens.			
1.3.1.17	Provide an indicator on any summary window if additional information is available and provide drill-down capability from that summary window. Support role-based remote wireless access and data transmission to MITS via the Internet as indicated by ODJFS.			
1.4	**MITS Report Access & Delivery**			
1.4.1	General Reporting Capabilities			
1.4.1.1	Generate reports for State for printing in the following formats: • Letter or legal size paper • Landscape or portrait orientation • Laser print with scalable screen and print fonts • Single-sided or double-sided print • On-line (e.g., PDF) • Customization of report templates			

MITS Business Requirement "Functional Fit" Survey				
Business Infrastructure				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
	• Standard format that includes header, footer, etc.			
1.4.1.2	Support automatic Windows-based report production and distribution to the State via the State Local Area Network (LAN).			
1.4.1.3	~~Phase 2 Provide workflow tracking, version control, and near real-time reporting functionality from legislation to law, to administrative rule, contract, business rule and audit activity and resolution repository. (This may involve interfacing with sub-systems such as the Legislative Information System (LIS) and LawTrac.)~~			
1.4.1.4	Provide the ability to display a graphical representation that identifies the near real-time status of critical MITS system and processing functions (e.g., "vital signs" such as claim volume, pended claims, calls on hold, exceptions posted, etc.) This feature must run in near real-time or near near real-time with very little delay.			
1.4.1.5	Provide a flexible reporting system that meets ODJFS business requirements.			
1.4.1.6	Download reports in various formats.			
1.4.1.7	Allow information via various presentation methods with the preferred format web based (e.g., PDF).			
1.4.1.8	Allow users to run a series of standard reports on a scheduled basis.			
1.4.1.9	Provide the ability to export reports for enhanced manipulation and analysis.			
1.4.1.10	Provide the capability and flexibility for multiple simultaneous users to create and run in near real-time, ad hoc and canned reports without going through a formal change control process.			
1.4.1.11	Produce operational reports.			
1.4.1.12	Create reports that provide supervisory and management with detailed or summary reports by staff person or unit.			
1.4.1.13	Allow users the ability, with help screens, to extract data from management reports, manipulate the extracted data, and specify the desired format and media of the output.			
1.4.1.14	Support near real-time on-line notification to the case manager of a consumer hospitalization, nursing home admission, Intermediate Care Facility for Mentally Retarded (ICF-MR) admissions and emergency room use.			
1.4.1.15	Provide flexible query tools allow staff to customize information retrieved and analyze data to answer specific program questions and support management decisions.			
1.4.1.16	Provide query tools that are easy to learn, with the flexibility to support data changes.			
1.4.1.17	Provide on-line access to metadata.			
1.4.1.18	Provide the following on-line metadata information including: • Describe the report • Provide the definitions of fields • Define any calculations • Built-in statistical measure objects.			
1.4.1.19	Provides for the electronic delivery of reports to identified destinations.			
1.4.1.20	Interface to the Legislative Information System (LIS) to track the status of rules filed			

MITS Business Requirement "Functional Fit" Survey				
Business Infrastructure				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
1.4.1.21	Provide the capability to produce multi-dimensional, flexible, ad hoc reports across business functions ~~using~~ which meet the following reporting needs such as: • Financial reporting • Budget forecasting • Fiscal planning and control • Claims payment accuracy • Cash flow • Timely reimbursement analysis • Recipient cost and user of services • Cost/benefit analysis • Third party recovery • Estate recovery • Prescription drug policy • Cost and user of prescription drugs • Recipient participation • Eligibility and benefit design • Geographical analysis • Program planning • Policy analysis • Federal waiver program evaluation • Program performance monitoring • Provider reimbursement policy • Institutional rate-setting • Medical assistance policy development • Provider participation • Service delivery patterns • Adequacy of and access to care • Quality of care • Outcomes assessment • Disease management • External reporting • Public information • MCP planning and analysis.			
1.4.1.22	Generate listings of any/all system maintained files, databases, or data as requested by the State.			
1.4.1.23	Generate a listing of all standard on-line reports available, the description of each report, and provide a hot link to the most recent report.			
1.4.1.24	Provide file search and save capabilities for reports, including searching by a variety of parameters, (e.g., file name, date, and other characteristics).			
1.4.1.25	Provide a process to import reports/data/information, which may be transferred by the State's email system.			
1.4.1.26	Segment reports based on functional area and further, by reports that contain PHI as defined by the State.			
1.4.1.27	Archival storage of reports shall comply with State records retention standards.			

MITS Business Requirement "Functional Fit" Survey				
Business Infrastructure				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
1.4.1.28	Store reports on Compact Disk-Read Only Memory (CD-ROM) and shall be able to be rapidly and efficiently retrieved using Windows-based menu- driven selection criteria.			
1.4.1.29	Allow users the ability, with help screens, to extract data, manipulate the extracted data, and specify the desired format and media of the output.			
1.4.1.30	Generate all reports in a format, media, and time frame acceptable to the State and/or CMS, without manual intervention or manipulation of data.			
1.4.1.31	Display consistent ODJFS-approved headers and footers.			
1.4.1.32	Identify and use consistent report fields.			
1.4.1.33	Display the generating program identification name and /or number on production reports. This display must be consistent from report to report.			
1.4.1.34	Provide a user-friendly way to schedule when, with what frequency, or on what regular days within a month (e.g., the first Wednesday after the last Sunday of a calendar month) various reports are generated and disbursed.			
1.4.1.35	Allow staff to create customized reports, using State-defined parameters, on an ad hoc basis.			
1.4.1.36	Provide for the electronic delivery of reports to identified destinations.			
1.4.2	Data Retention, Archival, Retrieval and Purge			
1.4.2.1	Ability to maintain an unlimited number of historical records of each consumer eligibility change.			
1.4.2.2	Provide the capability for ODJFS to specify/modify auto archive rules.			
1.4.2.3	Provide the ability to retain and access historical reference file data according to ODJFS retention requirements.			
1.4.2.4	Provide the capability to retain historical reference file data on-line for up to seven years.			
1.4.2.5	Provide the ability to retain up to seven years of claims history on-line, to include adjustments and all supporting financial transactions.			
1.4.2.6	Provide the capability to retain PA determinations on-line for up to ten years.			
1.4.2.7	Provide the capability to restore archived data for reviewing, copying and printing.			
1.4.2.8	Provide the capability to purge archived data in accordance with ODJFS archival and purge schedules.			
1.4.3	E-Library (General Report Repository and Management)			
1.4.3.1	Track and store detailed information regarding all reporting requests including, but not limited to: • Who requested the information • Date • Time • What the report included • Report storage upon completion • Route the entire history on-line.			
1.4.3.2	Provide the ability to categorize and organize reports by source system, data content, purpose, frequency and other staff selected options.			
1.4.3.3	Provide the ability to print to compatible networked printers.			

MITS Business Requirement "Functional Fit" Survey				
Business Infrastructure				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
1.4.3.4	Provide the ability to access all operations, administrative, financial, **** and **** Surveillance Utilization and Review (SUR)~~, external, Decision Support System~~ reports through a web- based reports repository.			
1.4.3.5	Provide the ability to establish and maintain a master reports list that staff will browse and select reports from.			
1.4.3.6	Provide the ability to add change, delete report categories in the masters reports list.			
1.4.3.7	Provide the ability to add change, or delete report titles that will appear in the master reports lists.			
1.4.3.8	Provide the ability to select and access a report from a pre-determined master reports list.			
1.4.3.9	Provide the ability to search the reports repository by date, time, report title, report ID, run date, key words, and other characters within the report.			
1.4.3.10	Provide the ability to highlight, cut, paste, and print any selection of the report.			
1.4.3.11	Provide the ability to sort the reports list by date, time report title, run date, and other criteria.			
1.4.3.12	Provide the ability to establish and apply archival and purge parameters to reports.			
1.4.3.13	Provide the ability to access all reports history through the same reports master list.			
1.4.3.14	Provide the ability to download report content formats to Microsoft Office Products.			
1.4.3.15	Provide the ability to easily and flexibly create new reports through an automated and user-friendly report writer tool.			
1.4.3.16	Provide the ability to aggregate data from multiple data files with the MITS data structures.			
1.4.3.17	Provide the ability to use identifier mathematical functions format and manipulate data within reports.			
1.4.3.18	Provide the ability to direct all report output to the report management and repository system.			
1.5	**Rule-Based Engine**			
1.5.1	General Requirements			
1.5.1.1	Provide a rule-based engine with the capacity to support ODJFS policy needs.			
1.5.1.2	Provide the ability add, modify, or obsolete ODJFS business rules on-line.			
1.5.1.3	Maintain a rules repository for on-line viewing.			
1.5.1.4	Provide on-line user configuration to create and/or maintain rules such as: • Procedure code • Claim edits and audit disposition • Benefit plan creation and maintenance.			
1.5.1.5	Use rule-based logic for MITS business functions such as claims and PA processing, document and work flow management, ~~eligibility determination,~~ and benefit package definition.			

MITS Business Requirement "Functional Fit" Survey				
Business Infrastructure				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
1.5.1.6	Match data attributes of the claim to the rule repository that include rules regarding ODJFS policy/benefit package and edit disposition.			
1.5.1.7	Provide role-based on-line, real-time modifications of rule-based tables and configuration of benefit packages.			
1.5.1.8	Provide on-line capability to easily add, end date, or modify health plan(s) and/or its related components.			
1.5.1.9	Use Windows interface to configure policy by relating attributes available in drop-down menus.			
1.5.1.10	Provide on-line help features.			
1.5.1.11	Retain an audit trail for all rule-based user actions (e.g., add, change, or end date).			
1.5.1.12	Limit or eliminate the need for programming /technical support.			
1.5.1.13	Provide the capability to instantly view the effect of changes.			
1.5.1.14	Provide the capability to view on-line rules used to process a claim, claim adjustment, or prior authorization.			
1.5.1.15	Utilize plain language business rules and processes to define program logic.			
1.5.2	Rule Representation/Administration/Scalability			
1.5.2.1	Provide the rule representation such as: • Jump start vocabularies • Multiple rule representation (e.g., decision tables, pseudo-linguistic with context) • Rule sequencing • Definition of macros and cascading meanings • Rule inheritance • Rule consistency checks • Rule collision checks • Rule overlap and “under-lap” checks • Lexicon support • Upon rule entry, link rule test to the rule.			
1.5.2.2	Provide easy administration such as: • Easy to change rules • Easy to test rules • Easy to visualize rule-firing sequencing • Expert help • Ruling-firing audit report capabilities • Ability to used in a wizard/plug-in for multiple development environments • Dynamic rule change support • Rules separate from engine • Supports rule extensibility • Integration/Coordination of distributed rules engine with a corporate master • Ability to re-run the engine for a point that has passed (e.g., after 1 January, able to rerun year end jobs with 31 December rules) • Constraints are naturally supported.			
1.5.2.3	Provide scalability for future business needs such as: • Must handle more than 20,000 rules			

MITS Business Requirement "Functional Fit" Survey				
Business Infrastructure				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
	• Ability to share rule sets across multiple engines • Dynamic and static execution of versions • Multiple, cross-platform support • Pre-built in rule paths • Rule pre-fetch memory • Parallel rule search.			
1.5.2.4	Provide the capability to compile rule sequences in basic languages.			
1.5.2.5	Link with business activity monitoring and optimization.			
1.5.2.6	Support multiple rule methodologies.			
1.5.2.7	Provide links to accomplish MITS enterprise-wide solution.			
1.5.3	Rule Maintenance			
1.5.3.1	Provide a strong rule management environment.			
1.5.3.2	Provide maintenance to support parallel rule execution.			
1.5.3.3	Support rule aggregation.			
1.5.3.4	Provide rule change impact analysis.			
1.5.3.5	Provide a master listing of rule integration/coordination.			
1.5.3.6	Provide the capability to enter new rules or changes to become effective on a future date.			
1.5.3.7	Provide rule consistency/collision checks.			
1.5.3.8	Provide rule versioning and release versioning and rollback.			
1.5.3.9	Provide role-based access.			
1.5.3.10	Provide rule security.			
1.5.3.11	Provide triggers and outputs.			
1.6	**Medicaid Management Information System (MMIS) Compliance**			
1.6.1	Overall Requirements			
1.6.1.1	Implement and maintain a certifiable MMIS.			
1.6.1.2	Meet all CMS certification requirements at implementation and throughout operations.			
1.6.1.3	Assure MMIS certification is valid throughout the term of the contract.			
1.7	**Disaster Recovery and Contingency Planning**			
1.7.1	Overall Requirements			
1.7.1.1	Compliance with State and Federal disaster recovery regulations and standards as defined by the State. Regulations and guidelines include: • HIPAA Security: Security Standards; Final Rule at 45 Code of Federal Regulations (CFR) Parts 150, 162, and 164 • Automatic Data Processing Physical Security and Risk Management (Federal Information Processing Standard (FIPS) Publication (PUB) 31) • Computer Security Guidelines for Implementing the Privacy Act of 1974 (FIPS PUB 41) • Guidelines for Security of Computer Applications (FIPS PUB 73), and Federal Regulations at 45 CFR 95.621.			
1.7.1.2	Provide a Disaster Recovery/Business Continuity Plan that complies with Federal and State rules and regulations, including at a minimum: • Daily back-up which is adequate and secure for all computer software and operating programs; databases; files; and system, operation, and user documentation (in electronic and non-electronic form) • Full and complete back-up copies of all data and software on tape and/or optical disk			

MITS Business Requirement "Functional Fit" Survey				
Business Infrastructure				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
	• Storage of all back-up copies in a secure off-site location • Routine testing to verify the completeness, integrity, and availability of back-up information • Support for immediate restoration and recovery of lost or corrupted data or software from a disaster event • Provide for back-up processing capability at a remote site(s) from the primary site(s) such that normal payment processing, as well as other State defined systems and services can continue in the event of a disaster or major hardware problem at the primary site(s).			
1.7.1.3	Provide sufficient transaction logging and database back-up to allow it to be restored. If multiple databases are used for work item routing and program data, restoration must ensure that databases are synchronized to prevent data corruption.			
1.7.1.4	Address, at a minimum, the following areas in the Disaster Recovery/Business Continuity Plan: • Business functions and other dependent functions that must be maintained • Business function priority • Business impact analysis including potential impact of loss of critical business functions • Recovery time for each major business function, based on priority • Level of services that must be restored • Role and responsibilities for the System Risk Management team • Legal/regulatory/contractual issues • Critical systems dependencies • Business workflow and workaround procedures • Criteria for executing the Business Continuity Plan • Alternate processing methods • Performance metrics • Recording and updating business events information, files, data updates, etc., once business processes have been restored • Key business information that would be required within 24/48 hours of a declared disaster/event. • Key stakeholders and business partners communication • Escalation procedures • Critical personnel (Vendor and ODJFS) to be contacted • Security procedures for protection of data.			
1.7.1.5	Provide back-up and disaster recovery plan for information submitted to Medicaid Portal, but not yet entered into MITS.			
1.8	**Notifications/Alerts**			
1.8.1	Overall Requirements			
1.8.1.1	Provide the ability to generate alerts.			
1.8.1.2	Provide the ability to generate individual system generated alerts with user-defined criteria (e.g., time intervals, events).			
1.8.1.3	Provide the ability to generate alerts when changes are made to policies and procedures and system tables or functionality.			
1.8.1.4	Provide the ability to generate alerts when the anticipated return time on a query or report job exceeds a defined time limit.			

MITS Business Requirement "Functional Fit" Survey				
Business Infrastructure				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
1.8.1.5	Provide the ability to generate alerts that assist in monitoring time-sensitive activities.			
1.8.1.6	Provide the ability to generate alerts to a user-defined group or individual.			
1.8.1.7	Provide the ability to generate alerts to staff based on the status or prior authorizations.			
1.8.1.8	Provide the ability to generate alerts to notify staff when they need to take action in connection with workflow events.			
1.9	**General System Performance Expectations**			
1.9.1	Overall Capacity and Throughput			
1.9.1.1	Provide, without any degradation in performance, concurrent access, through the State Wide Area Network (WAN), for at least five thousand (5,000) users. This includes eighty-eight (88) counties, sub-recipient State agencies, stakeholders and other State contractors.			
1.9.1.2	Provide sufficient capacity to handle the following processing volumes during times of peak operation while also meeting system response time requirements: • Adjudicate at a minimum 875,000 claims per day • Adjudicate at a minimum 200,000 encounters per day • Capacity to accept at a minimum 3.375 million pharmacy claims into payment on a monthly basis • Process at a minimum 1,750 claim adjustments per month • Process at a minimum 20,000 Prior Authorization (PA) requests per month • Support at a minimum 11,250 refunds per month • Support at a minimum 12,500 ~~various types of~~ **** other types of adjustments **** per month ****, excluding LTC adjustments **** • Support at a minimum 25,000 LTC adjustments per month • Support at a minimum 6,250 claim reversals per month • Support at a minimum 500,000 adjustments per month when mass/gross adjustments are executed • Image, index, and store at a minimum 50,000 pages per day • Handle workflow management for simultaneous processes (e.g., contracts, benefit package definition, etc.) • Support up to 50 reports running concurrently • Receive, log, and address at a minimum 55,000 customer calls through CRM per month.			
1.9.1.3	Provide sufficient data communication and processing capacity during times of peak operation to receive and process: • EDI transactions o Process at a minimum ****3.7**** ~~0.3~~ million Accredited Standards Committee (ASC) X12 270/271 eligibility inquiries and responses per month o Process at a minimum 3 million American National Standards Institute (ANSI) X.12 276/277 claim status inquiries and responses per month o Process at a minimum 6 million ANSI X.12 835 remittance transactions per month			

MITS Business Requirement "Functional Fit" Survey				
Business Infrastructure				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
	o Process at a minimum 3.7 million ANSI X.12 837 claim transactions per month o Process at a minimum 4.8 million responses or turnaround transactions (824, U277, 997, 999, TA1) per month.			
1.9.1.4	Build into the MITS architecture sufficient scalability to handle a 5% annual increase from "day one" peak volumes for a minimum of ten years.			
1.9.2	Response Times			
1.9.2.1	Meet system response time requirements. Response time shall be measured during normal working hours, which are 6:00 a.m. to 7:00 p.m., Eastern Time, Monday through Friday, and on Saturdays 8:00 a.m. to 12:00 p.m., Easterb Time except for State observed holidays. The Medicaid Portal response times will be measured 7 days a week, 24 hours a day, except during agreed upon downtime. The response time definitions do not apply to the data warehouse/DSS. The Vendor will only be responsible for that portion of the system and communication link for which the Vendor has responsibility and control. For example, the Vendor will not be responsible for the response times while a transmission is traveling over the State's LAN. The same logic will apply to transactions over the network controlled by the switch vendor, or individual providers, or their billing agents and services. The following definitions apply to networked workstations: • Record Search Time -- The time elapsed after the search command is entered until the list of matching records appears on the monitor • Record Retrieval Time -- The time elapsed after the retrieve command is entered until the record data appears on the monitor • Screen Edit Time -- The time elapsed after the last field is filled on the screen with an enter command until all field entries are edited with the errors highlighted • New Screen/Page Time -- The time elapsed from the time a new screen is requested until the data from the screen appears on the monitor • Print Initiation Time -- The elapsed time from the command to print a screen or report until it appears in the appropriate queue • Medicaid Portal Response Time -- The elapsed time from the command to view a response until the response begins to appear on the screen.			
1.9.2.2	Ensure that MITS components' response times meet the following minimum standards. Times will be measured for adherence to the requirements at the ODJFS' discretion. The Vendor must provide a system to monitor and report on response times. The response time requirements do not apply to the data warehouse/DSS. • Record Search Time -- The response time must be within four (4) seconds for 95 percent of record searches • Record Retrieval Time -- The response time must be within four (4) seconds for 95 percent of records retrieved • Screen Edit Time -- The response time must be within two (2) seconds for 95 percent of the time • New Screen/Page Time -- The response time must be within two (2) seconds for 95 percent of the time			

MITS Business Requirement "Functional Fit" Survey				
Business Infrastructure				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
	• Print Initiation Time -- The response time must be within two (2) seconds for 95 percent of the time • Medicaid Portal Response Time -- The response time must be within four (4) seconds for 99 percent of the time.			
1.9.2.3	****Operational**** ~~R~~reports must be generated according to the following timelines: • Daily reports delivered by noon of the next business day • Weekly reports and cycle processing report by noon of the next business day after the scheduled run • Monthly reports by noon within five (5) business days following the end of the month • Quarterly reports by noon within five (5) business days following the end of the quarter • Annual reports by noon within ten (10) business days following end of the year (Federal fiscal, State fiscal, or other annual cycle). • Ad-hoc and on-demand reports within the timeframes defined by ODJFS in the report request~~, but normally within five (5) seconds after the request is initiated ninety-five percent (95%) of the time~~. **** The State and the contractor will work collaboratively to define and set benchmark data queries to support the evaluation of ad hoc reports performance during the design phase of the project. ****			
1.9.3	Availability			
1.9.3.1	MITS access must be available at a minimum during ODJFS core working hours, which are 6:00 a.m. to 7:00 p.m., Eastern Standard Time, Monday through Friday, and on Saturdays 8:00 a.m. to 12:00 p.m., Eastern Standard Time, except for State observed holidays, and on an emergency basis if requested by the State.			
1.9.3.2	Data base system is available and accessible to multiple users 24X7 except for ODJFS-approved time for system maintenance.			
1.9.3.3	The Medicaid Portal, and other system components as required by ODJFS, must be available 7 days a week, 24 hours a day, except agreed upon downtime.			
1.9.4	Error Handling and Trouble Reports			
1.9.4.1	Submit system trouble reports to ODJFS-designated staff no later than close of business on the day the problems are identified.			
1.9.4.2	Notify ODJFS-designated staff of any system problem within one (1) hour of problem discovery.			
1.9.5	Protection Against Unauthorized Access			
1.9.5.1	The system shall provide security from anticipated threats or hazards to its data and shall restrict the availability of data to appropriate State staff and to other designated individuals and organizations through standardized system applications and data security capabilities.			
1.9.5.2	Ensure that all applications are protected against unauthorized access according to State and Federal guidelines. Additionally, all transmission lines and communications services and linkages between the data and each information system, and between each system and the LAN, must be secure from unauthorized access at all times.			

MITS Business Requirement "Functional Fit" Survey				
Member Services				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
2.1	**Consumer Eligibility & Enrollment**			
2.1.1	Requirements			
2.1.1.1	Maintain a principal repository for Medicaid eligibility data. In the event that data is stored in multiple systems, those systems must support near real-time synchronization and update capabilities.			
2.1.1.2	Maintain near real-time updates on all eligibility files from the eligibility systems.			
2.1.1.3	Maintain and display current and historical consumer eligibility data required to support ID card production, claims and premium processing, Social Security payment status, prior authorization processing, inquiry, eligibility verification and reporting to include, at a minimum: • Unique and/or universal consumer identifiers from the eligibility systems • Time-dependant eligibility data, including consumer eligibility group and program codes • Demographics, including race/ethnicity and preferred language • Third party coverage including benefit package information (private insurance, Medicare) • Premium assistance eligibility and activity (Medicare, employer-sponsored insurance) • Cost share amounts (spend-down/deduction, client liability, premiums, deductibles) • Managed care program membership status • LTC level of care authorization • Hospice enrollment • Waiver program enrollment • ID card status, to include replacement reasons • Service restriction (lock-in, limited benefit eligibility) • Healthchek status • Claims history • Percent of Federal poverty level of family • Residence and mailing address(es) • Phone numbers (home, cell, etc.) • Email address • Family income earned by source • Individual income earned by source • Family size (not assistance group size) • Application date • Signature date • Approval date • Retro and back dated eligibility flags • Geo-coded information, including X, Y census tracking information.			

MITS Business Requirement "Functional Fit" Survey				
Member Services				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
2.1.1.4	Provide authorized users limited role-based access to all current and historical consumer data by consumer ID number, name or partial name, Social Security number and the ability to use other factors such as gender and date of birth and/or county to limit the search. Partial name search must be provided through use of a proven mnemonic/phonetic algorithm.			
2.1.1.5	Maintain a unique universal consumer ID number provided by the eligibility systems for each consumer with capability to store ID numbers that are up to twelve (12) characters in history as directed by ODJFS.			
2.1.1.6	Utilize the following consumer identifiers as keys to the consumer eligibility files: • Unique consumer ID number from the eligibility systems • The ODJFS electronic eligibility determination systems case number (currently Client Registry Information System-Enhanced (CRIS-E) and SACWIS) • Names (current and historical) • Date of birth • Gender • Social Security Number (SSN).			
2.1.1.7	Provide an automated link to claims for the consumer under current and historical names and ID numbers.			
2.1.1.8	Provide an automated link to secondary demographic information such as: • Actual county of residence for consumers certified by a specialized agency that doesn't have the county identified by the agency code • Specific office locations within a county.			
2.1.1.9	Link all members of a Medicaid assistance group together and easily identify all members of that group, whether currently eligible or not.			
2.1.1.10	Link to demographic information in the eligibility system for Medicaid assistance group information to be used for other MITS processes (e.g., coordination of benefits, managed care, data warehouse interface, and mailings).			
2.1.1.11	Incorporate audit trails to allow information on all consumer update source transactions to be traced through the processing stages to the point where the information is finally recorded, regardless of the method used to update.			
2.1.1.12	Trace data from the final place of recording back to its source.			
2.1.1.13	Provide, at a minimum, audit trails to verify that update transactions are processed, to include an update source identifier, original date received, date processed, all data as sent from the update source, and if edits are set, the edit identifier and date the edit was resolved.			
2.1.1.14	Maintain an audit trail of changes to consumer data at the field or line level rather than at a higher tracking level of last change to screen or file.			

MITS Business Requirement "Functional Fit" Survey				
Member Services				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
2.1.1.15	Provide role-based access to authorized users to manually add/change MITS data via batch and/or on-line updates.			
2.1.1.16	Ensure that updates to consumer eligibility accurately track to the correct benefit package.			
2.1.1.17	Edit all systematic consumer update transactions for data presence, format, validity, and consistency with other data in the update transaction.			
2.1.1.18	Perform on-line data presence, validity, format, and relationship edits for manually entered updates.			
2.1.1.19	Produce consumer error reports for each eligibility transaction from the eligibility system that fails one (1) or more edits.			
2.1.1.20	Provide the capability to correct eligibility information on-line using day-specific start and termination dates, including the ability to reverse eligibility status before the eligibility start date and link back to the eligibility system of record.			
2.1.1.21	Link to the reason eligibility was terminated from the eligibility systems.			
2.1.1.22	Maintain an audit trail of the eligibility status code and benefit package assigned by the administrative agency that will be utilized for claims processing and Federal reporting categories.			
2.1.1.23	Provide a system to track premium amount(s) owed and received to include: • Consumer • Period for which payment owed • Amount owed • Date payment received • Payment method • Primary payer • Outstanding payments • Payment discrepancy reports • Program for which premium is owed.			
2.1.1.24	Allow for providers to electronically submit invoice(s) information for spend-down calculation.			
2.1.1.25	Use flexible, rule-based logic to support all processes that access and use eligibility data, including in the rules, data such as medical status codes, medical eligibility coverage groups and, program identifiers that include multiple program eligibility.			
2.1.1.26	Identify and prevent, to the extent possible, potential duplicate consumer records from updating and systematically combine the files of definite duplicate consumer records during initial update and ongoing.			
2.1.1.27	Allow benefit package to be changed by authorized individuals.			
2.1.1.28	Prevent, or recoup, claims payment for services rendered after date of death.			
2.1.1.29	Transmit all updates and add consumer subsystem data to the data warehouse.			

MITS Business Requirement "Functional Fit" Survey				
Member Services				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
2.1.1.30	Process updates to cost share amounts received daily from certifying agencies or ODJFS for consumers that have spend-down, deductible, patient liability, waiver cost share enrollment fees, or premium obligations.			
2.1.1.31	Update Medicaid eligibility for Section 1619a&b eligibles, as directed by ODJFS and as received from the State eligibility system(s).			
2.1.1.32	Provide the capability to create and distribute annual surveys to eligible groups.			
2.1.1.33	Process consumer hospice election and program withdrawal forms received from providers, updating the consumer's file for use in claims processing.			
2.1.1.34	Monitor and coordinate file information upon initial enrollment of hospice consumers that are residing in a nursing facility.			
2.1.1.35	Maintain information on presumptive eligibility, family planning waivers, and other programs as directed by ODJFS, assigning a unique ID number, if necessary, and produce consumer notification letters.			
2.1.1.36	Query Social Security Administration (SSA) on-line for Medicare information using State On-line Query to Social Security (SOLQ) as directed by ODJFS.			
2.1.1.37	Receive, process, and maintain consumer restriction data to support the claims processing functions, including restricted benefit packages, service types/codes, consumer lock-in enrollment, and effective start and end dates.			
2.1.1.38	Ensure that consumer data is routinely purged, archived as historical information, and protected from destruction, according to State and Federal requirements and on a schedule approved by ODJFS.			
2.1.1.39	Notify certifying agency workers when MITS is updated with newborn eligibility from reports received from providers.			
2.1.1.40	Provide role-based access to the consumer eligibility information using a variety of secure methods, including the Medicaid Portal, on-line direct connection through dial-up lines, switch vendor products, Eligibility Verification Systems (EVSs), and telephone to an Interactive Voice Response (IVR) line and/or eligibility staff person. Data provided for the eligibility verification includes: • Waiver enrollment • Dates of program eligibility • Managed care programs enrollment • Commercial health insurance coverage • Medicare coverage • Provider lock-in • Hospice enrollment • Limited benefit information • Medicaid, spend-down, consumer liability and deductible balances • Long term care liability and cost share amounts • Demographic information such as county of residence			

MITS Business Requirement "Functional Fit" Survey				
Member Services				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
	• Health Personnel Shortage Area (HPSA) • Medical benefit package			
2.1.1.41	Maintain role-based secure access to all current and historical (consumer lifetime) date-specific consumer eligibility information (7 years on-line and archived and retrievable in electronic form beyond that), per ODJFS guidelines.			
2.1.1.42	Phase 2 - Integrate State-provided standard card reader systems with MITS that provide labor saving efficiencies to the provider and consumer, for example, conducting eligibility and spend-down inquiries. There is a potential of 875,000 transactions per day from 36,000 providers.			
2.1.1.43	Phase 2 Include multiple card reader methods (There is a potential of 875,000 transactions per day from 36,000 providers.) such as: • Readers connected to personal computers that conduct eligibility and spend-down inquiries over the Internet • Readers compatible with point of sale systems from other industries such as credit card and debit card readers • Stand alone readers that provide eligibility inquiry and spend-down functionality via a connection to a phone line.			
2.1.1.44	Display and/or print all of the eligibility data that can be returned on a HIPAA 271 Eligibility Response transaction.			
2.1.1.45	Display and/or print consumers current spend-down information.			
2.1.1.46	Transmit monthly consumer premium no pay and late pay records to the Statewide eligibility determination system according to the ODJFS-defined schedule.			
2.1.1.47	Store and utilize consumer specific information to link benefit packages that identify specific services available to the consumer.			
2.1.1.48	Provide role-based access to individual eligibility data for budget forecasting to staff designated by ODJFS.			
2.1.1.49	Build in data quality assurance measures such as identification of error prone profiles.			
2.1.1.50	Provide the capability to receive date of death information from various sources (e.g., county board of health, hospitals, etc.), validate data against an external vital statistics database, and update consumer eligibility records.			
2.1.1.51	Provide the capability to generate a report that provides specified information for all recipients served by an identified provider or providers for a specific date span.			
2.1.1.52	Provide the capability to receive, store, and report on information related to the operation of a Long Term Care Insurance Partnership program.			
2.2	**Coordination of Benefits (COB)/Third Party Liability (TPL)**			
2.2.1	Requirements			
2.2.1.1	Support the management of TPL information as defined by the State per Federal guidelines.			
2.2.1.2	Receive, store, and process TPL information from various eligibility system sources (currently CRIS-E, Support Enforcement Tracking System (SETS), and SACWIS).			

MITS Business Requirement "Functional Fit" Survey				
Member Services				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
2.2.1.3	Query an ODJFS-defined list of insurance carriers (including at least the top ten) within one business day of eligibility to determine whether new or re-determined Medicaid consumers have other healthcare benefits.			
2.2.1.4	Query Federal Beneficiary and Earnings Data Exchange (BENDEX) information within one business day of eligibility to determine whether new or re-determined consumers have other healthcare benefits.			
2.2.1.5	Maintain all third party coverage information and benefit package information, including multiple TPL sources, for Medicaid consumers for all periods of eligibility.			
2.2.1.6	Maintain all third party resource information at the consumer specific level, consistent with ASC X12N 270/271 transactions, including: • Insurance Carrier name and ODJFS-defined identifier (NAIC and/or National Plan Identifier (NPI)) • Policy number and group number • Effective date and end date of coverage, if applicable • Add date, change date and verification date of insurance • Type of Insurance (e.g., MCP, Preferred Provider Organizations (PPO), Indemnity plan, etc.) • Source and type of insurance information identifier • Policy holder name, address, SSN, date of birth, relationship to insured, employer name and address • Coverage types (e.g., hospital, surgical, vision/dental plan, pharmacy, etc.) included in a TPL matrix to be used in claims adjudication • Medicare Parts A, B, C, D • Supplemental (Medi-Gap policy).			
2.2.1.7	Maintain a file of all insurance carriers that includes: • Carrier name and identifier (NAIC and/or NPI) • Technical entity contact information, including phone number • Corporate contact name, address, and telephone number • Claims submission address and phone number • Indicators of participation in insurance disclosure, billing media (e.g., clearinghouses, trading partners, etc.) effective and end dates of activity • Active/inactive status • Group and policy numbers and benefit packages supported by individual insurance carriers.			
2.2.1.8	Provide a flexible interface that receives and stores TPL coverage information from a variety of external systems and sources, including Medicare, Managed Care Organizations, absent parent information from counties, and providers, and that accepts EDI 270/271 transactions.			
2.2.1.9	Maintain audit trails for all changes/updates to consumer insurance data including those that were unable to be applied.			

MITS Business Requirement "Functional Fit" Survey				
Member Services				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
2.2.1.10	Provide ODJFS staff with inquiry access to TPL case tracking information and TPL accounts receivable based on ODJFS-defined roles.			
2.2.1.11	Generate annual extract to Defense Enrollment Eligibility Reporting System (DEERS) and process response records according to Department of Defense (DOD) schedule.			
2.2.1.12	Provide the capability, using business rules, to specify and change the order of ODJFS payment with respect to TPL as required. (For instance, Medicaid is usually the payer of last resort, but for children with medical handicaps and victims of crime, those programs are the payer of last resort.)			
2.2.1.13	Provide download of consumer files to TPL post pay recovery vendor as per TPL post pay contract.			
2.2.1.14	Provide monthly verified TPL data, including Medicare, to the ODJFS contracting Medicaid MCPs.			
2.2.1.15	Provide a daily file of verified TPL data, including Medicare, to the Selection Services Contractor (SSC).			
2.2.1.16	Provide the ability to update TPL data on-line based upon authorized role-based access and with appropriate audit trails.			
2.2.1.17	Generate verification at ODJFS-defined intervals, of TPL information for Medicaid consumers using TPL clearinghouses utilizing EDI 270/271.			
2.2.1.18	Provide for on-line letter creation, generation, maintenance, modification, tracking, storage, and historical viewing of standard and ad hoc letters.			
2.2.1.19	Provide for mass change or archiving of TPL records affected by dissolved insurance companies or employers.			
2.2.1.20	~~Integrate functions within an existing TPL contract, an EDI exchange contract, and a child support contract, as needed.~~			
2.2.1.21	Provide statistical reports from the TPL interface tracking file, the TPL Master File, and the 270/271 exchange.			
2.2.1.22	Provide near real-time access of the TPL database to contributing source systems using role-based access defined by the ODJFS.			
2.3	**Managed Care Programs Membership**			
2.3.1	Requirements			
2.3.1.1	Implement secure on-line communications with MCPs and other medical professionals facilitate the transfer of information in compliance with HIPAA security and privacy standards.			
2.3.1.2	Accommodate near real-time program modifications and maintenance for care management programs, including: policy and process changes, edit and audit implementation, MCP participation changes, benefit coverage, service areas, program indicators, premium payment/procedure code and reporting requirements.			
2.3.1.3	Maintain, display on-line and utilize for the membership process, the following care management programs data: • Maximum number of members allowed for each MCP			

MITS Business Requirement "Functional Fit" Survey				
Member Services				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
	• Current number (aggregate) of members for each MCP on a monthly basis • Open/closed indicator to display whether MCP is eligible for new members • Primary and extended service areas.			
2.3.1.4	Track MCP availability to accept membership by assignment, reenrollment or choice, based on the current number of MCP members.			
2.3.1.5	Increment and/or decrement the number of eligible individuals assigned to the MCP, as members are added or terminated on a near real-time basis.			
2.3.1.6	Provide ODJFS staff with role-based near real-time access to activate or deactivate assignment, auto-reenrollment and choice, by MCP or by service area.			
2.3.1.7	Track MCP service areas and optional benefit coverage.			
2.3.1.8	Determine whether individuals are eligible for voluntary or mandatory MCP membership based on service area and/or program type following ODJFS-defined criteria.			
2.3.1.9	Select and assign, or reassign, all assistance group members eligible for membership in the same MCP based on ODJFS-defined criteria.			
2.3.1.10	Allow all Assistance Group (AG) members to be enrolled in an MCP even if the plan's maximum membership is reached after one (1+) or more case members are enrolled.			
2.3.1.11	Allow AG members to be enrolled in different MCP plans based on ODJFS policy as captured in business rules.			
2.3.1.12	Allow individuals to be enrolled in more than one MCP plan based on ODJFS policy as captured in business rules.			
2.3.1.13	Allow membership lock-in of a member to an MCP for a specific amount of time, according to ODJFS policy.			
2.3.1.14	Calculate the begin and end dates for membership lock-in based on ODJFS-defined criteria.			
2.3.1.15	Provide for day-specific MCP membership begin dates.			
2.3.1.16	Retroactively add/terminate newborns and others based on ODJFS-defined managed care criteria.			
2.3.1.17	Provide an audit trail of all MCP membership transactions and changes to enrollment including at a minimum: changes made, date of change, reason for change, and user ID of the individual making the change.			
2.3.1.18	Identify dual-eligibles (Medicaid and Medicare) and prevent them from being placed in an MCP according to ODJFS-defined criteria.			
2.3.1.19	Allow for "carve-outs" of premium payments or split premium payment according to ODJFS-defined criteria.			
2.3.1.20	Provide ODJFS with a role-based capability to maintain the provider charge file for Comprehensive Managed Care (CMC) program and CM rates.			

MITS Business Requirement "Functional Fit" Survey				
Member Services				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
2.3.1.21	Assure Bureau of Managed Health Care (BMHC) ability to hold and divert funds from the monthly premium check of those MCPs that have been fined.			
2.3.1.22	Retain at least seven years of premium payment data on-line.			
2.3.1.23	Provide a capability for authorized role-based users to enter case notes via the CRM, using access channels including the Medicaid Portal and secure wireless hand-held devices.			
2.3.1.24	Ensure continuity of eligibility and CMC/CM membership data across all repositories.			
2.3.1.25	Enable SSC to transmit CMC and CM membership data to the ODJFS eligibility file in a secure electronic format.			
2.3.1.26	Assign eligible consumers to MCPs based on MCP service area and/or program type according to ODJFS-defined criteria.			
2.3.1.27	Exempt certain terminated members from the auto-reenrollment process, based on ODJFS-defined criteria.			
2.3.1.28	Provide the capability for the SSC to enter membership additions/changes/deletions on-line or in batch mode, per ODJFS policy.			
2.3.1.29	Provide the capability to the SSC or other enrollment entity to enter MCP and other capitated programs membership data using on-line screens per ODJFS-defined criteria.			
2.3.1.30	Limit MCP membership changes to periods of time based on ODJFS-defined criteria.			
2.3.1.31	Generate and send via the CRM ODJFS-approved MCP membership materials to eligible individuals, at a minimum, on a weekly basis.			
2.3.1.32	Generate and electronically transmit eligibility and demographic information for all MCP eligible consumers to the SSC on a daily basis.			
2.3.1.33	Generate and send letters via the CRM to MCP new members and terminating members per ODJFS policy.			
2.3.1.34	Maintain and display on-line MCP member data including the following: • The MCP for each effective data span • Effective date of membership • Effective date of termination of membership • MCP lock-in dates and assignment indicator • Reason codes for membership or termination of • Membership exemption codes ~~• MCP morbidity codes~~ • County or region-specific codes.			
2.3.1.35	Provide for the automatic re-enrollment in the same MCP for members who lose Medicaid eligibility but regain eligibility within a specified period of time without the members having to go through the initial enrollment process.			
2.3.1.36	Accept and process MCP membership data received electronically from ODJFS' eligibility system(s), and **** data entered **** manually ~~from other sources~~ **** by MITS users.****			

MITS Business Requirement "Functional Fit" Survey				
Member Services				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
2.3.1.37	Allow authorized, role-based access to users to override MCP membership, as defined by ODJFS.			
2.3.1.38	Generate electronic and/or hard copy reports of members for distribution to MCPs. Electronic transmissions (e.g., 834 transactions) must comply with State and Federal requirements.			
2.3.1.39	Send member status information to MCPs on a daily, weekly or other schedule, as defined by ODJFS.			
2.3.1.40	Identify and generate letters to MCP members impacted by a global change in MCP service areas, ownership or participation in the Medicaid program.			
2.3.1.41	Generate and send letters to MCP members at least sixty days prior to the annual open selection month for their county/region of residence to notify them of their option to change plans.			
2.3.1.42	Support on-line change to assignment, reenrollment and choice options, by managed care organizations or by service area as directed by the ODJFS.			
2.3.1.43	Base termination of MCP membership on ODJFS-defined criteria.			
2.3.1.44	Terminate or change MCP membership and/or exempt eligible individuals from MCP membership on-line or via batch processing.			
2.3.1.45	Provide the capability to move multiple members from one MCP to another MCP or to fee-for-service, based on ODJFS-defined criteria.			
2.3.1.46	Provide the capability for date-specific termination of membership (e.g., death) or MCP membership changes.			
2.3.1.47	Provide the capability to retroactively change MCP membership enrollment or termination-of-membership and adjust premium payments accordingly.			
2.3.1.48	Track the membership status for each assistance group (AG) member.			
2.3.1.49	Enable SSC to submit membership exception requests (e.g., just cause) to ODJFS via a secure electronic format.			
2.3.1.50	Enable MCPs to retrieve reconciliation templates and submit completed reconciliation files via the Medicaid Portal.			
2.3.1.51	Automatically route all incoming reconciliation files to appropriate ODJFS staff and notify them of their arrival.			
2.3.1.52	Identify all potential duplicate member files for analysis and resolution prior to membership effective date to avoid paying duplicate premium payments to the MCP(s).			
2.3.1.53	Calculate premium payments based on current or retroactive membership dates.			
2.3.1.54	Generate HIPAA 820 transactions to all MCPs including those MCPs that have a negative premium payment balance for the month. (The transactions must contain data about every premium owed for the current month, any retroactive months (adjustments), and any claim credit reversals (take back of premium payments) owed to the State.)			

MITS Business Requirement "Functional Fit" Survey				
Member Services				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
2.3.1.55	Provide the capability to define reports that will be run on a regular schedule as well as produce ad hoc reports based on ODJFS-defined criteria.			
2.3.1.56	Allow for staff to receive, access, query, and generate reports on: • Grievance data reports submitted by the MCP • Consumer contact records provided by the SSC • Just Cause requests for termination or change of membership • Continuity of care membership deferment requests • Inpatient hospital membership deferment requests • Exclusion request actions, statistics, and correspondence • Newborn notification records.			
2.3.1.57	Provide the capability to ODJFS-designated staff to perform on-line queries of premium payments by member and by month.			
2.3.1.58	Provide status reports that detail the accuracy and timeliness of MCP membership processing by the SSC.			
2.3.1.59	Identify errors or exceptions prior to the next membership and premium payment cycle after entry of new or changed data to prevent inaccurate membership reporting and/or premium payments to the MCPs.			
2.3.1.60	Periodically reconcile membership data across repositories (eligibility systems and MITS) on a ODJFS-defined time schedule.			
2.3.1.61	Allow ad hoc queries for premium reports by age, gender, county, or cap code for MCP.			
2.4	**Special Enrollment**			
2.4.1	Requirements			
2.4.1.1	Phase 2 Utilize EDMS workflow technology to manage and track all LTC facility and waiver programs including: • Aging • ODJFS programs • LTC facilities • Mental Retardation/Developmental Disabilities (MR/DD) programs • Hospice.			
2.4.1.2	Accept and store into MITS in support of claims adjudication: • Prior authorized services, hours, and limits • Provider demographic and rate data including room and board versus health care costs • Cost share data.			
2.4.1.3	Retain the following eligibility information transferred from the State eligibility system for the purposes of claims adjudication: • Application dates (ELIG) • Request for enrollment/dis-enrollment including dates (ELIG) • Level Of Care (LOC) determination (ELIG) • Assessment date (ELIG) • Approval dates (ELIG) • Letter generation (consumer notice or other type of notification) (ELIG) • Track level of care changes (ELIG)			

MITS Business Requirement "Functional Fit" Survey				
Member Services				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
	• Effective date or the date of change for level of care determination (ELIG) • PASRR review (ELIG) • Reason codes for any component denial (ELIG) • Denial dates (ELIG).			
2.4.1.4	Provide an automated eligibility determination recommendation process that will be presented to a State-identified individual for service authorization approval (ELIG).			
2.4.1.5	Provide role-based access via the Medicaid Portal to State-authorized sub-recipient State agencies to include: MR/DD, Passport Administrative Agencies, ODA, ODH, and ODMH. Web access would be limited to State-defined functions including inquiry and form completion.			
2.4.1.6	Provide an automated alert process to notify responsible agency of adverse PASRR, LOC, or financial eligibility determinations and alerts for changes in program and/or financial eligibility according to State-defined criteria (ELIG).			
2.4.1.7	Provide a presumptive eligibility process allowing for claim payments using State-defined financial and program eligibility criteria and circumstances. This process would use State-defined hierarchal relationships that would supersede overlapping eligibility spans, such as spend-down cases. This functionality would be program specific.			
2.4.1.8	Provide an automated process for suspension of waiver claims without affecting consumers' waiver eligibility. Must allow for concurrent eligibility spans but not allow for payments of claims for both institutions and waivers except as defined by ODJFS.			
2.4.1.9	Provide role-based access to all waiver data for tracking, oversight, research, and planning purposes.			
2.4.1.10	Provide and maintain a secure hearing tracking and reporting process based on program-specific criteria.			
2.4.1.11	Provide the capacity for the development, generation, and distribution of State-defined waiver program reports.			
2.4.1.12	Establish and track costs against a definitive person-specific cost cap for waivers.			
2.4.1.13	Verify cost cap, authorized provider, and authorized units of goods and services when adjudicating claims, including an option for plan of care.			
2.4.1.14	Authorize waiver and LTC facility services for a specific time period (e.g., six (6) months or one (1) year) as defined by the State.			
2.4.1.15	Notify waiver program staff if the specific dollar amount or units are reached and future claims will not be paid.			
2.4.1.16	Accept hospice enrollment information records/forms from a variety of sources (hospice providers, various data bases) and via a variety of formats and media (Medicaid Portal, EDI, fax, paper, etc).			

MITS Business Requirement "Functional Fit" Survey				
Member Services				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
2.4.1.17	Validate submitted information against health plan member records/files and incoming hospice enrollment information records/forms, and use business rules approved by ODJFS to resolve discrepancies (e.g., the rejection or the invocation of a decision scheme which would take health plan member record/file information over incoming/submitted information).			
2.4.1.18	Send notifications of the receipt and acceptance of hospice enrollment information or the receipt and rejection of the hospice enrollment information. Notification should include, at a minimum, the date and time of the receipt or rejection and key demographics (e.g., consumer Medicaid ID and provider Medicaid ID/NPI).			
2.4.1.19	Image and archive copies of the submitted hospice enrollment information records/forms.			
2.4.1.20	Create, develop and maintain hospice enrollment files/records which include: Type of hospice action (e.g., election, revocation, discharge or death, change hospice organization, change individual demographics). • Submission date • Effective date • Begin/end date span of the hospice action period • Hospice agency name • Hospice Medicaid provider number • Hospice National Provider Identifier (NPI) when NPI is in effect • Medicaid consumer's name • Medicaid consumer's Medicaid billing number • Terminal diagnosis description • International Classification of Disease-9th revision (ICD-9) code that best coincides with terminal diagnosis • Place of residence • Medicaid waiver program • Other insurance (e.g., Medicare, private, other) • Patient liability.			
2.4.1.21	Automatically populate ODJFS hospice enrollment files/records in near real-time upon the receipt of hospice enrollment information records/forms within not more than one business day of receipt.			
2.4.1.22	Relationally link the ODJFS hospice enrollment files/records to be an integrated part of the health plan member enrollment files to assure the appropriate benefit administration of the member's entitled benefits.			
2.4.1.23	Interface with or make information contained in hospice enrollment files/records accessible to claims adjudication, reference file, claims pricing, benefit package, and pharmacy benefit processes and available for any other associated business processes in accordance with established business rules.			
2.4.1.24	Provide the capability to send an alert to the waiver case manager if the consumer is also enrolled in a waiver or hospice program.			

MITS Business Requirement "Functional Fit" Survey				
Member Services				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
2.4.1.25	Provide the capability to send a notification to a LTC facility, specifying that the individual is enrolled in hospice and facility reimbursement must be obtained from the hospice organization.			
2.4.1.26	Provide the ability to interface with the State eligibility system to initiate changes to the Medicaid card issuance process to assure that the card identifies that the consumer is enrolled in a hospice.			
2.5	**County Department of Job and Family Services (CDJFS)**			
2.5.1	Requirements			
2.5.1.1	Provide the capability for county staff to have role-based access to Medicaid data (that is directly related to county work functions) including: • Eligibility data • Provider locator system • SSI information • Buy-In data • TPL data • Healthchek data (Early Periodic Screening Diagnostic Testing (EPSDT) data) • Pregnancy Related Services (PRS) data.			
2.5.1.2	Support edits for spend-down which prevent the provider from billing the full amount of the service if the consumer is on spend-down.			
2.5.1.3	Phase 2 – Provide an interface to the eligibility system for benefit package information to be used in the production of medical cards.			
2.5.1.4	Provide county staff the ability to have role-based access to produce ODJFS-defined reports, including: • Healthchek reports • Types of services and benefits being received by population			
2.5.1.5	Track the number of times an individual has used the Emergency Medical Transportation (EMT) service.			
2.5.1.6	Generate monthly reports to the State Emergency Medical Transportation (EMT) Unit on ODJFS-defined parameters.			

MITS Business Requirement "Functional Fit" Survey				
Benefits and Service Administration				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
3.1	**Benefit Packages**			
3.1.1	Requirements			
3.1.1.1	Build rule-based components for ODJFS benefit packages.			
3.1.1.2	Maintain the following information for each health plan and/or health plan component offered by ODJFS in a manner which assures the information is accurate for each date of service and at the time & date the transaction is processed (i.e., transactions could be a claim, an encounter claim, an inquiry, a prior authorization (PA) request, an adjustment, a premium payment, etc.): • The members enrolled in the health plan and their qualifying eligibility categories. Also see relationship to member enrollment process and associated file maintenance processes/sub-processes • The available benefit package(s) described, in general at each component level, and in detail at the procedure/service code level. Also see relationship to reference file sub-process and claim edits under the claims adjudication process • The list of participating providers by provider type, by service category, by specialty, by demographic area (e.g., county, etc.) and any other classification defined by the State. Also see relationship to provider network management process/sub-process. For certain provider types (e.g., professional group practices), the system must also maintain the list of individual providers associated with the provider entity.			
3.1.1.3	Provide capability to easily add, delete, or modify health plan(s) and/or its related components.			
3.1.1.4	Generate expenditure, eligibility and utilization data by health plan(s) and/or any of its components to support budget forecasts, monitoring and health care program modeling.			
3.1.1.5	Provide standardized testing/modeling facilities or tools to determine impact of modifications to the health plan(s) and/or any of its components.			
3.1.1.6	Generate the reports needed to file fee schedule and other rules with the Joint Committee on Agency Rule Review (JCARR) once modifications to health plans and related components have been successfully tested in the testing/modeling facility.			
3.1.1.7	Provide capability for users to review, on-line or through extracted ad hoc or standard reports, all relevant data associated with the administration of a health plan, benefit package, health plan component, or program covered under ODJFS/OHP. Data would include information on MCP & county programs, covered medical benefits and services, coverage criteria and limitations, reimbursement, edits and audits compiled in a variety of classifications.			

MITS Business Requirement "Functional Fit" Survey				
Benefits and Service Administration				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
3.1.1.8	Provide capability to maintain and/or redesign health plans and/or any related components on a date-specific basis to meet business needs.			
3.1.1.9	Maintain identifiers for individual providers, provider types and specialties participating in the different health plans and/or any related components.			
3.1.1.10	Provide staff the ability to determine the health plans benefits packages and/or related components for which providers are participating and/or are eligible.			
3.1.1.11	Provide multiple benefit plan capabilities and maintain each covered waiver program (administered directly by ODJFS or by a sub-recipient State agency) as a separate health plan, benefit package and/or health plan component that has a distinct and separate provider participation list, covered services and limitation structure and consumer eligibility criteria and enrollment spans. While the waiver eligibility will be mutually exclusive for each waiver program participating providers and some services may or may not be duplicative across all waiver programs.			
3.1.1.12	Maintain an audit trail of all modifications made to health plans and/or related components with beginning and end dates in accordance with general specifications. Change management accountability documents must be maintained on-line for the greater of 7 years or 11 date spans.			
3.1.1.13	Maintain an audit trail/change record with dates, who requested the change, who authorized the change, and who implemented the change, and the description of the change.			
3.1.1.14	Provide staff with access to reports on changes and modifications made to health plans and/or related components by beginning and end dates.			
3.1.1.15	Provide on-line role-based lookup capability to ODJFS staff, providers, and other stakeholders identified by ODJFS for all files and parameters necessary to complete and document Benefits and Service Administration business processes.			
3.1.1.16	Maintain and update information in accordance with ODJFS policy, including limitations on services authorized under each benefit package and service included or excluded for each benefit package.			
3.1.1.17	Maintain and track service and/or dollar utilization on processed claims. Edit submitted claims not to exceed the individual consumer-specific limitation information (i.e., limits on units or dollars by the benefit package level, the procedure code level or some other component level within a specified time period). For example, reimbursement for waiver services for an individual is limited to $1500 per month.			

MITS Business Requirement "Functional Fit" Survey				
Benefits and Service Administration				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
3.1.1.18	Provide on-line role-based lookup capability that will enable ODJFS and providers to identify, within a benefit package or a health care component (e.g., physical therapy, chiropractic, or psychological services), whether a consumer has reached a benefit limit/maximum (units or dollars) and/or identify how much of the benefit limit/maximum remains. Identify the number of units used and/or the dollar amount paid to date at any given point.			
3.1.1.19	Provide the capability to quickly and easily accommodate new or updated service limits or exclusions within each benefit package.			
3.1.1.20	Maintain a historical record of services where the procedures are limited over a specific time period, e.g., annual limit, lifetime limit, and make that available to ODJFS staff.			
3.1.1.21	Notify automatically staff designated by ODJFS of changes to health plans and/or related components (e.g., databases, modules, rules, etc.) and their effective dates to help assure the accurate implementation of policies relating to coverage of health care services, premium payments, and/or invoices.			
3.1.1.22	Generate reports on service limitations and exclusions for each health plan and/or related component.			
3.1.1.23	Maintain for each health plan, benefit package and/or component a customized set of coverage and service limitations on a variety of specific parameters (e.g., provider type limits, place of service limits, unit of service limits, claim submission limits, dollar limits, clinical coverage criteria, pre-approval criteria, rate limits). Also see key parameters specified in the reference file maintenance sub-process and edit requirements in the claims adjudication process.			
3.1.1.24	Tie certain categories of health care services (i.e., health care components) to alternative delivery system spans within the benefit package and including all the key parameters listed in reference file requirements.			
3.1.1.25	Link to & assure that service benefits are limited to the rules associated with these programs from the perspective of covered services, eligible providers, eligible consumers, and component specific limitations for each component associated with special enrollment/eligibility spans.			
3.1.1.26	Provide the capability to handle all sub-recipient State agency-administered programs as distinct and separate health plans, benefit packages or other health care components based on a set of rules or rule-driven parameters as determined by ODJFS and the sub-recipient State agency. Some sub-recipient State agency programs are linked to an enrollment span and the associated business requirements would apply (e.g., Pre-Admission Screening System Providing Options and Resources Today (PASSPORT)) and some are not (e.g., community mental health services).			

MITS Business Requirement "Functional Fit" Survey				
Benefits and Service Administration				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
3.2	**Claims Pricing**			
3.2.1	Requirements			
3.2.1.1	Support on-line updates / revisions to pricing logic.			
3.2.1.2	Provide on-line role-based pricing formula creation and update capabilities to designated staff.			
3.2.1.3	Allow for consistent calculation of payment amounts according to all reimbursement methodologies approved by ODJFS, including provider specific and universal fee schedules, per diems, LTC facility room and board charges, Diagnosis Related Groups (DRGs), Medicare coinsurance / deductible, formulas, percentages and other prospective payment methods.			
3.2.1.4	Support ODJFS-approved pricing activities during claims processing for all approved claim types and reimbursement methodologies and maintain a minimum of the greater of seven (7) years or eleven date spans of pricing history. Obtain and compile inputs as identified by ODJFS, including: • Rates • Cost reports • Consumer specific MDS/IAF data • Hospital information • Facility specific Case Mix Score • Formulas • Peer group • Other health industry market and fiscal resources as determined by ODJFS. • Provider quality information • Resident and Family Satisfaction Survey results.			
3.2.1.5	Maintain information that allows procedures to be automatically priced according to ODJFS–defined business rules, rates and effective dates.			
3.2.1.6	Provide on-line role-based access to pricing formulas and their associated parameters/variables, including the ability to view and modify pricing formulas. Parameters should include anesthesia conversion factors, anesthesia base rates, Vaccine for Children (VFC) rates and Ambulatory Surgery Center (ASC) groups (no black boxes).			
3.2.1.7	Provide the ability to conduct testing in a region for modeling and estimating/evaluating the fiscal impact prior to promotion of pricing changes to production. This test area must be available for all health plans or benefit packages and reporting. The system should be flexible to accept new parameters such as line level Central Accounting System (CAS) codes, that are not currently used in claims adjudication and other future parameters as defined by ODJFS or through HIPAA.			

MITS Business Requirement "Functional Fit" Survey				
Benefits and Service Administration				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
3.2.1.8	Generate pricing data for all provider programs on ODJFS-specified media using selection parameters specified by the State.			
3.2.1.9	Provide an automated process, approved by ODJFS, to acquire Medicare Rates and Pricing Profiles, and ensure conformance with Federal requirements regarding Medicare pricing.			
3.2.1.10	Establish edits for production or test region adjudication and notify ODJFS staff of exceptions.			
3.2.1.11	Maintain a DRG file as determined by Alert/notify ODJFS staff to exceptions to use in pricing inpatient hospital claims. The greater of seven (7) years or 11 date spans of data must be maintained. The DRG file will contain, at a minimum, elements such as: • DRG code • English translation of code (DRG description) • Add date • Begin date • End date • DRG weight (relative value) • Outlier days (low and high days) • Outlier charges (low and high charges) • Audit trail • Average length of stay.			
3.2.1.12	Maintain the following hospital-specific inpatient and outpatient rate data, by effective date(s) including: • Inpatient DRG rate components • Inpatient and outpatient cost to charge ratios • Retroactive adjustment indicator and date • Other hospital specific payment components such as per diems, percentages.			
3.2.1.13	Accommodate multiple outpatient hospital reimbursement methodologies based on business rules provided by ODJFS, including outpatient prospective payment, per discharge/visit, percent of charge, Fee-For-Service (FFS) procedure code prices for outpatient hospital care, line level and revenue center code pricing.			
3.2.1.14	Accommodate multiple inpatient hospital reimbursement methodologies based on business rules provided by ODJFS, including DRG, per discharge/visit, per diem, percent of charge, peer group level of care for inpatient hospital care, line level and revenue center code pricing.			
3.2.1.15	Maintain an outpatient hospital pricing file based upon bundled rates for services per visit by provider urban/suburban/rural classification. Rules would be based on provider location, classification, etc.			

MITS Business Requirement "Functional Fit" Survey				
Benefits and Service Administration				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
3.2.1.16	Perform mass updates, from multiple sources determined by ODJFS, on the test region and upon approval migrate to production on a schedule defined by ODJFS.			
3.2.1.17	Maintain multiple rates for all providers and provider types as identified by ODJFS.			
3.2.1.18	Provide the capability to flag and reprocess previously paid claims within the designated service date span if a rate change happened to be a retroactive rate change. Implement into production the reprocessed claims only after authorized staff review the outcome and approved implementation. Provide the capability to report on those claims.			
3.2.1.19	Distinguish and identify interim and final rates, per provider.			
3.2.1.20	Transmit and/or provide on-line inquiry access to pricing files for outside vendors and entities determined by the State.			
3.2.1.21	Provide capability to determine and adjust pricing based on package size (e.g., DME).			
3.2.1.22	Adjust and maintain pricing data for all health plans and/or benefit packages and identify and calculate payment amounts according to rates and rules established by ODJFS for various categories of pricing methods, for claim types other than retail pharmacy claims, including: • Fee schedule • Per diem rates, assigned to each LTC provider with a corresponding date span for pricing • Negotiated rates • Premium rates for MCPs and case management services • Multiple-level dispensing fee for drugs (e.g., compound, enhanced, repackaged allowances, etc.) • Maximum allowable fee per service (note: some situations require paying Federal portion of fees) • Percent of charge (billed amount) pricing • Provider-specific percent pricing • Enhanced or adjusted incentive payments as determined by State-defined pricing rules (e.g., dental pediatric incentive, HPSA pricing) • Sub-recipient State agency pricing • Anesthesia pricing • Consumer specific pricing based on consumer location (i.e.,; hospice), monthly cost caps per consumer (i.e.,; for waiver programs) • Medicare pricing or payment rates • Provider specific rates • Provider specialty (pricing locality specific rate) • Contracted rate per service or provider • Procedure code modifier pricing • Manual pricing (medical consultant-determined rate per service)			

Req Number	Requirement	Phase (1 or 2)	Response Code	Page Ref
	• Drug cost plus dispensing fee per prescription • LTC facility daily rate, room and board charges • LTC Prospective Payment System (PPS) rates • Payment rates and effective dates for each rate, per facility • Inpatient hospital diagnosis-related group (DRG) rate per stay discharge • Different rates to hospitals that qualify as: acute care and rehabilitation, drug and alcohol, psychiatric units of acute care hospitals, or mental health institutes • Different rates for transplants and organ acquisition costs • Different rates for acute care hospitals that qualify for special payments for Acquired Immune Deficiency Syndrome (AIDS)/Human Immunodeficiency Virus (HIV), ventilator and brain injury payment adjustments • Inpatient rate per diem • Inpatient capital and medical education pass through payments • Inpatient hospital managed care out-of-plan stays (DRG rate per stay/discharge, plus capital and medical education add-ons) • Outpatient hospital-specific rate per visit (day) • Outpatient PPS rates • Multiple claim pricing methodologies specific to Medicare Part A, B, C, and D, and/or Plan coverage. Examples include limiting to co-insurance/co-payment and deductible rates or other amounts defined by ODJFS. • Aggregate co-pays and co-insurance on the family level with a trigger to insure co-pays or co-insurance charge would not be levied on family members whose family had reached the annual maximum co-pay/co-insurance of 5% of household income. • Assistant-at-Surgery pricing • Incentive payment pricing (e.g., performance payments, location) • Maximum Allowable Cost (MAC), Estimated Acquisition Cost (EAC), Average Wholesale Price (AWP), AWP Minus, Wholesale Acquisition Cost (WAC), WAC Plus, Federal Upper Limit (FUL), and direct pricing for drugs, plus a dispensing fee per prescription • Package size pricing • Individual consideration pricing (e.g., hospital outliers) • Geographic location of provider or consumer • Adjust prices based on consumer location (hospice and waiver) • Multiple surgery logic using national standards approved by the State • ASC group pricing as determined by ODJFS • Provider specific rate at the modifier level. • VFC pricing and rates by procedure code • Ability to accept National Drug Code (NDC) on hospital claims and use for pricing			

MITS Business Requirement "Functional Fit" Survey				
Benefits and Service Administration				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
	• Ability to edit across provider types for services provided to a consumer. • Resident specific rates for long term care facilities • Long term care facility rates that would support alternative purchasing solutions • Ability to freeze a cost base for nursing facility and/or intermediate care facility for the mentally retarded rate-setting while still maintaining a record of subsequent audit adjustments to those costs.			
3.2.1.23	Override established pricing calculations if the claim or the provider billing the claim meets the requirements defined by ODJFS for pricing exceptions.			
3.2.1.24	Provide the capability to determine how Medicare would adjudicate the submitted claims and compare rates and pricing policies. This should include the ability to plug in purchased pricing software.			
3.2.1.25	Provide ODJFS with on-line role-based access for updating MCP premium rates, including retroactive adjustments.			
3.2.1.26	Maintain various capitation/premium rate periods (e.g., fiscal year, calendar year, or other period) for specific rates for each MCP.			
3.2.1.27	Store daily or monthly premium rates to generate daily or monthly premium payments.			
3.2.1.28	Process mass adjustments to MCP-specific premium rates as required by ODJFS.			
3.2.1.29	Use consumer-specific information to process and evaluate monthly cost caps by individual and by waiver type.			
3.2.1.30	Support supplemental payments program calculations/pricing e.g., determination of distribution formula for Hospital Care Assurance Program (HCAP).			
3.2.1.31	Maintain the ability to utilize multiple rate-setting methodologies for long term care facilities (i.e., NF and ICF-MR, short term and long term stay, traditional Medicaid and selective contracting).			
3.2.1.32	Calculate long term care facility rates, and provide the capability to establish them at the provider or consumer level, using factors that may include, but are not limited to • Provider cost experience • Provider location • Provider size • Quality and performance indicators • Resident acuity • Inflation factors • Provider tax rates • Occupancy • Medicaid utilization.			
3.3	**Pharmacy**			

MITS Business Requirement "Functional Fit" Survey				
Benefits and Service Administration				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
3.3.1	Requirements			
3.3.1.1	Integrate with a Pharmacy Benefit Management System (PBM) that is accountable to ODJFS.			
3.3.1.2	Develop daily interfaces to the PBM to assure the availability of accurate information regarding client eligibility, drug pricing information, provider eligibility, other insurance resources (including Medicare), client benefit limitations, managed care enrollment status and other data necessary for the PBM to process pharmacy claims.			
3.3.1.3	Process non-retail pharmacy claims that are not billable under HIPAA in the NCPDP format (e.g., any valid pharmacy provider that does not fit the HIPAA definition of a retail pharmacy may be considered a non-retail pharmacy).			
3.3.1.4	Implement an on-line edit/audit process that is parameter or table driven to meet the dynamic needs of the non-retail pharmacy program.			
3.3.1.5	Develop interfaces as needed to accommodate the receipt of crossover, encounter or other outside claims and/or non-retail pharmacy information.			
3.3.1.6	Provide for batch updating of the drug file with information received on the First Data Bank Pharmacy Blue Book file and/or other pricing service.			
3.4	**Early Periodic Screening Diagnostic Testing (EPSDT)**			
3.4.1	Requirements			
3.4.1.1	Maintain all Healthchek (HC) /EPSDT program eligibility records, periodicity schedules, consumer notification and notification response dates, screening dates, and client notices, as directed by ODJFS.			
3.4.1.2	Maintain, for each Healthchek (HC) /EPSDT eligible consumer, the screening date and immunization and blood lead level testing status, including results for blood lead level testing. System interface with the Statewide Immunization Information System (SIIS) will include up-to-date immunizations, and lead test results from Statewide Tracking of Elevated Lead Levels and Remediation (STELLAR) at age-applicable moments. When claim is submitted the system should be able to identify applicable information from the SIIS/STELLAR interface.			
3.4.1.3	Identify EPSDT screening services and EPSDT referrals regardless of how the claim was submitted (CMS1500 or EDI electronic claim).			
3.4.1.4	Identify EPSDT data elements that trading partners are submitting via the EDI EPSDT loops and check the claim record to verify that the necessary EPSDT data elements are populated into the appropriate fields on the claim record.			

MITS Business Requirement "Functional Fit" Survey				
Benefits and Service Administration				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
3.4.1.5	Retain indicators that denote that it is an EPSDT claim or EPSDT referral on historical claim records.			
3.4.1.6	Retain EPSDT and EPSDT referral indicators in the on-line version of the claim record.			
3.4.1.7	Identify whether services require Healthchek/EPSDT referral.			
3.4.1.8	Link EPSDT services claims that contain referrals to the referral claim. This would also filter back to the physician and HC coordinator for identification of received services and/or referrals.			
3.4.1.9	Provide ODJFS staff with on-line access to Healthchek/EPSDT and claims data.			
3.4.1.10	Provide on-line capability to query consumer Healthchek/EPSDT data to allow providers to check whether a consumer is due for a Healthchek screening.			
3.4.1.11	Limit coverage for EPSDT services to AAP (American Academy of Pediatrics) Guidelines and benefit packages as defined by ODJFS. Child Day Care (CDC) and House Bill (HB) 248 guidelines applicable where needed for lead and immunizations.			
3.4.1.12	Compare periodicity schedule to actual number of visits in a certain time period and by age.			
3.4.1.13	Provide an electronic on-line method that tracks outreach activities performed by staff.			
3.4.1.14	Provide capability to determine EPSDT consumers who have not received their scheduled screenings over varying periods of time.			
3.4.1.15	Determine the last time a consumer received an EPSDT service.			
3.4.1.16	Provide near real-time access to the State immunization database for staff, enrolled providers, and consumers.			
3.4.1.17	Provide role-based access to the State blood lead level registry			
3.4.1.18	Alert Healthchek County Coordinators and physicians when children's blood lead level exceeds State thresholds. Physician notifications as well as staff notification are applied every 30 days once a lead test is ordered. Claim adjudication for a lead test comes in from another source and should filter back to ordering physician and staff to indicate either level of lead test (from Ohio Department of Health (ODH) interface) and/or that no test has been documented (ODH) or a claim has occurred. Notification includes automatic generation of letter to physician, county staff, ODH, LPP and parent.			
3.4.1.19	Generate EPSDT screening notification reminders within timelines specified by ODJFS and county staff and incorporated into business rules.			
3.4.1.20	Provide automatic notifications for scheduled milestones as defined by ODJFS. This includes notification on lead tests needed and immunizations needed within timelines specified by business rules.			

MITS Business Requirement "Functional Fit" Survey				
Benefits and Service Administration				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
3.4.1.21	Generate automatic follow-up notifications (to ODJFS, county and consumer) based upon EPSDT claim history detail and specific EPSDT criteria as defined by ODJFS for EPSDT consumers when an appointment is missed following EPSDT health criteria.			
3.4.1.22	Produce a monthly report that identifies eligible consumers who have not had their blood lead level test, EPSDT screenings, immunizations (according to the periodicity schedule) and any other diagnostic defined by ODJFS at age-applicable timeframes.			
3.4.1.23	Support near real-time data exchange updates with the State Immunization Registry (ODJFS claims to ODH and ODH to ODJFS).			
3.4.1.24	Produce summary level reports on a quarterly basis to Medicaid MCPs on providers enrolled and using the State Immunization Registry.			
3.4.1.25	Generate quarterly summary level blood lead level reports for EPSDT consumers.			
3.4.1.26	Generate on-line Healthchek/EPSDT or other children's primary care outreach reports to MCPs and other State-approved entities.			
3.4.1.27	Generate Healthchek/EPSDT or other children's primary care utilization reports to MCPs and other ODJFS-approved entities by frequency and demographics identified by ODJFS.			
3.4.1.28	Provide ad hoc reporting to ODJFS and county approved staff utilizing EPSDT data. Examples of ad hoc reports include: • A list of all EPSDT consumers who have not received their scheduled screening • A list of all EPSDT consumers and the date of their latest screening • Blood lead levels for all EPSDT consumers and date last tested • Immunizations given in a timely manner • Missing immunizations • Listing of VFC/Medicaid providers enrolled and using the registry • Providers who provided EPSDT exams.			
3.4.1.29	Compile and issue Federally required reports pertaining to EPSDT information in accordance with the Federal specifications and ODJFS specifications. • Identify the number of consumers receiving EPSDT services • Identify the number of referrals from the screening by age group • Generate the data needed to produce the CMS-416 Annual EPSDT Participation Report (combination of claims and eligibility data).			

MITS Business Requirement "Functional Fit" Survey				
Benefits and Service Administration				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
3.4.1.30	Provide a methodology to un-duplicate the claims to obtain an accurate count of EPSDT screening services, immunization services, blood lead tests, and EPSDT referral services for situations when ODJFS business rules allow multiple types of claims (e.g., both a professional and institutional claim) to be submitted for the EPSDT service.			
3.4.1.31	Maintain all Healthchek/EPSDT program eligibility records, periodicity schedules, consumer notification and notification response dates, screening dates, and client notices, as directed by ODJFS.			
3.4.1.32	Maintain, for each Healthchek/EPSDT eligible consumer, the screening date, immunization and blood lead level testing status, including results for blood lead level testing.			
3.4.1.33	Send lead test results back to the ordering provider by consumer ID. If there are no results or claim, notify provider that no claim was filed or no results were received.			
3.4.1.34	Notify ODH of lead test claims submitted to Medicaid; however it is not necessary to create a record in STELLAR at that point.			
3.4.1.35	Allow for VFC or SIIS provider indicator in applicable provider or reference file indicator.			
3.4.1.36	Allow consumers should be able to print off their own immunization, lead testing and well child examination records in accordance with privacy and security processes.			
3.5	**Reference File**			
3.5.1	Requirements			
3.5.1.1	Provide ODJFS-defined on-line role-based access for approval/update/edit of reference file data.			
3.5.1.2	Provide user-friendly navigation among the various reference files.			
3.5.1.3	Allow on-line input from ODJFS-approved sources.			
3.5.1.4	Allow ODJFS to test and approve any update to reference file data prior to moving data to production.			
3.5.1.5	Provide current revenue codes on-line.			
3.5.1.6	Provide data that supports claims edits, audits, and pricing logic in accordance with ODJFS policy. The application of these policies is subject to change; therefore, the edits, audits, and pricing methodologies described in this Request for Proposal shall not be considered an exhaustive list.			
3.5.1.7	Operate and support all reference data maintenance functions, files, and data elements as specified by ODJFS.			
3.5.1.8	Assure updates do not overlay or otherwise make historical information inaccessible. Must maintain back-up features to assure changes in parameters are maintained.			
3.5.1.9	Provide on-line inquiry capability to all current and the greater of seven (7) years of history or at least eleven date spans.			

MITS Business Requirement "Functional Fit" Survey				
Benefits and Service Administration				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
3.5.1.10	Link covered procedures to specific authorized provider types and to authorized service categories corresponding to those assigned by ODJFS to providers. Must be able to link historical policies to covered date spans or bill spans.			
3.5.1.11	Provide the ability to maintain and update: • Reference file data • HIPAA mandated code sets, ▪ HL 7 LOINC code sets • Approved versions of Health Common Procedure Coding System (HCPCS) procedure codes, • International Classification of Disease (ICD)-9-CM diagnosis and procedure codes, • Current Dental Terminology (CDT) procedure codes, • Revenue codes, • Managed care program payment codes • Relative value units • Diagnostic and Statistical Manual (DSM) diagnosis codes, including DSM age 0-3, • Diagnostic Related Groups (DRG), and • NDC drug codes • Edit/Audit criteria and disposition tables • Business rules • Exception code file.			
3.5.1.12	Accept local level codes used by sub-recipient State agencies and provide a cross walk to National/State codes.			
3.5.1.13	Accept on-line and automated updates, additions, and deletions by tape or electronic transmission to all reference files, with the ability to make changes to individual records or mass changes to groups or classes of records (e.g., across provider type and specialty).			
3.5.1.14	Allow on-line role-based inquiry and update to the edit/audit criteria and disposition tables related to benefit package criteria.			
3.5.1.15	Generate on-line audit-trail reports that detail reference file updates and the directives that initiated them in a format and media approved by ODJFS.			
3.5.1.16	Provide the ability to alert designated ODJFS staff upon completion of updates of reference file data. This alert must identify all changes and revisions, deletions, and replacements and provide a cross-reference.			
3.5.1.17	Support ODJFS-approved pricing activities during claims processing for all approved claim types and reimbursement methodologies and maintain a minimum of seven (7) years of pricing history (e.g., viewing and on-line updating of activities). Provide additional electronic historical data off line that captures all changes to reference file data going forward.			

MITS Business Requirement "Functional Fit" Survey				
Benefits and Service Administration				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
3.5.1.18	Configure the reference file to allow the same procedure code to be priced differently (e.g., based on age of consumer for the same date span).			
3.5.1.19	Allow the tracking of changes to the reference file using on-line notes capability.			
3.5.1.20	Generate audit trail reports for all data sets showing before and after images of changed data, the ID of the person making the change, ODJFS-defined reason code, and the change date and time. The system should support multiple spans of identification for auditing purposes.			
3.5.1.21	Maintain an on-line cross-reference between HCPCS and International Classification of Diseases-9 (9th revision)-Clinical Modification (ICD-9-CM) procedure codes.			
3.5.1.22	Maintain an on-line cross-reference between ICD-9-CM and DSM diagnosis codes and DSM diagnosis, including DSM age 0-3 diagnosis.			
3.5.1.23	Display on-line for each billing procedure code the following information/elements that must be maintained on the reference file including: • Procedure code (CDT, HCPCS, Current Procedure Terminology (CPT), Revenue Center Codes (RCC), NDC, ICD-9 procedure) • Modifiers • Denotation of the authorized provider types • Denotation of the authorized category of service (service category type) • Denotation of the authorized specialty and taxonomy • Denotation of the authorized sub-specialty and taxonomy • Denotation of the required CLIA certification type • Denotation of the required CMS lab code classification assignment (micro, chemistry, hematology, etc) • Denotation of any consumer age limits • Denotation of any consumer gender limits • Denotation of the PA requirements (e.g., always required, sometimes required, never required) • Denotation of valid/invalid Place Of Service (POS) limitations • Denotation that the service qualifies as an EPSDT service (child well health service) • Denotation specifying if there is a co-payment for the service and associated data including the co-payment amount/per service unit and/or aggregate out-of-pocket co-payment thresholds for the service			

MITS Business Requirement "Functional Fit" Survey				
Benefits and Service Administration				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
	• Denotation that the service always qualifies; never qualifies as or conditionally qualifies as a family planning service or must have a documented alternative methodology for identifying the procedures eligible for enhanced Federal Financial Participation (FFP) • Denotation of diagnosis code requirements including the list of valid/invalid diagnosis codes and if diagnosis is required (header/line) for claims adjudication • Maximum quantity units per a designated time period(s). The time period specified by pre-set time period values and the specified units. In addition need to know the lifetime limits • Denote if multiple units may be submitted for the procedure code at the line level • Pertaining to other duplicate edit parameters, denote all duplicate claim/line level limits on same or different claims; same or different rendering providers; same or different group/pay to providers; unit level or code level either through a series of duplicate check indicators (see example, below) or through some other documented methodology which specify all the duplicate edits associated with this procedure code: o Limit procedure code to a single line per date of service o Limit code by same or different rendering provider o Limit by same or different group/pay to provider o Allow procedure code on multiple line on same claim for same date of service (by same provider and/or different providers, all three) o Allow proc code multiple lines on different claims same date of service (by same and/or different providers, all three) • Identify procedure code as requiring sterilization form (always or conditionally, ability to embed conditions in rules link to indicator) • Identify procedure code as requiring hysterectomy form (always or conditionally, ability to embed conditions in rules lined to the indicator) • Identify procedure code as requiring abortion form (always or conditionally, ability to embed conditions in rules linked to the indicator) • Provide complete narrative descriptions of the code • Provide short descriptions of the code that are specific enough to determine uniqueness of the code from other procedure codes in a series			

MITS Business Requirement "Functional Fit" Survey				
Benefits and Service Administration				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
	• Medicare coverage indicators: (e.g., always covered, conditionally covered (sometimes), never covered or some other documented methodology which would enable the use to know how Medicare cost avoidance edits are to work for the procedure code • LTC facilities coverage indicators (values) and living arrangement indicator values. Coverage indicators must include at a minimum values to denote: if service is bundled into facility payment corresponding to the living arrangement; values to denote the service is covered as an add-on service (i.e., in addition or independent to the facility payment) by living arrangement; and values to denote the service is not covered as either (i.e., separately or as a bundled service). Living arrangement indicators must include, but would not be limited to Skilled Nursing Facility (SNF), Nursing Facility (NF), ICF-MR, assisted living facility, group home, other qualifying setting • For dental procedure codes, must have an indicator (or some other method) to denote if a tooth number or tooth surfaces information is required when the procedure code is billed. Must denote the valid tooth numbers or tooth surfaces that may be billed • For anesthesia services, maintain anesthesia base values. Directly related to this, must also maintain the anesthesia pricing conversion factor tables for an applicable date span within the reference file or in some other on-line file which can be updated in the test region and/or production). Must have a way to indicate if procedure code is paid only base value only; base value + time values; other possible applications • Denote if the procedure code consists of both professional and technical components, is only a professional service or is only a technical service. Marking these as such could be accomplished through some rule-based applications using information from the RVUs, but the reference file should make allow the user to know if the code fits these categories. Corresponding to this must have a methodology to denote the variations in payment for the professional technical splits. For many of the codes, modifiers are required so this can be handled through the modifier pricing impact requirements. The remainder of the codes has specific code numbers splitting them into the professional/technical/complete procedure category • Denote if the code has special payment incentives (in-office surgical incentive); site differential/incentive payments. Must be able to denote the resulting pricing impact these parameters have on the pricing of the code			

MITS Business Requirement "Functional Fit" Survey				
Benefits and Service Administration				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
	• Denote the general pricing status of the code for each relevant pricing segment. At a minimum we would require values for the following payment categories: o Fee schedule o Bundled into capitation payment o Add on payment to capitation o Provider charge file (perhaps a variety) o Anesthesia formula pricing o Transportation formula pricing o Sub-recipient State agency pricing (pass through agency to agency) o Sub-recipient State agency pricing (direct provider payment) o Case-by-case pricing (by report, manually priced, etc.) o PA pricing fee schedule o PA pricing case-by-case o Non-specified formula pricing. • Denote the post operative day(s) parameter used for determining bundling policy for surgical claims/visits • Denote if referring provider number is required for the procedure code • Denote if multiple surgery pricing applies to the procedure code and the extent to which Multiple Surgery (MS) pricing is applicable (the MS rule followed by business rules, canned or customized to meet ODJFS needs) • Revenue Center Codes (RCC) must denote if itemizations of HCPCS codes are required claims processing and identify the list of valid/invalid HCPCS codes.			
3.5.1.24	Maintain a drug file using the NDC, which can accommodate weekly updates from a contracted drug pricing service and the CMS Drug Rebate file and State rebate program updates. The drug data set must contain all of the data for the contracted drug pricing service including: • Eleven (11) digit NDC • Brand, generic, and label drug name • Add date • Begin date • Effective date • CMS termination date • Obsolete date • Specific therapeutic class and description • Route of administration (two (2) alpha characters) • Previous NDC (for three (3) years) • Minimum and maximum dosage units and days • Minimum quantity size field of five (5) positions • Allow for decimal units			

MITS Business Requirement "Functional Fit" Survey				
Benefits and Service Administration				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
	• Generic Code Number (GCN), Generic Sequence Number (GSN), Hierarchical Ingredient Code List (HICL) sequence number, HIC3 (Hierarchical Specific Therapeutic Class Code) number, American Hospital Formulary Service (AHFS) code • Unlimited date-specific pricing segments which include all prices needed to adjudicate drug claim records in accordance with State policy • Indicators for multiple dispensing fees • Indicators for multiple prices • Pricing indicators to accommodate at least the following seven (7) reimbursement methodologies: FUL, MAC, EAC, and AWP, WAC, AWP-minus, WAC-plus, ASP and other pricing methodologies as they become available. • Name of manufacturer and labeler codes • State-specified restrictions on conditions for a claim to be paid to include minimum/maximum days supply, quantities, refill restrictions, consumer age/gender restrictions, medical review requirements, PA requirements, place of service, and special indicators. • Indicator of preferred drug list status • Identification of CMS rebate, State rebate program status and corresponding dates • Generic product indicator • Identification of strength, units, and quantity (package size) on which price is based • CMS unit of measure • Yes/no indicators for DESI drugs, EPSDT, co-pay, manual review, long term care, unit-dose packaging and family planning • Pricing amount • Indicators of prescription required (or Over the Counter (OTC)) status • Indicators for schedule assigned to controlled drugs • Indicator for dispensing fee • Indicators for prior authorization requirements, including the reason PA is required • Indicators to identify drugs covered under Medicare Part D • Pricing field size should be 11-bytes (7,decimal,3) • Indicators for multiples programs (FFS, Disability, etc) • Multiple-level dispensing fee for drugs (e.g., compound, enhanced, repackaging allowance, etc.) • Other indicators as necessary (e.g., to denote behavior service, or control disposition of claims processing).			
3.5.1.25	Flag procedure codes if technical/professional component exists by procedure code and link to percentage split and alternative pricing methodology.			

MITS Business Requirement "Functional Fit" Survey				
Benefits and Service Administration				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
3.5.1.26	Define and enforce the use of appropriate procedure coding scheme (e.g., HCPCS, ICD-9-CM, CDT) and/or diagnosis coding scheme (e.g., ICD-9-CM, DSM) based on parameters as referenced above.			
3.5.1.27	Identify procedure codes that invoke incentive/disincentive payments.			
3.5.1.28	Identify Revenue Center Codes that designate whether procedure codes are to be itemized and additions to revenue codes.			
3.5.1.29	Provide a crosswalk from HCPCS injection codes (e.g., J-codes) to the 11-digit NDC, when applicable.			
3.5.1.30	Associate a minimum of 160 valid two-character/digit modifiers for each procedure code. The list must be associated with date spans for a valid date of service period or valid billed date period.			
3.5.1.31	Allow role-based users to have on-line view and/or update capabilities.			
3.5.1.32	Perform electronically mass modifier updates for a group of code sets. For example, new anesthesia modifiers were issued could replace the old with the new as valid modifiers to the anesthesia codes).			
3.5.1.33	Link associated valid modifiers by procedure code with the pricing impact/payment adjustment impact as it compares to the unmodified procedure code pricing (i.e., the fee schedule rate, provider charge file rate, etc.). Must denote if the impact reduces payment, increases payment or is informational only. Must denote if the impact (+/-) is a lump sum or a percentage change.			
3.5.1.34	Allow the modifier validity, definitions (HIPAA-compliant) and the pricing impact of the modifier specific to each code within the same and/or different health plan/benefit packages (i.e., the same modifier can have different pricing impact).			
3.5.1.35	Denote if the procedure code must be submitted with a modifier for pricing (e.g., anesthesia codes, certain professional services, etc.).			
3.5.1.36	Identify the immunization codes by the following categories: (1) exclusively covered under the Vaccine for Children (VFC) program; (2) not covered under the VFC; (3) combination coverage, VFC for children, non-VFC for adults. Must have the capacity to add other categories.			
3.5.1.37	Invoke category specific pricing and provide on-line view of the VFC administration rates for periods not spanning less than 7 years. For combination category there is a fee schedule rate or a VFC administration rate paid so must have both available to user. Must have the capacity to update VFC administration rate on-line.			

MITS Business Requirement "Functional Fit" Survey				
Benefits and Service Administration				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
3.5.1.38	Indicate covered Revenue Center Codes (RCC) by institutional claim type (inpatient hospital, outpatient hospital, NF, ICF-MR, dialysis center, free-standing clinic, ambulatory surgical center, and others as needed).			
3.5.1.39	Link deleted procedure codes to (cross-walked) replacement codes and vice versa, whether there is a one to one, many-to-one or one-to-many relationship for at least one previous pricing span.			
3.5.1.40	Associate service code coverage to a specified health plan, benefit package and/or service category.			
3.5.1.41	Specify if the code is valid for a claim type (e.g., professional, dental, etc.) as defined by ODJFS or claim input media type (e.g., paper, EDI, other) as defined by ODJFS.			
3.5.1.42	Sub-categorize services into a minimum of two levels of service within the CPT (e.g., surgery/gastroenterology), HCPCS (e.g., Durable Medical Equipment (DME)/wheelchairs), CDT, RCC. Must have the capacity to add other levels.			
3.5.1.43	Maintain reference file documentation specifying the functionality of each parameter, the edits associated with each parameter/field, valid/invalid values for each field, and the definition of each value used in any of the fields. Must be maintained in a manner that can be viewed on-line, or printed out hard-copy.			
3.5.1.44	Provide a testing area or "sandbox" to determine impact of changes to reference files.			
3.6	**Drug Rebate**			
3.6.1	Requirements			
3.6.1.1	Provide the capability to send a monthly file of paid claims for drug products adjudicated for non-retail pharmacies.			
3.6.1.2	Provide the capability to send a monthly file of paid Medicare and COB claims for drug products.			
3.6.1.3	Provide the capability to send a monthly file of paid Medicaid outpatient hospital and professional claims for drug products (J-codes).			
3.7	**Benefit/Coverage Pre-Determination**			
3.7.1	Requirements			
3.7.1.1	Edit PAs on-line for the presence of required data to include the following: • Valid provider ID and eligibility • Valid consumer ID and eligibility • Valid procedure and diagnosis codes • Presence of required claim type-specific data on the PA • Covered service • Duplicate authorization check to previously authorized or previously adjudicated code-specific services or groups of code-specific services (including denials) and duplicate requests in process			

MITS Business Requirement "Functional Fit" Survey				
Benefits and Service Administration				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
	• Valid referring or prescribing provider, if required.			
3.7.1.2	Identify errors on PA requests and/or on claims billing for prior authorized services with edits/audits that specify the field in error and would assist submitters in correcting problems.			
3.7.1.3	Execute a subset of claims adjudication edits (e.g., eligibility, provider type, etc.) on submitted PA requests, as defined by ODJFS, as well as edits for completing a PA request against the submitted PA request.			
3.7.1.4	Provide staff with on-line role-based access in order to force override edits on incoming PAs. System must have a feature that allows edit overrides only if valid reason is documented based on approved business rules. The final disposition of edits that posted during the PA review must then feed into or be accessible during the claims adjudication process.			
3.7.1.5	Alert/notify specified staff when a PA request pends indicating the edit and a brief edit description which caused the PA request to pend/suspend.			
3.7.1.6	Notify provider of invalid web-based and EDI PA entries.			
3.7.1.7	Create PA edit system so some edits, as defined by ODJFS, will return the PA request to the provider prior to initiating the PA approval process, while other edits will allow receipt of the PA request and will be used to determine or assist in the determination of the final disposition status of the PA request (i.e., PA edits can result in the following outcomes; deny, defer, approve with amendments/adjustments, approve, etc.).			
3.7.1.8	Identify and report duplicate PA requests for exact service requests and for related or similar type service requests (e.g., services bundled into other prior authorized service codes).			
3.7.1.9	Automatically notify users of duplicate or possible duplicate requests.			
3.7.1.10	Allow users to accept or reject duplicates, but must have a mechanism which allows acceptance or rejection exceptions to occur only if valid reasons are documented based on approved business rules.			
3.7.1.11	Assign a PA number as soon as the PA gets into the system and has passed the initial set of edits.			
3.7.1.12	Assign unique PA numbers that will not be used again.			
3.7.1.13	Notify the providers immediately after the PA number is assigned.			
3.7.1.14	Route PA requests into queues as defined by ODJFS based on types of PA requests.			
3.7.1.15	Utilize workflow management capabilities to manage the PA process (routing, reviewing, adjudicating, tracking, and updating PA requests and amendments) as determined by ODJFS-defined business rules, including: • Flexible workflow assignment of PAs to reviewers			

MITS Business Requirement "Functional Fit" Survey				
Benefits and Service Administration				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
	o Normally automated on a First-In-First-Out (FIFO) basis o Manual by selecting a given PA from the work queue o As determined by business rule changes. • Work prioritization • Alerting • Flexible staff assignment.			
3.7.1.16	Allow for manual entry of PAs, although automated entry is preferred.			
3.7.1.17	Keep statistics and report on the number and types of PA requests (as well as other criteria defined by ODJFS) entered into the system, reviewed, and pended on a periodic basis.			
3.7.1.18	Create PA Reports that are viewable on-line and available in any other format and media (e.g., hard-copy) defined by ODJFS.			
3.7.1.19	Allow for electronic submission of PA request attachments (e.g., EDI 275, HL7).			
3.7.1.20	Store digital photos or electronic imaging of PA attachments and link them to the PA request, regardless of mode of submission.			
3.7.1.21	Capture and display on-line, PA data which includes, at minimum, the following: • PA number • Billing, rendering, and referring provider information, including name and address, telephone number, and provider ID • PA type • Consumer information, including Consumer ID, date of birth, address, name, and gender • Diagnosis Information, including: o Primary diagnosis code and description o Start date – Spell of Illness (SOI) o First date of treatment – SOI o Secondary diagnosis code and description • Service Information, including: o Status of service (e.g., approved, modified, denied, pending) o Requested start date o Rendering provider number o Procedure/NDC code o Modifiers o Place of service o Description of service o Manufacturer description o Manufacturer product number o Manufacturer price list o Manufacturer o Quantity requested by days, number of services, dollars o Quantity authorized o Quantity used			

MITS Business Requirement "Functional Fit" Survey				
Benefits and Service Administration				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
	o Dollar amount charged o Begin (grant) and expiration date • Status of the PA request, including pending, denied, approved, or modified • Receive date • Date approved • Expiration date • History of all actions taken on PA request, including amendments • Date of last change, ID of person changing, and information changed for each PA record • Date of request for additional information • Amend date • Adjudication date • Review date • Date adjudication notice sent to provider and consumer • ID of authorizing person • Free-form text area for special considerations, along with a flag to allow the system to identify authorizations with special considerations • A text area which will be printed on the PA notice, using predefined messages as well as unique messages (e.g., informing providers of cases where the original code requested was changed to reflect the diagnosis on the PA) or special considerations, along with a flag to allow the system to identify authorizations with special considerations.			
3.7.1.22	Provide on-line search capability for PA data using the following search criteria (alone or in combination) at a minimum: • Consumer ID • Consumer name • Provider ID • Provider name • Date range • PA status • Rendering/billing/referring/prescribing provider ID • Provider (ID or name) and service type • PA number • Up to four (4) modifiers • Detail status (procedure) • Date approved • Begin (grant) and expiration date • Add date • Service code • Description field • HCPCS/CPT definition			

MITS Business Requirement "Functional Fit" Survey				
Benefits and Service Administration				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
	• Miscellaneous actual service.			
3.7.1.23	Alert/notify PA reviewers of PA requests automatically, awaiting provider feedback if the provider has not responded within a timeframe defined by ODJFS.			
3.7.1.24	Automatically alert providers of the need for additional information (e.g., HIPAA 278 transaction).			
3.7.1.25	Provide multiple staff with simultaneous on-line role-based access to a PA request at the same time, but build in features that would preclude the actions of one staff member not to be unintentionally overlaid by the actions of another staff member.			
3.7.1.26	Allow staff to amend a PA record multiple times and display the history on-line.			
3.7.1.27	Maintain detailed audit trails for all changes to PA records (when, what, who, why, etc.).			
3.7.1.28	Develop business rules which dictate whether the rate established under the PA approval takes precedence over other payment rules (e.g., lesser of billed charges cannot exceed the maximum fee scheduled) or vice versa. Assure that, if non-PA pricing rules take precedence, pre-determined override procedures and business rules are followed to make special pricing exceptions requiring that special documentation be completed for the override to work.			
3.7.1.29	Assure that the system can limit the payment at the time of adjudication to the billed charges submitted by the provider (instead of maximum allowable or the authorized price) if the provider's submitted billed charges are less than the maximum allowable if ODJFS' business rules dictate this applies.			
3.7.1.30	Alert staff with the responsibility of reviewing and approving overrides to traditional pricing and give these role-based staff the ability to accept or reject the override when requested amounts exceed maximum allowable/or the established pricing rules.			
3.7.1.31	Provide the ability to automatically assign appropriate override codes when staff makes a pricing override exception notification.			
3.7.1.32	Allow reviewers to select equipment from a price list and automatically calculate the approved price based on those selections. (The claims pricing request should be supported by a database which contains manufacturer list prices for services, Medicare fee schedules, and other resources to assist in setting rates for services.)			
3.7.1.33	Notify the provider following the approval or denial of a PA.			
3.7.1.34	Notify other entities (e.g., MCPs) following the approval or denial of a PA.			

MITS Business Requirement "Functional Fit" Survey				
Benefits and Service Administration				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
3.7.1.35	Display on the notification to providers and/or consumers a reason description as an explanation to the disposition/outcome of the PA request, based on the reason codes selected automatically or by staff, on the notification to providers and clients.			
3.7.1.36	Generate a “Right to a Hearing” form with notification to the consumer when a PA denies.			
3.7.1.37	Allow staff to select the reason codes explaining the disposition of the request when a PA denies/approves.			
3.7.1.38	Provide the ability to enter notes on the PA.			
3.7.1.39	Include descriptions of miscellaneous codes with the PA request.			
3.7.1.40	Track items that were originally requested as well as what was actually approved.			
3.7.1.41	Allow staff to review PA history on-line and filter results based on criteria defined by ODJFS.			
3.7.1.42	Check PA history and automatically pull claims for similar types of services.			
3.7.1.43	Create on-line PA request/service utilization history to contain data elements specified and defined by ODJFS. Link the paid claim record used to decrement the PA record (including units and/or dollars used) to PA history.			
3.7.1.44	Provide access to eligibility data when reviewing the PA request.			
3.7.1.45	Retain PA records for varying periods of time for each type of PA as defined by ODJFS.			
3.7.1.46	Allow staff to authorize payment after a service has been administered. System should have an indicator that will enable the tracking of prospective and retrospective PA requests at the service level, provider level and/or provider type level.			
3.7.1.47	Accept notification of inpatient admission by all hospitals, LTC facilities, ICF-MRs and all other Residential Treatment facilities within twenty four (24) hours of admission, including the date of admission and primary diagnosis of admission.			
3.7.1.48	Make authorization data available to ODJFS staff, if other vendors perform authorizations (e.g., hospital), to the same extent the information would be available if ODJFS performed the PA function.			
3.7.1.49	Accommodate two levels of authorization (outside vendor authorization and in-house authorization).			
3.7.1.50	Provide flexibility to allow waiver PAs to be capped at a dollar amount at the consumer level, at the service level, at the provider level or any combination that can be controlled and/or measured through available claim/PA file data as determined by business rules approved by ODJFS.			
3.7.1.51	Alert staff that letters/notifications have been generated.			

MITS Business Requirement "Functional Fit" Survey				
Benefits and Service Administration				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
3.7.1.52	Enable staff to customize for issuance the standard letter/notification content as needed on a case-by-case basis or for a mass issuance for a special short-term situation. Maintain a data base of all the customized letters/notifications issued by ODJFS assuring that the data base tracks individual providers/consumers or provider type groups/ consumer eligibility group who received the customized letters and the date of issuance. Enable reports by data base demographics to be created.			
3.7.1.53	Allow staff to track requests through the entire PA process.			
3.7.1.54	Accept and respond to PA requests/amendments by paper, fax, telephone, Medicaid Portal or electronic transmission. Accept and respond to Medicaid Portal and electronic transmission using the 278, 275, XML, HL7D Health Care Services Review standard and the National Council for Prescription Drug Programs (NCPDP) standard for retail pharmacy.			
3.7.1.55	Accept on-line, real-time entry and update of PA requests through the Medicaid Portal, including initial entry of PA requests pending determination.			
3.7.1.56	Image PA requests and attachments and make them available for on-line retrieval, regardless of the mode of submission.			
3.7.1.57	Implement and maintain an automated process to link PA attachments (no matter what format), such as X-rays and virtual dental models, with the corresponding PAs that have been submitted electronically.			
3.7.1.58	Track, identify, and display on-line the location of the PA, the individual assigned to review the PA, and the length of time at that review location (including both ODJFS and contractor consultants).			
3.7.1.59	Process PA requests/amendments according to ODJFS-approved guidelines and provide automated, near real-time responses to providers on the outcome (approved, pending, or denied), including the ability to override or bypass PA edits/audits.			
3.7.1.60	Generate and distribute ODJFS-approved PA request forms and attachments to providers.			
3.7.1.61	Identify and review PA requests for which an appeal has been submitted, indicate the outcome of such reviews, and identify PAs for which an appeal has been filed.			
3.7.1.62	Update PA records based on claims processing to indicate that the authorized service has been used or partially used, including units and/or dollars, during each PA request period.			
3.7.1.63	Identify service categories that are subject to the same limitation and accumulate the same combination of services. Use combined services to compare to service authorization limit.			

MITS Business Requirement "Functional Fit" Survey				
Benefits and Service Administration				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
3.7.1.64	Allow for modification to the scope of services authorized and extend or limit the effective dates of authorization.			
3.7.1.65	Process PAs for non-covered services per ODJFS guidelines.			
3.7.1.66	Close unused PA records automatically after an ODJFS -defined time period. Issue a log sheet of the PAs that were closed. Archive records of closed PAs and keep the standard history period specified in the general requirement period.			
3.7.1.67	Purge records from on-line system and archive them on approved media as specified by ODJFS.			
3.7.1.68	Maintain provider-specific PA history and consumer-specific PA history.			
3.7.1.69	Allow staff to suspend PA requests, based on ODJFS rules, and identify the PA suspense status. Notify provider electronically or in a written format (e.g., mail) with results of PA clerical and/or clinical reviews and request additional information that is required from the provider.			
3.7.1.70	Allow providers access to pended PA's for near real-time corrections, but only have access to certain data fields (those fields that need to be corrected).			
3.7.1.71	Maintain and display on-line the following data for amended PAs: • Amendment number • Amended services codes and descriptions • Amended authorized amounts (units, dollars) • Amended date • Amended reason code and message • Amended reason message • Reviewer ID and authorizer ID.			
3.7.1.72	Provide on-line capability for ODJFS and contractor staff to analyze and report, at minimum, the following: • Claims applied against a PA • PA records/amendments meeting specified criteria • Up to at least seven years of on-line PA history except for dental and/or other services whose approval period exceeds that period • PA submission, expenditure, and service patterns of billing and rendering providers • PA submission and adjudication characteristics and results, by provider type, by consumer type, by place of service, type of service, by named provider or consumer, by diagnosis, by quantity of service, by frequency of service, and by individual authorizer • Total service amounts billed in certain categories or sub-categories of service (such as home health) compared with the total number of services authorized for a combination of categories and sub-categories			

MITS Business Requirement "Functional Fit" Survey				
Benefits and Service Administration				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
	• The number of authorized services provided and how many authorized services remain.			
3.7.1.73	Generate on-line reports at times specified by ODJFS, including: • Dollar value of services authorized • Suspended PAs • Duplicate PAs • Frequency of service codes requested and authorized • Quantity requested versus quantity approved • Utilization reports (including the number of times particular services were approved), by provider, provider type, consumer, individual types of services, and combinations of services • Denials (including denial reason), approvals, modifications, amendments, pends (including pend reason), with Year-to-Date (YTD) totals • PA reports to identify status of PA, type of PA and in which location (e.g., contractor, State) the PA is. • Provider's PA history showing which peer group the provider belongs to and giving a statistical analysis of where the provider stands in relation to peers in terms of number and type of PA requests • Outstanding approved PAs that have not been used within a specific time period • Summary and detail report by provider/agency on how many PAs were requested, approved, modified, or denied; outstanding PAs (authorized but unused services) and who authorized the services • Summary and detail reports showing type of PA, location, number of days in process, and adjudication decision • Summary and detail reports to track and summarize PAs processed by adjudication mode (e.g., automated or manual) • Summary reports that include consultant hours worked and projects worked on			
3.7.1.74	Accept level of care data electronically from ODJFS and its contractors.			
3.7.1.75	Provide ODJFS with on-line access to waiver services data.			
3.7.1.76	Allow for on-line entry, registration, and submission of PA data to the MITS via the Medicaid Portal. Data fields include: • ~~Individual ID~~ ****Consumer billing number**** • Service • Provider name and ID • Dates of service • Authorized services (units, effective dates) • Miscellaneous codes w/ notes field (for contractors) • Rates • Dollar cap			

MITS Business Requirement "Functional Fit" Survey				
Benefits and Service Administration				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
	• Local provider information • Provider demographic and rate data • Limits • Certification information • Room and board • Health costs • Waiver start date • Waiver program (benefit package) • Waiver wait list data • Cost share data			
3.7.1.77	Authorize waiver services for a specific time period (e.g., six (6) months or one (1) year).			
3.7.1.78	Approve service authorization requests for waiver services up to a specific dollar amount.			
3.7.1.79	Generate on-line reports at times specified by ODJFS for the following including: • Waiver functional eligibility • Outstanding liability from claims and PA • Outstanding consumer liability • Open Prior authorizations at any give time • Obligation based on authorization data. • Prior authorizations versus claims.			
3.7.1.80	Perform mass updates/revisions/ amendments to opened and impacted PA s or provide an alternative methodology to handle impacted PA s, when procedure codes and/or modifiers which require PA have been deleted as HIPAA-compliant codes and procedure codes have been replaced with other (new or revised) HIPAA-compliant codes. The alternative methodology must be one which minimizes the need to require re-submission and re-processing of PA requests and the need to accept and process claims with non-HIPAA-compliant codes.			
3.7.1.81	Require PA and process PA requests on a variety of covered services excluded from the long term care facility service/payment for residents of long term care facilities or LTC facility-inpatients (i.e., not residents but admitted to LTC facilities) or other settings (assisted living, group homes, etc.) when PA is not required individuals living in private residences.			

MITS Business Requirement "Functional Fit" Survey				
Benefits and Service Administration				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
3.7.1.82	Provide information automatically about the living arrangement of the consumer to the PA staff during the PA process. If the consumer is a resident of an LTC facility or is an LTC facility inpatient, pertinent LTC facility demographics should be made available to PA staff. Information would include level of care (LOC) & LOC effective dates, name of the facility and Medicaid provider number, LTC facility date spans, spend-down amount, Patient Liability Amount (PLA), and PLA effective dates.			
3.7.1.83	Prohibit PA approval from occurring if ODJFS business rules prohibit coverage of the service in an LTC facility setting and does not allow PA to ever override this business rule.			
3.7.1.84	Assure that even with an approved PA that the claim will not pay if ODJFS LTC facility living arrangements indicate that the individual lives in an LTC facility setting on the date of service if an LTC facility prohibition applies.			
3.7.1.85	Provide information automatically about the consumer's participation or enrollment in other programs that would affect the disposition of the PA to PA staff during the PA process. For example, enrollment in hospice, TPL, Medicare coverage, enrollment in enhanced care management or some case management program, enrollment in a waiver program, etc. The system should provide detailed demographics of the program as determined by the ODJFS.			
3.7.1.86	Prohibit PA approval from occurring if ODJFS business rules prohibit coverage of the service if the individual's enrollment or eligibility in the aforementioned programs precludes coverage of the service by Medicaid and the business rules do not allow PA to override this business rule.			
3.7.1.87	Assure that, even with an approved PA, the claim at the time of adjudication will not pay if ODJFS records indicate the individual is enrolled or covered by one of the aforementioned programs on the date of service if the prohibition applies.			
3.7.1.88	Assure that, when an overall service requiring PA will result in the submission of multiple claim types from a variety of provider types, the disposition of all PA requests (if the methodology requires a separate PA request for each claim that will be submitted) are consistent with one another. Link all related PA s either by the numbering mechanism to cross-reference documentation. (For example, if gastric-bypass surgery requires PA, the disposition for the hospital facility payment, the surgeon's payment, and the anesthesiologist's payment should have the same disposition (approved, denied, deferred, etc.) and we should be able to pull up the related PA requests as a complete service package.)			

MITS Business Requirement "Functional Fit" Survey				
Benefits and Service Administration				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
3.7.1.89	Handle HCPCS codes with a minimum of up to four modifiers. When processing prior authorized claims, the system must match the PA-required procedure codes submitted on the claim against the approved PA request at the modifier, or if applicable, at the multiple modifier level.			
3.7.1.90	Consider any PA overrides and/or the final edit dispositions before a claim is adjudicated. Based on business rules, match edit dispositions/overrides or allow edit dispositions/overrides to vary between the two processes.			
3.7.1.91	Accept information/files/communications from any other ODJFS vendor whose contracts/agreements require the entity to perform utilization management and/or prior/post authorization functions and/or enhanced care management and/or sub-recipient State agency/ODJFS program case management services (e.g., hospital utilization review vendor).			

MITS Business Requirement "Functional Fit" Survey				
Customer Relationship Management (CRM)				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
4.1	**General MITS CRM System**			
4.1.1	Requirements			
4.1.1.1	Implement a CRM solution to integrate with MITS, existing consumer and provider ACD systems, existing IVR application and other office applications as identified.			
4.1.1.2	Manage contacts with providers, consumers, legislators, attorneys, stakeholders and others entities as identified by ODJFS across multimedia communications such as: email, phone, fax, Medicaid Portal, cell phone, Automatic Call Distribution (ACD) systems, Interactive Voice Response (IVR) application and other communication devices.			
4.1.1.3	Ability to track and manage inquiries, complaints, and/or grievances from customers and stakeholders (e.g., legislators, consumers, providers, managed care plans, provider associations, billing entities, trading partners, sub-recipient State agencies, medical associations and boards, and the general public) regarding State funded health care and other available health care programs provided through the Department.			
4.1.1.4	Integrate the CRM functionality with multimedia communications such as email, fax, Medicaid Portal, and phone to integrate electronic channels with existing call center functions and provide a single process to handle stakeholder interactions with computer telephony integrated with the ACD systems, IVR, centrex phone and desktop computer.			
4.1.1.5	Phase 2 Improve collaboration and workflow-driven processes among ODJFS staff and stakeholders by integrating CRM in MITS workflow, document management, and document imaging technology.			
4.1.1.6	Ability to communicate to consumers, stakeholders, and providers, information such as program benefits and payment and performance information.			
4.1.1.7	Track and report on those business functions identified by ODJFS.			
4.1.1.8	Provide an automated process to alert the responsible agency when a hearing is filed regarding special Medicaid enrollment.			
4.1.1.9	Track all contacts such as calls, correspondence, grievances and complaints from date of receipt through resolution process.			
4.1.1.10	Ability to generate alerts, reports and notifications via multiple medias such as the Medicaid Portal, wireless technology or other mechanisms as identified by ODJFS to consumers, internal staff, case managers, county coordinators, providers and other entities as identified by ODJFS.			
4.1.1.11	Enter, update, store, and retrieve on-line customer service notes related to service information.			

MITS Business Requirement "Functional Fit" Survey				
Customer Relationship Management (CRM)				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
4.1.1.12	Provide customer and transaction analysis that leverages all existing data across ODJFS.			
4.1.1.13	Provide near real-time reporting capability regarding customer service and delivery to include performance metrics diagnostic metrics and participation metrics.			
4.1.1.14	Integrate all other customer functions to provide information on customer behavior, preferences, and trends.			
4.1.1.15	Receive, track and store direct referrals from outside sources (e.g., providers, etc.) on consumers that are possible over-users of Medicaid services.			
4.1.1.16	Ability to send alerts directly to medical care providers, care managers, Medicaid consumers, Medicaid Managed Care Plans and/or OHP staff, as authorized. Alerts will be generated based upon considerations of the types of medical services (e.g., diabetes exams, hospitalization), the timeliness of specific medical services (e.g., Healthchek exams, lead screening test), or the sequence of specific medical services (e.g., immunizations, pap smears).			
4.1.1.17	Interface with external public and private health care data sources (e.g., State Immunization Registry, Census information, lead poisoning database, and sub-recipient State agencies) to allow access to data that can be used to improve the quality or coordination of care provided to Medicaid consumers.			
4.1.1.18	Assign a unique tracking number for each contact (e.g., phone, correspondence) logged.			
4.1.1.19	Link tracking numbers to previous contacts.			
4.1.1.20	Track call/contacts with basic identifying information such as time and date of contact, provider number, consumer number, caller name, contact name, nature of inquiry, length of call, caller's county, customer representative ID, response provided by ODJFS staff, status of inquiry, and if status was elevated or referred and to whom.			
4.1.1.21	Track all correspondence, inquiries, grievances, complaints and subsequent responses coming into OHP through the following channels including: • Consumer ACD Hotline • Provider Services IVR • Provider Services ACD • Governor's office • State and Federal legislative offices • ODJFS Director • Counties • Consumer • Provider • OHP			

MITS Business Requirement "Functional Fit" Survey				
Customer Relationship Management (CRM)				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
	• Sub-recipient State agencies • Office of Inspector General (OIG) • State Auditor • General correspondence.			
4.1.1.22	Identify the type and priority of the grievance, complaint and/or inquiry.			
4.1.1.23	Grant role-based staff access to CRM information to include Medicaid-related correspondence data, even if it is stored in separate databases.			
4.1.1.24	Link correspondence data to appropriate MITS business process(e.g., provider, eligibility, data warehouse/DSS, and claims data).			
4.1.1.25	Receive and track correspondence that comes through multiple communication channels (e.g., fax, email, Medicaid Portal).			
4.1.1.26	Incorporate State, Federal and HIPAA security procedures and protocols into CRM correspondence tracking to support role-based access.			
4.1.1.27	Index all correspondence using parameters as defined by ODJFS (e.g., provider number, consumer number).			
4.1.1.28	Query correspondence records and reports using ODJFS-defined criteria.			
4.1.1.29	Ability to scan all inbound and outbound OHP correspondence to CRM system.			
4.1.1.30	Link scanned images to correspondence and records to provide one view of all related material (e.g., images, letters, interactions, and tracking number).			
4.1.1.31	Provide on-line role-based access to correspondence history for a period up to seven (7) years.			
4.1.1.32	Auto-archive correspondence records for a time period as defined by ODJFS and maintain the ability to purge those records to the ODJFS archiving system.			
4.1.1.33	Incorporate work item routing and queuing to send on-line alerts to identified ODJFS staff and escalate correspondence and phone contacts which have not been responded to within ODJFS defined timeframes to appropriate supervisory staff.			
4.1.1.34	Generate and distribute standardized templates used to respond to correspondence as directed by ODJFS.			
4.1.1.35	Generate ad hoc and standard reports for incoming and outgoing correspondence as defined by ODJFS.			
4.1.1.36	Track all correspondence sent to the counties or any follow-up activities communicated to the county or county agencies. Note: County follow-up activities do not need to be tracked unless they will be incorporated into the CRM system.			
4.1.1.37	Generate notices to requestors automatically or on demand.			

MITS Business Requirement "Functional Fit" Survey				
Customer Relationship Management (CRM)				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
4.1.1.38	Capture the following metrics and make available in report format and frequency as defined by ODJFS: • Time from entry of correspondence to response • Time through the process.			
4.1.1.39	Provide access to publications such as EDI companion documents, policy, training guides, consumer pamphlets thru multiple communication channels, (e.g., email, Medicaid Portal and fax).			
4.1.1.40	Provide the capability to support a desktop publishing application.			
4.1.1.41	Track correspondence with basic identifying information such as time and date, provider name/number, consumer name/number, contact name, nature of contact, county of residence, status of inquiry, if status was elevated and to whom.			
4.1.1.42	Provide standard letter templates and the ability to add supplemental free form text specific to the inquiry in order to develop individualized responses for unique or more complex issues.			
4.1.1.43	Capture contact information when calls are routed through the Automatic Call Distribution System (ACD) as defined by ODJFS.			
4.1.1.44	Populate call/contact management tracking system screens with relevant consumer and provider information including: • Consumer eligibility and demographics • Provider certification and demographics • Claims information • Other related calls/contacts.			
4.1.1.45	Ability to transfer, refer and track call/contacts to and from contractor or ODJFS staff for follow-up.			
4.1.1.46	Provide the ability to include the following information for referrals: • Call/contact priority • Referral date • Resolution due date (ability to calculate date as defined by the State) • Resolution date • Referral unit/person ID • Name and ID of person resolving the call • Track resolution/disposition of calls.			
4.1.1.47	Ability to archive and purge calls/contacts/correspondence from the CRM as directed by ODJFS.			
4.1.1.48	Allow inquiry and on-line display of call/contact/correspondence records by type, original call/contact date, consumer or provider name or number, caller name (if different than consumer), customer service correspondent name or ID, or any combination of these data elements.			

MITS Business Requirement "Functional Fit" Survey				
Customer Relationship Management (CRM)				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
4.1.1.49	Support easy navigation from call/contact/correspondence logging screens to other data relevant screens or other relevant system screens.			
4.1.1.50	Allow multiple screens to be displayed at one time.			
4.1.1.51	Provide inquiry routing and escalation capabilities based on priority and length of time as defined by ODJFS for inquiries that are outstanding.			
4.1.1.52	Generate a system notification to alert a customer service correspondent or other ODJFS staff that a call/contact/correspondence has been assigned to them.			
4.1.1.53	Include analytic functionality to collect customer (e.g., consumer, provider, county) information and the ability to classify customers into segments and by educational information.			
4.1.1.54	Provide on-line tutorial CRM user training for State staff.			
4.1.1.55	~~Interface and exchange data with other State-identified CRM systems.~~			
4.1.1.56	Verify that consumers and/or their representatives are verified/authenticated prior to releasing information in accordance with the State and Federal PHI requirements.			
4.1.1.57	**** Access**** ~~Interface with~~ the ****MITS-based**** Patient Disease Registry, ~~and/or~~ ****and/or interface with external**** ~~other such~~ databases, and send alerts regarding clinical information such as flu shots, Healthchek/EPSDT screening, and pharmaceutical use to the health service provider, consumer, prescribing provider, and the managed care plan responsible for the care management of the patient.			
4.1.1.58	Create ODJFS defined extract files from the CRM application that contain summary information on all calls/contacts/correspondence received during a specified timeframe.			
4.1.1.59	Refer and track call/contact to other contractor or ODJFS staff for follow-up. When the call/contact/correspondence is referred, in addition to the basic call/contact/correspondence identifying information, the referral shall include: • Call/contact priority • Referral date • Resolution due date • Actual resolution date • Referral unit/person • Name and/or ID of person resolving the call/contact • Description of the resolution.			
4.1.1.60	Ability to track calls that do not go through the ACD system to the CRM application.			

MITS Business Requirement "Functional Fit" Survey				
Customer Relationship Management (CRM)				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
4.1.1.61	Interface CRM with the ACD applications to track and respond to telephone inquiries and also provide the capability to enter face-to-face contacts.			
4.1.1.62	Track and store detailed information regarding all reporting requests, including: • Who requested the information • Date • Time • What the report included • Report storage upon completion • Route the entire history on-line.			
4.1.1.63	Support near real-time notification to the case manager and/or other ODJFS identified personnel of the following consumer events including: • Hospitalization • LTC facility admission • ICF-MR admission • Emergency room admission.			
4.1.1.64	Provide the flexibility to update the system without interruption to service, to meet future business needs.			
4.1.1.65	Provide a response to the most commonly asked questions regarding program and benefit information.			
4.1.1.66	Provide interface with MITS that allows staff on-line role-based access to program and benefit information to include benefit packages with service limitation and usage.			
4.1.1.67	Generate alerts/advisory notices via multi-media channels to selected groups regarding updates to program and benefit information.			
4.1.1.68	Support the ODJFS strategic plan to provide clinical outcome measurements, performance measurements, and disease information.			
4.1.1.69	Link to the provider locator application .			
4.1.1.70	Provide a computer telephony integration system that automatically populates CRM screens with relevant provider information including: • Provider certification and demographics, including enrollment status, provider number, etc. • Claims information • Payment information • Other related calls/contacts.			
4.1.1.71	Provide templates regarding membership and premium information via web access to managed care plans.			
4.1.1.72	Provide the ability to electronically exchange several types of reports with the LTC provider community, for example, the MDS exception report.			

MITS Business Requirement "Functional Fit" Survey				
Customer Relationship Management (CRM)				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
4.1.1.73	Interface multi-media systems with the Medicaid Portal, ACD systems and IVR to capture, maintain, and report on the following performance, diagnostic, and participation metrics such as: • Customer service levels • Web activity • Service levels • Compliances • Bottlenecks • Number of escalations • Number of alerts • Number of referrals (all weekly, monthly, yearly) • Number of customer contacts • Specific functions used • Timelines of updates • Accuracy abandonment rates • Inappropriate use of system defaults.			
4.1.1.74	Generate alerts and notifications to the waiver program when specific dollar amounts or units are reached.			
4.1.1.75	Generate alerts to Healthchek county coordinators and physicians when blood lead levels exceed State thresholds and follow up notifications for EPSDT appointments.			
4.2	**Consumer Interface**			
4.2.1	Requirements			
4.2.1.1	Implement an automated customer relationship management system to interface with the existing Consumer Hotline Call Center ACD system used to manage consumer inquiries regarding health care programs including: • Eligibility enrollment spans for special programs (e.g., Hospice, Primary Alternative Care and Treatment (PACT), Waiver and PACE) • Benefit packages • Immunization (vaccine information) • Health education • Prior authorization status • Claim info and status • General complaints • Language translation • Access to providers • Appeals process & State hearings (reimbursement) • Policy • Delivery system • MCP information • Applications • Medicare Buy-In • Healthchek			

MITS Business Requirement "Functional Fit" Survey				
Customer Relationship Management (CRM)				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
	• Pregnancy related services • Disease registry • Blood testing.			
4.2.1.2	Capture and track consumer calls/contacts with basic identifying information. The information shall include the following: • Time and date of call/contact • Unique call/contact ID number • Consumer name • Consumer ID number or representative ID number • "How-heard-of" (how the consumer got the contact information) • Caller name (if not the consumer) and relationship to consumer • Consumer SSN • Nature of call/contact • Details of call/contact • Type of inquiry (e.g., phone, written, face to face, Medicaid Portal, email) • Capacity for free form text of at least three thousand (3,000) characters for description purposes • Status of inquiry (e.g., finalized, follow up needed, etc.) • Date of resolution • Who responded • Response given by customer service correspondent and format response give (e.g., mail, phone) • Length of call when a phone contact • Caller's county • If translation assistance was required and the requested language • Customer service correspondent name and ID • Current mailing address • Priority of call/contact (e.g., urgent, emergency, routine, etc.) • Business information • Service type • Service date • Provider information • If inquiry was elevated • To whom it was elevated • Provider information (if applicable).			
4.2.1.3	Allow consumers to select and store a preferred method of communication.			
4.2.1.4	Support an email directory of consumers.			
4.2.1.5	Support managed care "grievances and appeals" which will continue to be handled by the managed care plans as mandated and monitored by ODJFS.			

MITS Business Requirement "Functional Fit" Survey				
Customer Relationship Management (CRM)				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
4.2.1.6	Provide CRM ability to log and track managed care issues such as "just cause". Currently a stand alone system supports this function.			
4.2.1.7	Generate and distribute ODJFS approved automated messages to selected consumers via phone, fax, and/or Medicaid Portal.			
4.2.1.8	Provide consumers with a secure message center where messages can be sent and received by ODJFS.			
4.2.1.9	Interface CRM with the Consumer Hotline ACD system to capture performance metrics for service delivery reporting such as: • Number of daily calls/contacts answered • After hours calls/contacts • Total calls abandoned • Abandoned/lost rate percent • Call/contact customer service correspondent hours logged • Daily totals of calls/contacts for each customer service correspondent • Average calls/contacts (inbound) per Full Time Equivalent (FTE) • Average calls/contacts (inbound) per hour • Average wait time/minute • Average hold time in queue • Average talk time (minutes) • Agent active/available percent • Average idle time per customer service correspondent • Total outbound calls • Calls/contacts routed to a number outside of the customer service lines • Totals of caller/contacts by type including consumers, county or SSA agencies, advocates and others • Call topics regarding specific categories including FFS, managed care, finding a dental provider, benefit coverage, food stamps and others • Calls/contacts by hour (Busy Hour Report) to include calls received during business hours including average calls by day of week report • Calls/contacts assigned to an individual customer service correspondent or group • Number of messages left on voice mail • Number of returned responses categorized by phone, mail, fax or Medicaid Portal (email and portal) • Referrals to other units, including local income maintenance agencies, and other State specified units • Customer Service Correspondent active/available percent			

MITS Business Requirement "Functional Fit" Survey				
Customer Relationship Management (CRM)				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
	• Daily totals of calls/contacts for each customer service correspondent • Call topic. • Total number of calls per day and month, • Number of solved inquiries, • Number of inquiries referred, and • Tracking agent specific performance.			
4.3	**Provider Interface**			
4.3.1	Requirements			
4.3.1.1	Interface the CRM with the existing Provider Call Center's Automatic Call Distribution (ACD) and the Provider Interactive Voice Response (IVR) systems that handles provider calls to capture service delivery performance metrics for incidents such as total number of calls per day and month, number of solved inquiries, number of inquiries referred, and with the capability to track agent specific performance.			
4.3.1.2	Capture and track provider calls/contact data with basic identifying information. The information shall include the following: • Time and date of call/contact • Provider name and ID number • Type of provider • Caller or contact name (if not the provider) • Contact phone number and email • Nature and details of the call/contact • Type of inquiry (e.g., phone, written, face to face, Medicaid Portal, email) • Length of call when a phone contact • Caller's county • Customer service correspondent name and ID • Response given by customer service correspondent and the format in which the response was given (e.g., written, telephone, email) • Status of inquiry (e.g., closed, follow-up needed, etc.) • Capacity for free form text of at least five hundred (500) characters to describe problems and resolutions. • Authentication • Number of times called.			
4.3.1.3	Interface CRM with the provider ACD and IVR systems to capture performance metrics for service delivery reporting such as: • Incoming calls/contacts answered • After hours calls/contacts • Cumulative calls/contacts answered • Total calls abandoned			

MITS Business Requirement "Functional Fit" Survey				
Customer Relationship Management (CRM)				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
	• Abandoned/lost rate percent • Call/contact customer service correspondent hours logged on • Daily totals of calls/contacts for each customer service correspondent • Average calls/contacts (inbound) per FTE • Average calls/contacts (inbound) per hour • Average wait time/minute • Average hold time in queue • Average talk time (minutes) • Agent active/available percent • Average idle time per customer service correspondent • Total outbound calls • Calls/contacts routed to a number outside of the customer service lines • Totals of caller/contacts by type including provider, billing entity, agencies, advocates and others • Call topics regarding specific categories to include managed care, claim status, provider payment, provider and consumer eligibility and prior authorization • Calls/contacts by hour (Busy Hour Report) to include calls received during business hours including average calls by day of week report • Calls/contacts assigned to an individual customer service correspondent or group • Number of messages left on voice mail • Number of returned responses categorized by phone, mail, fax or Medicaid Portal (email and portal) • Referrals to other units, including local income maintenance agencies, and other ODJFS specified units • Customer service representative active/available percent • Daily totals of calls/contacts for each customer service correspondent • Call topic • Number of call contacts • Cumulative year-to-date statistics • Year-to-year comparisons and trend			
4.3.1.4	Provide CRM capability to manage provider (customer) relationships by capturing claim data to anticipate/forecast the provider's needs, incorporating learned information about the provider and generating individualized responses.			
4.3.1.5	Provide CRM capability to identify, log, route, track, and archive all provider correspondence such as letters, inquiry forms, and corresponding attachments such as claims, x-rays, and prior authorization.			

MITS Business Requirement "Functional Fit" Survey				
Customer Relationship Management (CRM)				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
4.3.1.6	Allow inquiry and on-line display of CRM call/contact records by type (letter, fax, phone, etc.), original call/contact date, consumer or provider number, caller's name (if different than provider), customer service correspondent name or ID, inquiry status, or any combination of these data elements.			
4.3.1.7	Interface CRM with the Decision Support System to identify providers that may require additional educational support and to provide provider pay for performance information as defined by ODJFS.			
4.3.1.8	Interface CRM with the provider enrollment application to identify and notify both the newly enrolled providers and training unit of the need to schedule training.			
4.3.1.9	Provide the capability through the CRM to compile and generate a summary of responses from provider training questionnaires from all sessions, select field representative encounters, and meetings.			
4.3.1.10	Provide the capability to track all written provider inquiries from date of receipt to final resolution using an automated system.			
4.3.1.11	Provide a listserv capability which will enable providers to subscribe to OHP/ODJFS email notifications.			
4.3.1.12	Provide on-line access and/or links to the following such as OHP/ODJFS publications, EDI companion documents, provider handbooks, training guides, and managed care plans through multiple medias (e.g., Medicaid Portal, CDs, other) to designated providers, consumers or other groups.			
4.3.1.13	Generate on a monthly basis, a summary report to identify all publications issued during the month.			
4.3.1.14	Generate training reports (by provider type) to include: • Training schedules • Training registration forms • Number of attendees • Provider survey results • Number of provider training sessions and workshops • Number of meetings • Number of publications • Calls handled by field representatives • Provider visits. • Association and group Meetings.			
4.3.1.15	Interface CRM with MITS for access to remittance advice information, credit balances, and payment information through the Medicaid Portal.			
4.3.1.16	Provide on-line access training schedules and meeting information through the Medicaid Portal.			
4.3.1.17	Provide the capability for providers to query LTC databases to include cost reports, rate setting, and case mix data through the Medicaid Portal.			

MITS Business Requirement "Functional Fit" Survey				
Customer Relationship Management (CRM)				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
4.4	**Provider Enrollment/Maintenance**			
4.4.1	Requirements			
4.4.1.1	Provide a Medicaid Portal application to support OHP business processes such as provider enrollment, provider credentialing, and provider maintenance to be used by providers, trading partners, sub-recipient State agencies and managed health care organizations.			
4.4.1.2	Allow on-line and/or batch entry and storage of provider data. Effective begin and end dates for appropriate elements must be provided for each update. Provider data includes: • Provider number • Disclosure /ownership information • Office hours • New patient information • Language • Provider name – store names in a standard format as specified by ODJFS; (both legal name and DBA name) • Provider type, specialty, and/or taxonomy • Enrollment and certification dates • Enrollment status • Certification status • Certified providers accepting new patients • Degree information • Multiple addresses including mailing address, payment address, multiple practice location and prior authorization notice or other notice addresses. Address format should conform to postal regulations and allow a zip plus 4 digit code. • County and locality information • Phone number(s) • Contact person(s) • Multiple fax number(s) • Multiple E-mail address(s) • National Provider Identifier (NPI) per HIPAA requirements, when implemented • Uniform Provider Identification Number (UPIN) • Drug Enforcement Agency (DEA) number • Social Security Number (SSN) • Federal Employer Identification Number (FEIN) • Clinical Laboratory Improvement Act (CLIA) number • Medicare numbers • License/certification/registration number • Categories of services for which a provider is allowed to bill • Approved transactions under the Trading Partner Agreement • Provider billing, rendering, or non-billing provider number and/or NPI			

MITS Business Requirement "Functional Fit" Survey				
Customer Relationship Management (CRM)				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
	• Identify pre-scriber only providers who are allowed to prescribe medication but are not enrolled or certified under other services. • Identify providers that receive publications and the type of service specific publications (e.g., physician, chiropractic, dental, other) • Any data elements required for proper program administration • Approved HIPAA transactions • Other provider related data required for EFT processing.			
4.4.1.3	Store in provider subsystem, provider demographic information included in ASC X12, EDI transactions 274 such as: • Health Care Provider Inquiry and Information Response Guide • Health Care Provider Credentialing Implementation Guide • Health Care Provider Directory Implementation Guide • Health Care Provider Information Implementation Guide.			
4.4.1.4	Allow providers to complete, submit, resubmit, modify, or cancel applications and updates via the Medicaid Portal.			
4.4.1.5	Incorporate into the provider subsystem all information collected on the current types of provider enrollment applications.			
4.4.1.6	Incorporate relationship editing, as defined by ODJFS, into interactive Medicaid Portal application.			
4.4.1.7	Use a single enrollment application with required fields being driven by provider type as identified by ODJFS. Active provider numbers will not be assigned until all the verification, accreditation, and credentialing is complete. Note: There will be differences in required data for MCPs, and the system must be able to distinguish by provider types which fields must be completed.			
4.4.1.8	Edit to ensure the Medicaid Portal application and MITS requires completion of all required fields, as defined by ODJFS, before the application is accepted.			
4.4.1.9	Check for duplicate providers and owners when processing an enrollment application and/or update.			
4.4.1.10	Link providers/facilities to parent organizations.			
4.4.1.11	Incorporate electronic signatures that comply with Ohio Administrative Rule 123:3-1-0, with provider enrollment applications and updates.			
4.4.1.12	Use a zip code application to automatically populate on-line screen fields such as county and city.			
4.4.1.13	Edit and verify accuracy of all entered data for presence, format, validity and consistency with other data in the update transaction and on the provider subsystem (e.g., prevent duplicate provider enrollment).			
4.4.1.14	Provide the capability to update the provider subsystem in near real-time.			

MITS Business Requirement "Functional Fit" Survey				
Customer Relationship Management (CRM)				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
4.4.1.15	Provide the capability to update the provider files with service restrictions requested by ODJFS. Allow authorized users to add, change or delete all provider data on-line, near real-time contingent on role-based criteria defined by ODJFS with a tiered approval and management approach.			
4.4.1.16	Allow authorized users to add, change or delete all provider data on-line, near real-time contingent on role-based criteria defined by ODJFS with a tiered approval and management approach.			
4.4.1.17	Identify applications and updates by provider types that are assigned by ODJFS.			
4.4.1.18	Retain all open and closed segments along with information such as user identification, date and time for both the before and after image.			
4.4.1.19	Identify providers with a unique provider number using the ten (10) digit National Provider Identifier. Unique identifier information should include all locations, provider types, specialties, provider taxonomy, authorization/certifications/licensing for services, and all other appropriate information for that provider as a logical record linked to the one provider number.			
4.4.1.20	Provide the ability to assign provider identification numbers to non-medical providers.			
4.4.1.21	Crosswalk from legacy provider number to NPI.			
4.4.1.22	Store multiple provider addresses including: physical, contact and pay to.			
4.4.1.23	Use industry standards for provider specialty information.			
4.4.1.24	Provide on-line, near real-time creation and modification of provider types, program specialties and associated information.			
4.4.1.25	Provide on-line ability to identify, add and update transfer of funds to ****sub-recipient State agencies**** ~~providers~~.			
4.4.1.26	Input supporting documentation included in the enrollment process, such as paperwork related to verification of the license, into a document imaging application and then match that input with the enrollment application in the system.			
4.4.1.27	Provide staff on-line inquiry to supporting documentation related to an enrollment application in the system.			
4.4.1.28	Provide role-based on-line query and sort function for all provider enrollment application and update activities as defined by ODJFS.			
4.4.1.29	Notify on-line ODJFS staff that a new provider has been enrolled or re-enrolled.			
4.4.1.30	Provide help screens to define enrollment data requirements for providers and users.			
4.4.1.31	Alert appropriate staff that an enrollment application and/or update has pended for a certain amount of days as defined by ODJFS.			

MITS Business Requirement "Functional Fit" Survey				
Customer Relationship Management (CRM)				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
4.4.1.32	Automate the process used to perform review/verification and re-verification activities to include, but not limited, to all provider types, including enrollment, sanctions and appeal processing.			
4.4.1.33	Provide functions for ODJFS staff to review and track all applications throughout the review/certification process to final disposition of the application to include applications and/or updates submitted through the Medicaid Portal.			
4.4.1.34	Notify providers of acceptance/rejection as a Medicaid provider and send enrolled providers an electronic notice for web site locations regarding policy and billing information.			
4.4.1.35	Generate in an automated manner tracking numbers, for all provider types, for all applications and updates. In the case of MCPs, the testing tracking number must be compatible with the current eligibility system.			
4.4.1.36	Generate to the submitter a receipt notification with a tracking number when the application or update is submitted for review.			
4.4.1.37	Utilize a system generated tracking number for trading partner and managed care testing prior to certification in lieu of a provider number.			
4.4.1.38	Route applications and updates to the appropriate ODJFS staff to process.			
4.4.1.39	Allow access, with appropriate level of security, to providers to retrieve the status of their application.			
4.4.1.40	Provide on-line training application and help screens for the provider subsystem.			
4.4.1.41	Provide the ability to easily share certification and/or license information between sub-recipient State agencies.			
4.4.1.42	Provide automated data exchange with such entities as CMS, DEA, OSCAR, CLIA, Automated Survey Process Environment (ASPEN), OIG sanction list, National Plan and Provider Enumeration System (NPPES), and the National Practitioner Databank when verifying or credentialing the provider and for ongoing maintenance to support provider integrity.			
4.4.1.43	Maintain a cross-reference to identify prescribing physicians using the 10-digit numbering scheme developed by HCIdea (a national prescribing number being promoted by NCPDP).			
4.4.1.44	Automatically cross reference license and sanction information as defined by ODJFS such as other sub-recipient State agencies, other licensing or accreditation agencies, and the Federal Office of Inspector General sanction list to prevent enrollment and certification of any provider with outstanding sanctions.			
4.4.1.45	Send electronic notification to the provider based on the communication method chosen by the provider, which should be specified on the application.			

MITS Business Requirement "Functional Fit" Survey				
Customer Relationship Management (CRM)				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
4.4.1.46	Allow providers to request termination of their provider agreement, enroll and/or update their provider information on-line using the Medicaid Portal.			
4.4.1.47	Terminate providers that meet specific criteria (e.g., sanctioned by the Medicare Program).			
4.4.1.48	Automatically generate and send termination notices to providers based on ODJFS-approved criteria.			
4.4.1.49	Provide structured on-line templates regarding enrollment and maintenance to providers.			
4.4.1.50	Maintain history and audit trails for all changes and updates to the provider subsystem.			
4.4.1.51	Restrict data elements that providers can change on-line, as defined by ODJFS. Other changes will require approval by ODJFS staff.			
4.4.1.52	Communicate changes of provider numbers to the current eligibility system.			
4.4.1.53	Include provider agreements with the enrollment application except for LTC and MCP-subcontracted providers. The LTC provider agreement must be completed by the provider after ODJFS staff have reviewed the application and performed verification. For providers that are contracted with an MCP and with FFS, the FFS provider agreement should be included with the enrollment application and the MCP subcontract should be included in the MCP provider verification system.			
4.4.1.54	Store and provide on-line access to provider data for the certification, review and approval functions. Track information required for provider applications through final disposition, as well as the re-certification, change of ownership, and /or related update processes. Information should include: • Certification request date • Date certification materials sent • Date returned certification materials received • Application status (e.g., certified, pending, rejected) • Number of approved applications • Number of pending applications and length of time pending • Number of rejected applications and reasons • Provider name • Provider number • Provider type • Demographics • Missing data • Re-certification dates • Re-certification materials sent/dates • Narrative field • Tracking number.			

MITS Business Requirement "Functional Fit" Survey				
Customer Relationship Management (CRM)				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
4.4.1.55	Generate all required provider material based on ODJFS policy for new, re-enrolled, and certified providers.			
4.4.1.56	Identify and generate notices to providers due for re-certification/re-enrollment and include appropriate re-certification/re-enrollment materials based on ODJFS specified re-certification and re-enrollment schedules.			
4.4.1.57	Maintain and store electronic copies of provider materials for all approved and denied providers. The file for approved providers contains the application, provider agreements, copy of provider license, and all correspondence relating to certification or re-certification resulting in a provider file update. Files for denied providers will include applications and/or profile information and documentation regarding the reason for the denial.			
4.4.1.58	Provide the capability to download provider information from the National Plan and Provider Enumeration System (NPPES) that contains NPI information.			
4.4.1.59	Accept and perform mass data updates such as NPI, telephone information, licensing and credentialing.			
4.4.1.60	Track, maintain, and report provider enrollment status codes with their associated date spans. The enrollment status codes must include: • Closed or out of business • Approved • Change of ownership • Limited time-span enrollment • Enrollment pending • Terminated – voluntary/involuntary • Provider deceased • Provider retired.			
4.4.1.61	Allow tracking of provider activities/movements into and out of group practices.			
4.4.1.62	Use ODJFS defined standardized abbreviations for data fields in the provider file.			
4.4.1.63	Use a zip code application to automatically populate on-line screen fields such as county and city.			
4.4.1.64	Support possible policy changes in the future to enforce such higher-order provider qualifications for the purpose of improving quality of care, coordination of care, and health outcomes for Medicaid consumers.			
4.4.1.65	Ability to identify those providers who provide immunizations in the office.			
4.4.1.66	Ability to identify those providers who draw blood for tests in the office.			
4.4.1.67	Ability to identify those providers who perform lab tests.			

MITS Business Requirement "Functional Fit" Survey				
Customer Relationship Management (CRM)				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
4.4.1.68	Ability to identify those providers who perform X-ray services in the office.			
4.4.1.69	Ability to identify Durable Medical Equipment providers who offers delivery services.			
4.4.1.70	Maintain an audit trail on all updated transactions applied to the provider subsystem.			
4.4.1.71	Allow the trading partner subsystem to display, track, report, and archive all additions, deletions, and updates with corresponding date span of activity with user identification.			
4.4.1.72	Track provider IDs across organizations with which they are affiliated.			
4.4.1.73	Track different types of certification, (e.g., board certification).			
4.4.1.74	Generate reports on any occurrences of duplicate provider numbers and ownership.			
4.4.1.75	Provide on-line, and/or on-demand statistics and reports of provider enrollments/updates and audit trail reports to include the number of enrollments per day, week, month and year by provider type, and specialty, inventory management, data operator statistics, web site submissions, and returned applications.			
4.4.1.76	Allow provider data in the provider subsystem to be available to other appropriate subsystems in a near real-time manner.			
4.4.1.77	Purge, transfer, and archive provider records to storage for those providers who have been inactive for a period of three years or as identified by ODJFS.			
4.4.1.78	Support on-line certification and reporting of the Federal OSCAR file.			
4.4.1.79	Automatically update inpatient and outpatient rate information.			
4.4.1.80	Assign trading partner vendor numbers and maintain a subsystem for trading partner information such as linkage of trading partner and provider numbers, transaction testing status, corresponding dates, and what transactions are approved for the EDI vendor/provider relationship and corresponding dates.			
4.4.1.81	Integrate or interface with the MCP provider verification system as defined by ODJFS.			
4.4.1.82	Automatically reconcile provider Medicaid data with Medicare provider information from Carriers and Intermediaries.			
4.4.1.83	Provide on-line capability to establish provider hold and review information.			
4.4.1.84	Provide the ability to include bankruptcy information proceeding for a provider to include the date of filing with ability to identify those claims pre-petition and post-petition.			
4.4.1.85	Track, report and provide on-line capability for all information generated on the annual 1099 report and for previous years as defined by ODJFS.			

MITS Business Requirement "Functional Fit" Survey				
Customer Relationship Management (CRM)				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
4.4.1.86	****Provide the ability to enter, view, and modify**** ~~Access~~ information such as fines, Internal Revenue Service (IRS) levies/liens, ****court (fraud) monies on Medicaid via criminal/civil proceedings, and required**** ~~and~~ child support ****payments****.			
4.4.1.87	Provide on-line capability to establish installment plans for providers based on ODJFS defined criteria.			
4.4.1.88	Utilize on-line display and query for provider payment history as defined by ODJFS.			
4.4.1.89	Utilize tools and technologies to support provider enrollment activities across multiple channels to include the ACD, IVR, Medicaid Portal, telephone, email, fax and other communication devices.			
4.4.1.90	Integrate electronic channels with existing call center operations handing provider enrollment inquiries.			
4.4.1.91	Integrate with CRM to systematically manage provider relationships by capturing claim data to anticipate/forecast the provider enrollment and training needs, incorporating learned information about the provider and generating individualized responses.			
4.4.1.92	Track and capture call/contact information to manage provider enrollment inquiries from FFS and managed care providers, legislators, and other stakeholders (e.g., managed care plans, provider associations, billing entities, trading partners, sub-recipient State agencies/providers, medical associations and boards, and general inquirers) regarding State funded health care and other available health care programs provided through the Department.			
4.4.1.93	Provide the ability to identify and notify both the newly enrolled providers and training staff of the need to schedule training.			
4.4.1.94	Generates alerts/advisory notices via multi media channels to selected enrolled providers or provider groups regarding updates to program and benefit information.			
4.4.1.95	Maintain home/applicant information currently housed in Perseus, including: • Standard name • Phone • Fax • Mail to addresses • Pay to addresses • Licensure type (specific for NF and ICF-MR) • Number of licensed beds by category, including ICF-MR waiver of license beds and out of service beds • License numbers • ODMR/DD numbers			

MITS Business Requirement "Functional Fit" Survey				
Customer Relationship Management (CRM)				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
	• ODH numbers • Certification type (NF, SNF/NF, ICF-MR) • Number of certified beds by category • Provider name history • Provider agreement history (dates for re-certification) • Ownership data • Franchise fees • Maintenance issues (e.g., change of operators, Re-certifications, Bed changes, etc.) • Owner of the real estate (landlords) • Lessees and subleases • Management agreements of operators • Buyers and sellers for Change of Provider (CHOP) transactions • Non-Medicaid facilities (for future Franchise Fee (FF) purposes) • Medicaid status (active and inactive, with sub codes) • Separate business status (open for business, closed/out of business).			
4.4.1.96	Ability to enter a variety of risk status categories and corresponding effective date when enrolling LTC providers types.			
4.4.1.97	Ability to link provider names, Medicaid provider numbers, and NPIs of affiliated general/acute/rehabilitation hospital or assisted care living provider to that of the LTCF.			
4.4.1.98	Trigger a notice for certain changes, as will be defined by ODJFS, in the provider enrollment subsystem to the claims pricing subsystem to ensure that the appropriate NF or ICF-MR rate is assigned to the applicable service date span as a result of a change in the provider enrollment subsystem.			
4.4.1.99	Make available the following functionality currently exists in Perseus and must be available in the new system if Perseus will no longer be used: • Ability to produce bed count reports by licensure and certification types • Ability to produce lists of new and CHOP homes by time periods • Ability to produce lists of labels of facilities by types • Ability to record some providers that have rates set elsewhere (development centers, Veterans Homes) • Ability to distinguish outliers from regular facilities • Risk/alert status with effective date spans (e.g., homes whose licensures are proposed for revocation, homes under a ban on admission, homes found to be in immediate jeopardy, homes proposed for termination, homes under bankruptcy) • Ability to obtain ODH transfer application data and get certif. survey results			

MITS Business Requirement "Functional Fit" Survey				
Customer Relationship Management (CRM)				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
	• Ability to track sanctions by provider and effective dates (fines, denial of payment for new admission (i.e., bans) and send alerts to payment unit and counties • Ability to compare bed counts to other agencies' bed counts (e.g., Inter-agency agreement with ODMR/DD to invoice for beds above a certain count) • Ability to identify facilities by county (pull up a list of all facilities in a given county) • Ability to track information about the actual physical facility to link with all operators of that facility • Ability to insert comments about events and data, by data element type with effective dates and audit trail of users/authors • Ability to record cost of a change of operator (sale price, lease price, sublease price) and scan/import lengthy lease/sale agreements into provider files • Ability to record transaction type of change of operator (sale, lease, partnership, sale-leaseback, etc.) • Ability to scan business structural analyses into provider files (e.g., depicting corp. reorganizations and parent companies, related entities) • Ability to produce securities documents (escrow documents, promissory notes, etc.) automatically in cases of closure and change of operator notice receipts (using data from provider information and recent monthly vendor totals) • Ability to process re-certifications, with separate procedures for ICF-MR and NF • Ability to process two-month extensions for ICF-MR for provider agreement terms • Ability to identify facilities whose terms are ready to expire • Ability to process bed changes for initial Medicare approvals, for ICF-MRs and development centers, for waiver of licensure requests and for expiration of waiver of licensure requests for ICF-MR and dev. centers, and for taking beds out of service for renovations--all with effective date spans • Ability to process cancellation clauses for ICF-MR • Ability to produce standard letters responding to transaction notices (notice to change operator, to close, to change beds, to get licensure waivers, to add Medicare, etc.) • Ability to produce standard letters calculating penalties for failure to provide adequate notices for closure and change of operator • Ability to produce reports about penalties proposed and imposed • Ability to capture licensure data from ODMR/DD and ODH and Cincinnati Health Department			

MITS Business Requirement "Functional Fit" Survey				
Customer Relationship Management (CRM)				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
	• Ability to record provider records sent to off-site storage if all records aren't scanned into MITS • Ability to produce descriptive reports summarizing info about LTCF enrollment data and changes over time • Ability to track bed movement (transfers) from facility to facility (Certificate of Need (CON) rules, affects rate-setting) • Ability to incorporate separate enrollment protocols for new facilities with transferred beds, new facilities without transferred beds, and change of operators • Ability to link all operators of same facility ownership • Ability to compute assessments (based on bed counts), prepare assessments and track collections • Ability to compare owners, leasees, and subleases across providers • Ability to track 5% and greater owners within the operating company. • Ability to link to ODH survey data.			
4.4.1.100	Provide a test environment to assure MCP competency with EDI transactions governing membership, premium payment and encounter data, including EDI 820, 834, 835, 837I, 837P, and 837D in versions specified by ODJFS.			
4.4.1.101	Assign an internal test number prior to actual provider number assignment to the Managed Care Plan/Care Management provider. The signing of the provider agreement is contingent upon successful testing. The test number must be compatible with the eligibility system. The eligibility system must be able to validate this number in the MITS provider enrollment module. Note: The current eligibility system will only accept a seven (7) digit provider number. The CRIS-E number is cross-referenced to the Medicaid provider billing number and cannot be changed after it is added to the CRIS-E table. This number is also shared with the Selection Services Contractor (SSC) and the Health Care Transactions Processor (HTP) Contractor to use in the set-up of their data systems testing phase with the Plans as well.			
4.4.1.102	Provide the ability to capture and maintain data elements contained in the National Plan and Provider Enumeration System (NPPES).			

MITS Business Requirement "Functional Fit" Survey				
Contract Management				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
5.1	**Managed Health Care Plan Provider Agreements**			
5.1.1	Requirements			
5.1.1.1	Maintain provider agreements for each MCP including imaged signature pages and personalized attachments.			
5.1.1.2	Develop standard HIPAA-compliant encryption methodology to communicate electronically with MCPs, contractors and other medical professionals.			
5.1.1.3	Accept and maintain MCP contracted rates for seven years at a minimum.			
5.1.1.4	Phase 1 Accept electronically rates from actuarial contractors and update the provider charge file with new rate data.			
5.1.1.5	Accept changes and updates to rate schedule and rate cohorts entered on-line by role-based ODJFS-identified staff.			
5.1.1.6	Link the geographic area for each MCP within CMC/CM programs to premium payment generation and payment, down to the zip code level.			
5.1.1.7	Phase 1 Accept electronically and maintain managed care membership data files from the Selection Services Contractor (SSC).			
5.1.1.8	Accept electronic inquiries on newborns from MCPs and verify newborn eligibility as defined by ODJFS.			
5.1.1.9	Forward newborn inquiries and verification status to role-based users as defined by ODJFS.			
5.1.1.10	Phase 1 Generate a notice to the local CDJFS for each newborn who has not been added to the eligibility system for medical benefits as defined by ODJFS.			
5.1.1.11	Interface with the SSC system for the purpose of data sharing, inquiry and audit capabilities.			
5.1.1.12	Provide to role-based ODJFS staff the capability to make on-line changes and updates to MCP membership data as defined by ODJFS.			
5.1.1.13	Provide the capability to monitor, track, maintain, and access compliance performance with CMC/CM program requirements including: • Tracking all compliance assessment activity per MCP and in aggregate from time of assessment to time of resolution • Maintain compliance assessment logs per type of activity for both current and historical activities • Generate reports on compliance assessment activities as defined by ODJFS • Generate alerts for both ODJFS and the MCPs for submission deadlines and other events as defined ODJFS. • Utilize imaging and Optical Character Recognition (OCR) capabilities to store information and documentation received from MCPs including corrective action plans			

MITS Business Requirement "Functional Fit" Survey				
Contract Management				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
	• Calculate fines or other compliance assessments based on the type of penalty assessed as defined by ODJFS • Maintain a log of penalties assessed for ad hoc calculations and reports of MCP compliance status including the accumulation and penalty assessed against MCPs • Automate performance and measurement calculations as defined by ODJFS and integrate with penalty calculations where applicable.			
5.1.1.14	Accept, download, and generate reports on MCP required submissions, as defined by ODJFS.			
5.1.1.15	Track and generate reports on MCP performance as reported by outside sources (e.g., provider/consumer complaints), as defined by ODJFS.			
5.1.1.16	Maintain on-line forms for regular compliance activity and regular MCP correspondence including letters on particular types of compliance actions, forms for the submission of fines, and notices of late submissions.			
5.2	**Sub-Recipient State Agency Contracts**			
5.2.1	Requirements			
5.2.1.1	Phase 1 Automate the disability determination data file transfer from sub-recipient State agencies to MITS.			
5.2.1.2	Store and provide access to back-up documentation in support of inter-agency transfer payments.			
5.2.1.3	Store supporting data for Medicaid Administrative Claiming (MAC) from sub-recipient State agencies.			
5.2.1.4	Identify primary and secondary provider information on claim files, including both sub-recipient State agency and specific provider information.			
5.2.1.5	Allow sub-recipient State agencies to enter administrative information for eligibility into MITS.			
5.2.1.6	Generate reports including: • Outlier reviews (client and provider) • Service utilization reviews by providers, consumer, geographic region, etc. • Services received by consumer • Types of services billed by provider • Cross State billing.			
5.2.1.7	Generate reports for performance monitoring of sub-recipient State agency agreements.			
5.2.1.8	Track pre-established thresholds/performance measures of sub-recipient State agencies.			
5.2.1.9	Generate alerts to notify OHP if pre-established thresholds/performance measures of sub-recipient State agencies are not being met.			
5.2.1.10	Track and report on expenditures against purchase order amount.			

MITS Business Requirement "Functional Fit" Survey				
Contract Management				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
5.2.1.11	Phase 1 Automate file transfer of PASSPORT functional assessments, Nursing Facility (NF) Screens, PASRR Screens, Mental Retardation Waiver Functional Assessments and Minimum Data Sets (MDS) Assessments.			
5.3	**ODJFS Administered Home and Community Based Services (HCBS) Waiver Case Management Contracts**			
5.3.1	Requirements			
5.3.1.1	Provide the case management vendor with role-based access to MITS.			
5.3.1.2	Provide the flexibility to add “other” types of new case management contracts that may be required and / or applicable in the future.			
5.3.1.3	Accept electronically and maintain case management vendor contract deliverables including: • Quality management plan • Quarterly management report • Monthly performance report • Monthly initial assessment report • Monthly caseload report.			
5.3.1.4	Utilize workflow capability for review of case management contract deliverables.			
5.3.1.5	Receive and store case management vendor contract data including: • Contract amount • Performance expectations • Contract.			
5.3.1.6	Track deliverable status for case management vendor deliverables including: • Date submitted by vendor • Date reviewed by ODJFS • Accept or reject deliverable • Comments for rejection of deliverable • Date revised deliverable received • Approval date of deliverable.			
5.3.1.7	Alert ODJFS if deliverable from case management vendor is past due date.			
5.3.1.8	Link status of invoice receipt to deliverable acceptance.			
5.3.1.9	Accept electronically and store invoices from case management vendors.			
5.3.1.10	Interface with OAKS to send invoice for payment.			
5.3.1.11	Provide electronic notification to ODJFS of payment to case management vendor.			
5.3.1.12	Track actual versus planned case management vendor performance.			

MITS Business Requirement "Functional Fit" Survey				
Contract Management				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
5.3.1.13	Generate customizable reports for monitoring case management vendor performance.			
5.3.1.14	Provide for electronic submission of corrective action plan from case management vendor.			
5.3.1.15	Edit claims against authorized service level and authorized plan level.			
5.3.1.16	Electronically store All Services Plans (Plans of Care) data and provide the ability to establish and identify rules based thresholds for each All Services Plan to be used for adjudication, analysis and reporting purposes.			
5.3.1.17	Provide electronic storage and retrieval for historical All Services Plans (Plans of Care).			

MITS Business Requirement "Functional Fit" Survey				
Financial Management				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
6.1	**Ohio Administrative Knowledge System (OAKS) Integration**			
6.1.1	Requirements			
6.1.1.1	Integrate MITS with OAKS, which will utilize PeopleSoft Release 8 (or later) financial management software.			
6.1.1.2	Interface with OAKS and support seamless transfers of data between the two systems as required to support Claims Processing and other financial functions; other financial functions may include modules or functionality associated with Accounts Receivable, Budget Management and Analysis, Contract Management, Administrative Claiming, and inter-agency transfers payments.			
6.1.1.3	Provide control and reconciliation reports to track and balance financial information between MITS and OAKS.			
6.1.1.4	Provide an identification and tracking mechanism that allows aggregate information in OAKS to be associated with supporting detailed information in MITS and vice versa.			
6.1.1.5	Accept warrant numbers, EFT numbers, other payment information and invoice information from OAKS, including information associated with claim payments, stop payments, reissued warrants, voided warrants, encumbrances, accounts receivables, inter-agency transfers, MAC administrative claiming, contract management, etc.			
6.1.1.6	Identify, support on-line review, and generate reports of claims payment detail for claims paid or denied (rejected) through warrants or EFT's issued by the State.			
6.1.1.7	Generate detailed claims payment data reports on-line by warrant numbers, EFT numbers, provider numbers, Medicaid consumer identification, chart fields, fund, and other criteria.			
6.1.1.8	Send claims payment information at a level of detail defined by the State, to OAKS in order to facilitate actual payments to providers.			
6.2	**Budget Management and Analysis/ Revenue Management**			
6.2.1	Requirements			
6.2.1.1	Create each month a monthly summary of selected claims data fields and forward it to the data warehouse/DSS for use in financial forecasting. Such fields may include the following: • State agency (i.e., the agency that has or will make the payment) • Date of service • Date of payment • Expenditure • Provider type • Category of service • DRG code • Non-DRG code (e.g., to capture hospital claims that are paid as outliers) • Geographical location			

MITS Business Requirement "Functional Fit" Survey				
Financial Management				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
	• Eligibility groups (including waiver programs) • Age (according to cohorts defined by the State).			
6.2.1.2	Allow flexibility to change the fields included in the summary data.			
6.2.1.3	Support the retrospective re-creation of monthly data upon the change of the fields included in the budget data mart.			
6.2.1.4	Support on-line inquiries, made from desktops, of the data in the budget data mart.			
6.2.1.5	Generate ad hoc reports based on information in the budget data mart.			
6.2.1.6	Ability to access the summary data in the data mart.			
6.2.1.7	Provide on-line access to summarized caseload totals that are current to the previous day to support Federal approval of waivers including information related to: • Number of enrolled consumers • Number of case closures • Category of eligibility (including by waiver programs) • Age • County • Income • Gender.			
6.2.1.8	Ability to delay payment of claims on a targeted basis by the following categories including: • Category of eligibility • Provider type • State agency • Date of service • Initial receipt or processing date • Vendor • Relative to pre-determined limit on an aggregate or categorical amount to be paid.			
6.2.1.9	Provide the ability for designated staff to view, on-line in near real-time, information about claims in queue for payment, including information related to: • Category of eligibility • Provider type • State agency • Date of service • Initial receipt or processing date • Vendor • Amount of payment.			
6.2.1.10	Generate ad hoc reports in regard to claims in the queue for payment including information related to: • Category of eligibility • Provider type			

MITS Business Requirement "Functional Fit" Survey				
Financial Management				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
	• State agency • Date of service • Initial receipt or processing date • Vendor • Amount of payment.			
6.3	**Accounts Receivable (AR)**			
6.3.1	Requirements			
6.3.1.1	Provide the capability to associate receivables in OAKS with claims detail information in MITS and provide the capability to track the status of receivables captured in chart fields in OAKS.			
6.3.1.2	Provide on-line access and an ability to generate ad hoc reports that integrate information queried from OAKS with the following MITS information: • Payer type ("payer" here is the entity from which money is owed to the State or from whom the State otherwise receives payments associated with a receivable) • Payer tax ID • Reason code • Authorizing party • Service date (for claims-related) • Adjustment history by receivable • Denial codes from carriers to allow for identification of possible modifications to post payment recovery extraction and cost avoidance criteria and to update consumer-specific insurance information in the claims processing system.			
6.3.1.3	Track overpayments, adjustments, penalties and interest associated with receivable funds.			
6.3.1.4	Maintain a complete record for audit trail purposes of all relevant documents and records associated with receivables.			
6.3.1.5	Provide the ability to identify, review, and obtain in reports complete data from the paid claims associated with the original payments that have since been recovered, in full or in part, or that have otherwise been identified as recoverable funds.			
6.3.1.6	Provide flexible, rule-driven reporting and analytical capacity that can generate reports and perform calculations on the basis of multiple sources of claims-related and non-claim related data in order to determine, or support the determination of, accurate amounts of receivable funds associated with: • SURS recoveries • Drug rebates • Supplemental drug rebates • Hospital Care Assurance Program (HCAP) assessments ▪ Nursing home franchise fees ▪ ICF-MR franchise fees ▪ Managed care plan assessments			

MITS Business Requirement "Functional Fit" Survey				
Financial Management				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
	• Funds paid for participation in Upper Payment Limit programs (UPL) • Hospital cost settlements • Overpayments corrections associated with Nursing Homes and ICF-MR • Estate recoveries • Other provider fees and assessments • Premiums paid by Medicaid consumers to establish or maintain coverage • Administrative fees and other portions of receivables associated with HCAP, UPL, SURS, Medicaid Administrative Claiming (MAC), audits, and any other funds that are statutorily required to be deposited into the Health Care Services Administration fund.			
6.3.1.7	Generate reports related to estate recoveries that accurately identify amounts paid for services provided to now deceased consumers.			
6.3.1.8	Interface with Department of Health and the Attorney General's office to receive vital statistics information essential to the determination of estate recoveries or other claims adjudication in MITS.			
6.3.1.9	Automatically provide information to OAKS so that AR records can be updated whenever providers owe an outstanding balance.			
6.3.1.10	Support internal auditing procedures and cycles in accordance with Generally Accepted Accounting Principles (GAAP).			
6.3.1.11	Maintain account detail (e.g., claims payment detail) and summary information for each accounts receivable transaction including the following data: • Beginning and ending balances • Activity for the period • Pending credit • Recoupment schedule • Adjustments • Interest • Penalties • Summary totals.			
6.3.1.12	Maintain accurate and timely information (e.g., insurance information from the claims processing system claims history) to allow for precise selection of paid claims for post payment recovery.			
6.3.1.13	Generate bills for collections from Medicare, insurance companies, and other third parties who are liable for payments of claims-related receivables in formats as specified by ODJFS or the Federal government. This includes HIPAA-approved formats (including NCPDP) as well as formats such as the CMS1500 and UB92 claim forms.			

MITS Business Requirement "Functional Fit" Survey				
Financial Management				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
6.3.1.14	Send information to the claims processing system so that claims history can accurately reflect that receivables have been initiated and/or recovered in association with particular claims.			
6.4	**Accounts Payable (AP)**			
6.4.1	Requirements			
6.4.1.1	Transmit and maintain the necessary financial information into Accounts Payable in OAKS.			
6.4.1.2	Provide the capability to aggregate, retain, and transmit to OAKS the information needed to support its accounts payable function.			
6.4.1.3	Provide the capability to associate accounts payable in OAKS with claims detail information in MITS and provide the capability to track the status of accounts payable as captured in chart fields in OAKS.			
6.4.1.4	Generate financial trending reports by provider, provider type, provider category of service and contractor.			
6.4.1.5	Support the State's ability to issue payments or EFTs associated with Medicaid claims by transmitting necessary information to OAKS such as: • Payment period • Provider information, including tax ID, name, address, and amount to be paid.			
6.4.1.6	Provide checks and balances to verify that all necessary payments are submitted to OAKS, and accepted.			
6.4.1.7	Track payments down to the claim line level.			
6.4.1.8	Generate an audit trail for accounts payables that accommodates all claims submission types.			
6.4.1.9	Archive claim payments history for at least seven (7) years.			
6.4.1.10	Calculate payments directly for Medicaid consumers, according to protocol defined by the State.			
6.4.1.11	Calculate payments to Financial Management Service providers according to protocol defined by the State (e.g., for a Cash and Counseling Waiver).			
6.4.1.12	Support the ability to schedule or restrict payments according to any criteria associated with any element of the funding code.			
6.4.1.13	Electronically interface with or otherwise accept payment information from OAKS regarding: • Notification of payments of claims • Updates on the status of payment of claims • Warrant numbers associated with the actual payment of particular claims • Information about stop payments, re-issues and voids.			
6.4.1.14	Supply data to the data warehouse/DSS that can be used to establish a complete audit trail to provide information in response to queries from desktops and to support the creation of standard and ad hoc reports regarding Medicaid claims payment data including:			

MITS Business Requirement "Functional Fit" Survey				
Financial Management				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
	• A history of all transactions, including dates, associated with the payment • Warrant numbers associated with the actual payments • Warrant dates associated with the actual payments • Information about stop payments, re-issues, voids, etc. • Medicaid claim numbers • Medicaid claim types • Dates of service • Provider information • Category of service • Medicaid consumer.			
6.4.1.15	Recognize and provide OAKS with the information as needed to reissue payments when appropriate after an initial payment is stopped, voided, or cancelled.			
6.4.1.16	Accommodate automatic electronic feeds from the Federal Social Security Administration for information associated with SSI Benefits.			
6.4.1.17	Provide flexible, rule-driven reporting and analytical capacity that can generate reports and perform calculations (MITS) on the basis of multiple sources of data in order to determine, or support the determination of, accurate amounts of payable funds associated with: • Medicaid claims • Claims adjustments • Nursing Home reimbursements • Intermediate Care Facility for the Mentally Retarded reimbursements • Hospital Care Assurance Program • Upper Payment Limit programs • Cost settlements • Other provider payments/adjustments/settlements/incentives/refunds • Medicare Buy-In payments /adjustments • Premium payments and adjustments • Other supplemental provider payment programs • County Cost Reimbursement payments • ~~Drug Rebate refunds/interest~~ • Insurer refunds/premium payments • Dispute resolution settlements • SSI payments • Withholds for child support and IRS liens.			
6.5	**Federal Reporting**			
6.5.1	Requirements			

MITS Business Requirement "Functional Fit" Survey				
Financial Management				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
6.5.1.1	Synchronize paid claims data generated and stored by MITS with warrant and other payment information generated and stored in OAKS (or in a data warehouse) weekly in a way that supports the ability to generate reports that align paid claim detail with warrant and other payment information by specific accounting element and relative to all categories of service and spending that must be reported in the CMS 64, 372 cost neutrality reports, and other Federal reports. (OAKS data to include cost allocation and county administrative reporting. Claims specific information will reside in MITS with a tracking number related to OAKS.)			
6.5.1.2	Provide the capability to easily "drill-down" and generate paid claim and other detailed information that supports summary figures presented in Federal reports.			
6.5.1.3	Generate reports that compare OAKS data to MITS data to analyze and reconcile Payment Appropriation Report "out of balance" information, including specific accounting elements in OAKS.			
6.5.1.4	Support the generation of information for all Federal reports and supporting data required by CMS, including: • CMS 21 report (Administrative Claims for State Children's Health Insurance Program (SCHIP)) • CMS 64 report (Medicaid claims) • CMS 372 (Cost Neutrality Assessment for Waivers) • CMS 416 (Healthchek Report) • Medicaid Statistical Information System Data Reports (formerly CMS-2082) • Uncollectible Overpayments Report • Public provider payouts by State category of service • Non-collection write-off transactions applied to cash accounts receivable during the reporting period and not previously refunded to CMS as overpayments; report of checks that were voided and applied to overpayment accounts receivable records.			
6.5.1.5	Recover overpayments through accounts receivable including: (OAKS, OAKS Interface to MITS) • Tort-related recoveries • Cost-settlements • Credit balances • Estate recoveries; have the ability to account for data reporting requirements related to a long term care insurance partnership program. • SURS recoveries • Drug rebates • Franchise fees • Fraud recoveries.			

MITS Business Requirement "Functional Fit" Survey				
Financial Management				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
6.5.1.6	Calculate offsets netted in MITS in support of Federal Reports. including: (MITS, Interface to OAKS) • Claims adjustments • Third-party liability and/or payments • Adjudication and final settlements of nursing home and ICF-MR payments • HCAP assessments • Funds paid for participation in UPL programs • Audit findings.			
6.5.1.7	Provide on-line analytical capacity for completing calculations that are necessary in Federal reports that can be accessed from desktops.			
6.5.1.8	Support the generation of FFP reports and supporting documentation according to Federal and State requirements.			
6.5.1.9	Report on cash recoupment transactions, not previously refunded to CMS as overpayments, that occurred during the Federal reporting quarter by State category of service within Federal category of service.			
6.6	**Cost Reports/Settlements**			
6.6.1	Nursing Homes and Intermediate Care Facility for Mentally Retarded (ICF-MR)			
6.6.1.1	Provide for rate recalculation based on ODJFS defined inputs and criteria.			
6.6.1.2	Reprocess rates using audited versus un-audited information.			
6.6.1.3	Perform calculations defined by ODJFS and used in the overpayment correction process.			
6.6.1.4	Provide flexibility to calculate numbers of “days paid” as defined by ODJFS.			
6.6.1.5	Generate reports for all claims by fiscal year, by provider, or other criteria as defined by ODJFS.			
6.6.1.6	Match/run consumer ID against other room and board claims.			
6.6.1.7	Identify dates of service overlaps and to make adjustments to days paid due to overlaps.			
6.6.1.8	Generate reports to reconcile patient liability to the eligibility system.			
6.6.1.9	Adjust original patient liability based on the most current data on the eligibility system.			
6.6.1.10	Calculate rates times days minus patient liability, by consumer, by service month.			
6.6.1.11	Roll up all receivables by providers.			
6.6.1.12	Reconcile the amount paid to providers and calculate overpayment amounts by criteria including service month, per person, and fiscal year.			

MITS Business Requirement "Functional Fit" Survey				
Financial Management				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
6.6.1.13	Report fiscal year overpayments reflected in proposed adjudication orders to the Office of Fiscal Services' Bureau of Federal Reporting as identified and adjudicated on a quarterly basis.			
6.6.1.14	Track the status of recoupment by provider through all stages of the collection and appeals processes.			
6.6.1.15	Maintain an audit trail of all calculations used in the overpayment correction process, including payment amounts, the dates and times of key processing events, and warrant numbers for any outgoing payments.			
6.6.1.16	Generate proposed and final adjudication orders associated with the overpayment correction process for nursing homes and ICF-MR to those providers. Adjudication Order includes the following information: • Adjudication Order template/cover letter • Dollar amount • Reports of examination • Hearing and appeal information • Waiver form by which the provider can agree to accept a particular amount to be paid and waive their right to a hearing • Fiscal forms to assure that payments are credited to proper accounts.			
6.6.1.17	Store, track, and provide ODJFS staff with easy access to electronic storage of all waiver forms and/or other documentation received from providers and other sources that pertain to the overpayment correction actions.			
6.6.1.18	Automatically update the status of particular overpayment correction actions when waiver forms and other documents are received and logged on to the tracking system.			
6.6.1.19	Automatically initiate the assembly and mailing of final adjudication orders associated with the overpayment correction process (CPAO) when waiver forms are received.			
6.6.1.20	Generate data and reports as defined by the State or Federal Government and associated with adjudication orders and overpayment corrections as needed by the Office of Fiscal Services, Bureau of Federal Reporting, for preparation of relevant sections of the CMS 64 report.			
6.6.1.21	Generate cost settlement information for the CMS 64 report on a timescale specified by ODJFS to meet Federal regulations.			
6.6.1.22	Interface, or at least support a common data identifier, with OAKS.			
6.6.2	Hospitals			
6.6.2.1	Generate ****reports to identify**** "clean" paid claims within each provider's reporting period.			

MITS Business Requirement "Functional Fit" Survey				
Financial Management				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
6.6.2.2	Generate reports, on an ad hoc basis, of hospital summary data based on specific revenue centers, as defined in the cost report including the following criteria: • Paid days • Paid charges • Total third party payments • Total Medicaid payments • Number of discharges • Cost Outliers • DRG.			
6.6.2.3	Provide the capability to generate and view ad hoc reports on-line of claims adjustment information including the dollar amount of all adjustments, the dollar amount of the related charges, and if applicable, the days adjusted.			
6.6.2.4	Generate proposed and final adjudication orders associated with the cost settlement of hospital payments to providers. Adjudication orders includes the following information: • Adjudication Order template/cover letter • Dollar amount • Hearing and appeal information • Waiver Form by which the provider can agree to accept a particular amount to be paid and waive their right to a hearing • Fiscal Forms to assure that payments are credited to proper accounts.			
6.6.2.5	Store, track, and provide ODJFS staff with on-line access to electronic images of all waiver forms and or other documentation received from providers and other sources that pertain to the cost settlements of hospital payments.			
6.6.2.6	Automatically update the status of particular hospital cost settlement initiatives when waiver forms and other documents are received and logged on to the tracking system.			
6.6.2.7	Automatically initiate the assembly and mailing of final adjudication orders associated with hospital cost settlement initiatives when waiver forms are received.			
6.6.2.8	Generate data and reports as defined by the State or Federal Government and associated with the cost settlement of hospital payments as needed by to the Office of Fiscal Services' Bureau of Federal Reporting for preparation of relevant sections of the CMS 64 report.			
6.6.2.9	Track adjustments that result when collections of overpayments are realized through offsets to other vendor payments, and support the ability to verify that those offsets have occurred relative to specific overpayment collection initiatives.			

MITS Business Requirement "Functional Fit" Survey				
Financial Management				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
6.6.2.10	Interface with, or at least support a common data identifier with, OAKS and/or other stand-alone systems as necessary to support effective tracking of hospital payment cost settlements as accounts receivable or accounts payable.			
6.7	**Inter-agency Transactions**			
6.7.1	General Requirements			
6.7.1.1	Produce information used to generate transactions such as reports that summarize the costs associated with successfully processed claims for Medicaid services provided through programs managed by State agencies other than ODJFS.			
6.7.1.2	Accept , process , reimburse (OAKS), and pay claims (OAKS) from sub-recipient State agencies (e.g., State agencies other than ODJFS) that manage programs that provide Medicaid benefits and services.			
6.7.1.3	Maintain fee schedules established by sub-recipient State agencies and be able to reference rates in those fees schedule for each particular procedure code covered under programs managed by sub-recipient State agencies.			
6.7.1.4	Utilize rates in the fee schedule in order to price and initiate payment of claims in cases that require ODJFS to make direct payments to providers for services rendered under a program managed by a sub-recipient State agency.			
6.7.1.5	Generate reports to support the creation of inter-agency transactions when arrangements between ODJFS and sub-recipient State agencies require a local contracting entity to make direct payments to direct care providers and under which post-payment claims are submitted to ODJFS or an ODJFS vendor for the calculation of Federal match.			
6.7.1.6	Issue alerts when there are errors in the claims submitted by other agencies relative to fee schedules and based on other pre-defined business rules.			
6.7.1.7	Create custom ODJFS oversight edits for each sub-recipient State agency program based on pre-defined business rules determined by ODJFS and the sub-recipient State agency; the type of editing may include eligibility validation, limits on rates per procedure, units of service per procedure code, expenditures over an established time period, valid providers, date of service and a number of parameters documented in reference data bases.			
6.7.1.8	Recognize claims from sub-recipient State agencies and link the claim to the correct sub-recipient State agency program/benefit package/health care component and associated processing rules.			

MITS Business Requirement "Functional Fit" Survey				
Financial Management				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
6.7.1.9	Process sub-recipient State agency claims: 1) on a direct payment basis when claims are submitted directly to ODJFS & paid directly by ODJFS; 2) on an encounter basis for reporting information used to generating inter-agency transfer payments by which ODJFS reimburses the sub-recipient State agencies for Federal match associated with the cost of the claims; or 3) some alternative method which is a hybrid of the two.			
6.7.1.10	Provide information to support reports for accurate claiming of Federal match associated with payments and expenditures for services provided and reimbursed as part of the sub-recipient State agency benefit package and/or health care component, regardless of the payment arrangement or money exchange methodology.			
6.7.1.11	Accept in an electronic format, lists of valid participating providers for the sub-recipient State agency programs.			
6.7.1.12	Update from appropriate sources the consumer eligibility/enrollment spans which are associated with the sub-recipient State agency programs.			
6.7.1.13	Provide role-based access to reports of complete Medicaid claims payment information that reflects all of claims paid on behalf of individual or groups of Medicaid consumers, including information associated with claims paid by or on behalf of sub-recipient State agencies, and with an ability to select information by date of service.			
6.7.1.14	Generate standard and ad hoc reports that show claims-level detail behind summary cost reports associated with claims paid by or on behalf of other State agencies for Medicaid services; information about rejected claims should also be available in this way.			
6.7.1.15	Generate standard and ad hoc reports that show information about claims paid to particular providers, including the individual providers in the other agency systems.			
6.7.1.16	Provide the role-based access by sub-recipient State agencies to claims information at a preliminary stage in the processing of those claims, including information about claims that are initially scheduled for rejection, and support the ability of sub-recipient State agencies to make on-line adjustments to those claims in regard to errors, issues of validation, and benefits management.			
6.7.1.17	Accommodate changes in payment methodologies associated with claims for services provided through programs managed by State agencies other than ODJFS in order to accommodate possible changes in future Federal requirements from CMS in regard to claims processing and payment (e.g., if CMS requires that ODJFS pays all Medicaid claims directly).			

MITS Business Requirement "Functional Fit" Survey				
Financial Management				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
6.7.1.18	Accept information associated with Medicare “crossover,” or portions of the cost of services provided through sub-recipient State agencies that was paid or is eligible for payment by Medicare, and to calculate appropriate payment amounts after that information is taken into account.			
6.7.1.19	Accept information back from OAKS in regard to the disposition of inter-agency transactions and that supports an ability to tie particular transfers to particular Medicaid claims. (Interface from OAKS to MITS)			

MITS Business Requirement "Functional Fit" Survey				
Transactions, Claims, and Encounters				
Req Number	**Requirement**	**MITS Phase (1 or 2)**	**Response Code**	**Page Ref**
7.1	**Healthcare and Business Transactions**			
7.1.1	Requirements			
7.1.1.1	Anticipate and provide a flexible solution that is positioned to effectively meet the requirements of current and future HIPAA regulations.			
7.1.1.2	Accommodate changes with global impacts for all transactions currently supported or adopted by ODJFS in the future (e.g., implementation of International Classification of Diseases-10 (10th revision)-Clinical Modification (ICD-10-CM) diagnosis and procedure codes) at no additional cost to the State.			
7.1.1.3	Accommodate healthcare and business transactions when these transactions enhance ODJFS' ability to process health care information, (e.g., ASC X12N 275 Additional Information to Support a Health Care Claim or Encounter).			
7.1.1.4	Provide a system that meets all requirements of the HIPAA mandated National Provider Identifier (NPI) rule.			
7.1.1.5	Phase 2 - Provide a HIPAA compliant MITS system capable of processing all existing healthcare and business transactions and future transactions developed by any of the data standards maintenance organizations that support HIPAA (current and future). This includes ASC X 12, HL 7, NCPDP, Logical Observation Identifiers Names and Codes (LOINC), and XML formats Clinical Document Architecture (CDA) and Context Inspired Component Architecture (CICA.).			
7.1.1.6	Interface with the ODJFS EDI translator process and systems for the processing of all EDI transactions.			
7.1.1.7	Accept and process or generate the following HIPAA mandated batch and near real-time transactions, other versions or standards that may be mandated, and other transactions including: • Health Care Claims: o ASC X12N 837 Health Care Claim: Professional o ASC X12N 837 Health Care Claim: Institutional o ASC X12N 837 Health Care Claim: Dental o National Council for Prescription Drug Programs (NCPDP) Version 5, Release 1, and equivalent NCPDP Batch Standard Version 1, Release 0 • Eligibility for a Health Plan: o ASC X12N 270/271 Health Care Eligibility Benefit Inquiry and Response • Health Care Claim Status: o ASC X12N 276/277 Health Care Claim Status Request and Response • Referral Certification and Authorization:			

MITS Business Requirement "Functional Fit" Survey				
Transactions, Claims, and Encounters				
Req Number	**Requirement**	**MITS Phase (1 or 2)**	**Response Code**	**Page Ref**
	o ASC X12N 278 Health Care Services Review - Request for Review and Response • Health Plan Premium Payments: o ASC X12N 820 Payroll Deducted and Other Group Premium Payment for Insurance Products • Enrollment and Dis-enrollment in a Health Plan: o ASC X12N 834 Benefit Enrollment and Maintenance • Health Care Payment and Remittance Advice: o ASC X12N 835 Health Care Claim Payment/Advice • Coordination of Benefits: o ASC X12N 837 Health Care Claim: Professional o ASC X12N 837 Health Care Claim: Institutional o ASC X12N 837 Health Care Claim: Dental • National Council for Prescription Drug Programs: o (NCPDP) Version 5, Release 1, and equivalent NCPDP Batch Standard Version 1 • Acknowledgements: o ASC X12 824: Application Reporting Version 4010 o ASC X12 277: Health Care Payer Unsolicited Claim Status • New transaction content to include: o ASC X12N 269: Health Care Coordination of Benefits Request and Response o ASC X12N 270/271: Health Care Eligibility/Benefit Inquiry and Response (with commercial insurance carriers) o ASC X12N 274: Health Care Provider Inquiry and Information Response Guide - ASC X12N Health Care Provider Credentialing Implementation Guide - ASC X12N Health Care Provider Directory Implementation Guide - ASC X12N Health Care Provider Information Implementation Guide - ASC X12N Additional Information to Support a Health Care Services Review o ASC X12N 275: Additional Information to Support a Health Care Claim or Encounter o ASC X12N 841: Specifications/Technical Information			
7.1.1.8	Comply with all ODJFS companion guides related to EDI transactions.			
7.1.1.9	Track EDI transactions/versions submitted by trading partners for test and/or production.			
7.1.1.10	Provide the capability to crosswalk codes on input and output.			
7.1.1.11	Display rules or codes applied at the field or loop level.			
7.1.1.12	Point and click access to stored documents.			

MITS Business Requirement "Functional Fit" Survey				
Transactions, Claims, and Encounters				
Req Number	**Requirement**	**MITS Phase (1 or 2)**	**Response Code**	**Page Ref**
7.1.1.13	Apply appropriate security for production, certification, and test environments.			
7.1.1.14	Allow user to set up each transaction set as both test and production by the trading partner.			
7.1.1.15	Maintain control number for transaction set by the trading partner.			
7.1.1.16	Consolidate and associate multiple healthcare providers and claims with a single or multiple trading partner destinations.			
7.1.1.17	Provide the ability to calculate the value of certain fields.			
7.1.1.18	Define precision for numeric or monetary “R” type fields.			
7.1.1.19	Perform concatenation/un-concatenation of composite data elements.			
7.1.1.20	Provide ability to build tables to test HIPAA standards still in the trial stage.			
7.1.1.21	Provide recovery and back up mechanisms in the event of system failure, file corruption, or any unexpected event that makes it necessary to reprocess data.			
7.1.1.22	Provide ability to recover (resend) by date.			
7.1.1.23	Provide ability to recover (resend) by transaction.			
7.1.1.24	Provide ability to recover (resend) by document type.			
7.1.1.25	Provide ability to recover (resend) by trading partner.			
7.1.1.26	Provide detailed auditing capabilities that can assist the support team, provide for non-repudiation of file, and comply with Medicaid and HIPAA standards for privacy and security.			
7.1.1.27	Create audit trail of system and table changes by user ID.			
7.1.1.28	Report number of documents translated.			
7.1.1.29	Report by document type the number of documents processed for each business partner.			
7.1.1.30	Date and timestamp all data content flowing through the system.			
7.1.1.31	Provide a test environment to assure MCP competency with HIPAA transactions governing membership, premium payment and encounter data, including ANSI X12 820, 834, 835, 837 I, P, and D in versions specified by ODJFS.			
7.1.1.32	Generate and distribute 835 health care payment advice companion documents that provide information on how to interpret data on the 835.			
7.2	**Claims Submission**			
7.2.1	Requirements			
7.2.1.1	Support claims submission via: • EDI • Medicaid Portal • Other electronic devices such as hand held devices • Application programming interface • Paper.			

MITS Business Requirement "Functional Fit" Survey				
Transactions, Claims, and Encounters				
Req Number	**Requirement**	**MITS Phase (1 or 2)**	**Response Code**	**Page Ref**
7.2.1.2	Accept, process and prepare for transmission the content of any electronic transactions developed by any of the data standards maintenance organizations that support HIPAA (current and future) -- including: ASC X 12, HL 7, NCPDP and XML formats CDA and CICA. ****Also,**** ~~S~~support claims/encounters submitted in an ODJFS-approved proprietary ****electronic**** format.			
7.2.1.3	Develop interfaces as needed to accommodate the receipt of cross-over claims, encounter claims, and claims from commercial insurance carriers and other information (such as attachments) to support claims processing.			
7.2.1.4	Accept other claim, encounter and/or attachment inputs to MITS, including: • Claims for Medicare coinsurance and deductible (cross-over claims), in both paper and electronic formats • Adjustment forms 6766, 6768, 6767 • Medical review form 6653 • Ability to accept cost reports • Paper claim types UB92, CMS1500, 6780, and ADA claim form, or current HIPAA compliant paper claim forms in use at the time of implementation • Attachments required for claims adjudication, including: o Coordination of benefits and Medicare explanation of medical benefits o Sterilization, abortion, and hysterectomy consent forms o X-rays o Surgical reports o Digitized photos o Manual or automated medical expenditure transactions which have been processed outside of MITS (e.g., spend-down and premiums for Medicaid Buy-In) o Non-claim specific financial transactions such as fraud and abuse settlements, insurance recoveries, and cash receipts.			
7.2.1.5	Track claims/encounters that are rejected back to a provider, including: • Provider • Date returned • Reason for the return.			
7.2.1.6	Track and report submission errors to the submitter.			
7.2.1.7	Alert appropriate ODJFS business unit of claim submission errors.			
7.2.1.8	Image paper claims/encounters and attachments and store electronically for on-line retrieval through the document management and imaging system.			

MITS Business Requirement "Functional Fit" Survey				
Transactions, Claims, and Encounters				
Req Number	**Requirement**	**MITS Phase (1 or 2)**	**Response Code**	**Page Ref**
7.2.1.9	Assign TCNs (Transaction Control Numbers) to all claims, encounters, items in pending status, and attachments.			
7.2.1.10	Provide on-line data entry to MITS for claims, encounters and attachments.			
7.2.1.11	Provide on-line access to three years of prior claims processing data on date of implementation.			
7.2.1.12	Accept claims/encounters and attachments and be able to match attachments to the appropriate claims, regardless of order received.			
7.2.1.13	Utilize appropriate validity edits for external claims submission using the Medicaid Portal.			
7.2.1.14	Claims, transactions, encounters and attachments submitted via the Medicaid Portal or other electronic access channels, are required to be in EDI format and HIPAA compliant.			
7.2.1.15	Convert the most recent 7 calendar years (including month to date) at time of implementation..			
7.2.1.16	Notify provider of pended status and TCN assigned to claim/encounter or attachments so that missing component(s) can be submitted and matched to existing component(s).			
7.2.1.17	Re-notify submitter of pending status after 30 days.			
7.2.1.18	Deny claim/encounter if status is pending more than 60 days. If the item is an attachment, delete the attachment.			
7.2.1.19	Accommodate and retain electronic signatures in accordance with CMS/State guidelines.			
7.2.1.20	Identify and reconcile TCNs that fail to balance control counts.			
7.2.1.21	Flag ODJFS specified documents to be routed automatically to appropriate destination for multistage manual review (e.g., Provider Network Management, Medicaid Operations Section (MOS), etc).			
7.2.1.22	Provide the ability to test end-to-end: new releases, transactions, or business rules, including what-if scenarios for analysis, testing, and modeling.			
7.3	**Claims/Encounters Adjudication**			
7.3.1	Requirements			
7.3.1.1	Process and adjudicate FFS and encounter claims on-line.			
7.3.1.2	Adjudicate FFS, waiver , sub-recipient State agency, alternate delivery system, and care management claims.			
7.3.1.3	Support claims payment on a daily basis, or at other time intervals as defined by ODJFS.			
7.3.1.4	Provide a flexible rule-based engine to support the adjudication process.			
7.3.1.5	Prevent payment for duplicate services(s) except for those situations identified by ODJFS.			

MITS Business Requirement "Functional Fit" Survey				
Transactions, Claims, and Encounters				
Req Number	**Requirement**	**MITS Phase (1 or 2)**	**Response Code**	**Page Ref**
7.3.1.6	Ensure that all claims received are processed to the point of payment, denial, or suspense.			
7.3.1.7	Interface with data warehouse/DSS, EDMS, IVR, ACD, and CRM.			
7.3.1.8	Provide the ability to calculate and pay interest.			
7.3.1.9	Provide the capability to purge claims based on ODJFS criteria.			
7.3.1.10	Provide the capability to query claims with flexible search criteria as identified by ODJFS.			
7.3.1.11	Track and display eligibility for those services that have limits (time and dollar) for specific time frames.			
7.3.1.12	Pay, pay and report, deny or suspend FFS claims as defined by ODJFS.			
7.3.1.13	Accept all encounter claims, including those paid, partially paid, or denied, so that they can be adjudicated and accepted, partially accepted, or rejected by ODJFS.			
7.3.1.14	Utilize HIPAA compliant claim adjustment reason and remittance advice remark codes for processing and display on-line without the need to crosswalk to legacy codes.			
7.3.1.15	Automatically route and process claims based on eligibility type (e.g., waiver, LTC, and other programs) through the adjudication process.			
7.3.1.16	Automatically route suspended claims to designated units for review according to ODJFS defined criteria using the EDMS workflow system.			
7.3.1.17	Generate alerts to appropriate work units notifying them of suspended claims requiring review.			
7.3.1.18	Generate alert to work unit management, at timeframe defined by ODJFS, if suspended claim has not been worked.			
7.3.1.19	Suspend claims that require pre-payment review.			
7.3.1.20	Send adjudicated (paid and denied) claims and encounter data to data warehouse/DSS, the financial reporting system, or other systems as appropriate, and to claims history, as defined by the ODJFS.			
7.3.1.21	Provide the capability to distinguish between encounter data payments, premium payments, and FFS claims.			
7.3.1.22	Provide role-based on-line inquiry access, for internal use only by ODJFS staff, to all claims using the following selection (search) criteria: • Consumer ID (Currently “Medicaid Billing Number”) • Provider ID • TCN • Claim adjustment reason codes • RA Remark codes • Procedure and diagnostic codes • All UB code sets			

MITS Business Requirement "Functional Fit" Survey				
Transactions, Claims, and Encounters				
Req Number	**Requirement**	**MITS Phase (1 or 2)**	**Response Code**	**Page Ref**
	• Information submitted on COB claims • Inquiry by specific parameters (e.g., date range) defined by ODJFS • Claim type • Note: For excessive volume requests, provide the capability to run in batch mode.			
7.3.1.23	Support on-line viewing of all data used to process a claim with navigation from the claim record to the reference files that support adjudication.			
7.3.1.24	Allow on-line modification to edits/audits as dictated by policy.			
7.3.1.25	Maintain an on-line audit trail for all edit/audit changes.			
7.3.1.26	Maintain an on-line audit trail for each claim record that shows each stage of processing, the date the claim entered each stage, and any edit/audit codes posted to the claim at each step in processing.			
7.3.1.27	Process all modifiers submitted on a claim.			
7.3.1.28	Designate, change, and maintain history of begin and end dates for each edit/audit per ODJFS guidelines.			
7.3.1.29	Incorporate software for edits and audits per ODJFS policy to detect fraud and abuse, including bundling/unbundling, multiple surgery, medically unnecessary services, and overuse of services for all claims, and for criteria, provider types, and consumer categories, and program eligibility.			
7.3.1.30	Adjudicate professional surgery claims in a manner which supports the CPT surgical concept. Services that should be bundled based on the surgical package concept and in accordance with CPT and ODJFS policy must be cost avoided (e.g., visits for pre and post visits, local anesthesia).			
7.3.1.31	Provide a methodology for identifying “add-on codes”, multiple surgery exempt codes, diagnostic codes and therapeutic surgical codes for which the package concept may not be applicable and process them as exceptions (e.g., CPT appendix D and E codes).			
7.3.1.32	Adjudicate professional surgery claims to cost avoid surgical and other procedures which are a component procedure of another procedure billed on the same date of service.			
7.3.1.33	Adjudicate multiple surgical procedures that are performed at the same operative session, process professional surgery claims to adjust (reduce) the maximum reimbursement of all procedures (e.g., secondary, tertiary, etc.) with the exception of the primary procedure and those procedures that are typically exempted from multiple surgery payment reductions in accordance with the CPT and/or ODJFS policy (e.g., CPT appendix D and E codes).			

MITS Business Requirement "Functional Fit" Survey				
Transactions, Claims, and Encounters				
Req Number	**Requirement**	**MITS Phase (1 or 2)**	**Response Code**	**Page Ref**
7.3.1.34	When bilateral surgical codes are performed at the same operative session, process professional surgery claims to adjust reimbursement to reflect bilateral pricing. Must have a methodology to determine when bilateral pricing concepts apply and when left and right side procedures should not invoke bilateral pricing logic.			
7.3.1.35	Adjudicate assistant-at-surgery claims in the same manner as professional surgery claims, except apply assistant-at-surgery pricing.			
7.3.1.36	Adjudicate and process anesthesia claims containing allowable surgical codes (e.g., surgical codes recognized as allowable in addition to the anesthesia procedures codes).			
7.3.1.37	Provide for distinct edits by program type, benefit package, and benefit package component category.			
7.3.1.38	Identify and track EPSDT screening services and referrals made to other providers, regardless of how the claim was submitted Health Care Financing Administration (HCFA) 1500 or EDI electronic claim).			
7.3.1.39	Track a visit made to another provider resulting from an EPSDT referral.			
7.3.1.40	Perform exceptional adjudication of claims edits and audits in accordance with ODJFS approved guidelines (e.g., deny, override) including special claims (e.g., multi transfer or transplant claim and LTC claims).			
7.3.1.41	Include functionality in claims and encounter processing that properly handles payments in situations where there are annual dollar limits (or annual number-of-visit limits) that need to be considered when adjudicating the claim and/or determining payment amounts. Needed functionality includes the capability to: • Adjudicate claims to pay up to, but not more than the amount remaining in the annual dollar limit • View on-line how much of an annual dollar limit remains prior to adjudication of a new claim • Perform on-line edits or set parameters that limit the dollar or unit reimbursement amount for specific providers for specific procedure codes for specific periods of time for designated benefit packages • Generate alerts that would warn providers that a consumer is nearing their annual dollar limit or their annual visit limit for various services (e.g. Physical Therapy (PT), Speech Therapy (ST), chiropractic, psychological counseling, or others as defined by ODJFS.).			

MITS Business Requirement "Functional Fit" Survey				
Transactions, Claims, and Encounters				
Req Number	**Requirement**	**MITS Phase (1 or 2)**	**Response Code**	**Page Ref**
7.3.1.42	Provide flexible, on-line edit/audit disposition codes in accordance with ODJFS health care plan and waiver program policies and procedures. MITS must have the capability to post an unlimited number of edits/audits to a claim.			
7.3.1.43	Define claim edit/audit dispositions and exceptions (pay, pay and report, deny, suspend) including bill type, submission media, provider type, or individual provider number.			
7.3.1.44	Define encounter claim edit/audit dispositions and exceptions (reject, accept, partially accept), including bill type, submission media, provider type, or individual provider number.			
7.3.1.45	MITS must be easily expandable to add new entries to rule-based tables in accordance with ODJFS health plan and waiver program policies and procedures.			
7.3.1.46	Allow for specific procedure codes for encounter claims to be processed for payment as defined by ODJFS (e.g., delivery codes).			
7.3.1.47	Allow the disposition of edits to be easily changed to pay, pay and report, suspend to a specific location, suspend to the provider for correction, deny and report on the RA the claim disposition or the 835 with reason and remark codes.			
7.3.1.48	Maintain at least three (3) years of on-line adjudicated (paid and denied) claims history including all other claims for procedures exempt from regular claims history purge criteria as defined by ODJFS. The on-line history file shall be used in audit processing, on-line inquiry and update, and generate printed responses to claims inquiries. Adjudicated claims history data includes: • 837 transaction data • NCPDP data • 834 transaction data • 820 transaction data • 835 transaction data • 275 transaction data • 277 transaction data • 278 transaction data.			
7.3.1.49	Group or assemble like suspended claims and make changes (mass changes) as appropriate.			
7.3.1.50	Deny, suspend, release groups of like claims as defined by ODJFS.			
7.3.1.51	Systematically accept global changes to suspended claims based on ODJFS defined criteria. Process and mass release suspended claims according to parameters defined by ODJFS and capture and retain adequate audit trail documentation.			
7.3.1.52	Identify edit number(s) for which the claim was suspended.			

MITS Business Requirement "Functional Fit" Survey				
Transactions, Claims, and Encounters				
Req Number	**Requirement**	**MITS Phase (1 or 2)**	**Response Code**	**Page Ref**
7.3.1.53	Maintain claim correction screens that display all claims data as entered or subsequently corrected by either the provider or ODJFS staff.			
7.3.1.54	Maintain inquiry and update capability to claim correction screens with access by TCN, provider ID, consumer ID, and/or claim location or other criteria as defined by ODJFS.			
7.3.1.55	Generate unsolicited 277 content for translation back to provider.			
7.3.1.56	Allow on-line near real-time resolution of any claims that suspend for edits/audits.			
7.3.1.57	Adjudicate claims with up to 999 lines or other claims size standard as mandated by Federal or State regulations.			
7.3.1.58	Adjudicate claims according to the rules defined in the reference files.			
7.3.1.59	Utilize National Provider Identifier (NPI) in the adjudication process.			
7.3.1.60	Utilize National Association of Insurance Commissions (NAIC) number in the cost avoidance process.			
7.3.1.61	Provide the capability to withhold payments or partial payments based on IRS liens, child support payments, or other reasons as defined by the State.			
7.3.1.62	Utilize 269 COB EDI transactions to verify previous payers' payments.			
7.3.1.63	Process COB claims at the line level including Medicare cross-over claims.			
7.3.1.64	Process all header and line level claim adjustment reason codes on COB claims (including Medicare cross-over claims).			
7.3.1.65	Using ODJFS business rules and audit policies, edit against the following, including: • TPL information specific to coverage type/benefit package • Valid program service • Valid program eligibility for both provider and consumer • Level of care • Required attachments are present • Consumer's age when appropriate • Cost-sharing requirements on applicable claims or benefit plans • Provider participation as a member of a billing group • Valid billing, attending, and/or prescribing provider number and/or NPI • Age of claim (based on date of service) • State defined filing deadlines • Diagnosis and procedure codes that are present on Medicare cross-over claims and other applicable claim types • Valid consumer ID number • Valid consumer date of birth			

MITS Business Requirement "Functional Fit" Survey				
Transactions, Claims, and Encounters				
Req Number	**Requirement**	**MITS Phase (1 or 2)**	**Response Code**	**Page Ref**
	• Valid consumer name and cross-checking against previous consumer names • Valid insurance or Medicare indicator as it exists on the eligibility file if insurance or Medicare is indicated on the claim • Consumer eligibility on date(s) of service and retroactive eligibility with audit trail • Pre-payment review required • Prior authorization (PA) met as appropriate • Valid procedure, drug, diagnosis, and revenue codes • Identified history related services (e.g., dental) • Limit on the maximum dollars and/or units • Other data specified by ODJFS.			
7.3.1.66	Verify carrier on claim versus carrier identification on TPL master file.			
7.3.1.67	Establish unverified TPL master record and generate 270 eligibility inquiry transactions to carriers.			
7.3.1.68	Edit to ensure that claims submitted for consumers assigned to a specific provider under the consumer lock-in program are either billed by the assigned provider or performed by the assigned provider, or that the assigned provider is present on the claim as the referring physician.			
7.3.1.69	Edit for lock-in program specific (CM, hospice, etc.) procedure codes.			
7.3.1.70	Allow exceptions to edits (e.g., county determination) for special circumstances as defined by the ODJFS.			
7.3.1.71	Edit/audit against PASRR requirements as specified in ODJFS rules.			
7.3.1.72	Provide the capability to edit LTC and waiver claims against consumer level of care, consumer Medicaid eligibility and PASRR determinations according to State and Federal requirements.			
7.3.1.73	Provide the capability to edit provider eligibility to ensure that the provider is eligible to perform the type of service rendered on the date of service including: • Category of service • Provider type • Provider's CLIA identification number.			
7.3.1.74	Account for lifetime reserve days according to Federal requirements.			
7.3.1.75	Using a rules-based engine, provide the capability to notify select ODJFS staff when a specified edit/audit posts to a claim.			
7.3.1.76	As applicable to ODJFS business rules and audit policies, edit LTC facility claims against the following including: • Admit and discharge • Timely submission requirements			

MITS Business Requirement "Functional Fit" Survey				
Transactions, Claims, and Encounters				
Req Number	**Requirement**	**MITS Phase (1 or 2)**	**Response Code**	**Page Ref**
	• One claim per month, per provider, per consumer • Duplicate claim submissions • Payment to other providers for services rendered to a consumer with the claim span • Bans on admissions • Date of death and/or date of birth • Improper consumer transfer or resources • Several eligibility categories (e.g., QMB coinsurance and deductibles, dually eligible consumers) • Patient liability • NF bill type • Leave days • Provider enrollment status • Provider eligible to provide NF services • Base Medicaid eligibility • Dates of service with the claims span fall within hospice, hospital, or waiver service span • Overlapping SNF or Medicare Part C or ICF-MR claim • Total number of days on the claim • Overlap of the total number of days • PASRR requirements met • Level of care requirements met • Dates of service do not coincide with dates of PACE enrollment • Date of admission on the claim matched to the last digit of the bill type.			
7.3.1.77	Provide for exceptions to the one claim per month per provider per consumer according to ODJFS requirements for LTC facility claims.			
7.3.1.78	Track and account for the number of leave days for each consumer in a LTC facility, according to ODJFS requirements.			
7.3.1.79	Pay for leave days according to ODJFS requirements for PASSR, LTC facility and hospice claims.			
7.3.1.80	Account for the number of covered days in a claim span according to ODJFS requirements for LTC facility claims.			
7.3.1.81	Adjudicate Medicare cross-over claims for co-insurance and deductibles versus LTC facility room and board claims.			
7.3.1.82	Provide for exceptions to timely submission for claims awaiting prior payment from third party payers, including LTC facility claims.			
7.3.1.83	Identify prior payment from third party payers including LTC facility claims.			
7.3.1.84	Provide on-line automated functionality for claims status checks throughout the claims lifecycle.			

MITS Business Requirement "Functional Fit" Survey				
Transactions, Claims, and Encounters				
Req Number	**Requirement**	**MITS Phase (1 or 2)**	**Response Code**	**Page Ref**
7.3.1.85	Accept and process all HIPAA compliant (current and future) code sets and other code sets as defined by ODJFS			
7.3.1.86	Accept HIPAA compliant ANSI X12 276, batch or near real-time content for claims status inquiry.			
7.3.1.87	Adjudicate claims from sub-recipient State agencies or from their providers.			
7.3.1.88	Respond to electronic claim status inquiries with a HIPAA compliant ANSI X12 277 transaction content both batch and near real-time.			
7.3.1.89	Provide the ability to view at least seven (7) years of remittance advice (835) on-line. Load history beginning with 01/01/2004.			
7.3.1.90	Send RA's back to providers, billing agents, or sub-recipient State agencies via electronic media (including CD, Medicaid Portal, and 835) or via paper or both.			
7.3.1.91	Generate paper RAs if required by ODJFS to including: • No limits of wording length on provider notices • An itemization of submitted claims that were paid, denied or adjusted and any financial transactions that were processed for that provider, including sub totals and totals • Adjusted claim information showing both the original claims information and the adjusted claim information with an explanation of the adjustment reason code • OAKS description relating to the claim payment reduction, denial, or payment • Summary section containing earnings information regarding the number of claims paid, denied, suspended, and adjusted and financial transactions for the current payment period, month to date, and year (calendar, State fiscal, provider fiscal) to date.			
7.3.1.92	Provide capability to generate targeted newsletters to providers by provider type, provider category-of-service, procedure codes, claim-adjustment-and-remittance-advice-remark codes, etc.			
7.1.1.93	Transmit information regarding sub-recipient State agencies claim payment to OAKS.			
7.3.1.94	Provide on-line capability to change adjudication cycles based on budget, cash, and fiscal management as directed by the State.			
7.3.1.95	Provide a mechanism to generate a communication via the web or paper to providers that are in credit balance.			
7.3.1.96	Generate content so that the 835 transaction can be used to communicate credit balance information on the 835 remittance advice.			
7.3.1.97	Adjudicate claims to process Federal Qualified Health Center (FQHC), rural health clinic, and outpatient health facility supplemental payments as TPL claims and other supplemental payments.			

MITS Business Requirement "Functional Fit" Survey				
Transactions, Claims, and Encounters				
Req Number	**Requirement**	**MITS Phase (1 or 2)**	**Response Code**	**Page Ref**
7.3.1.98	Provide the capability for payment of vaccine code to differ based on whether claim is for child Vaccine for Children (VFC) or adult (non VFC). Must be date specific.			
7.3.1.99	Provide an ad hoc capability to define and generate claims adjudication reports.			
7.3.1.100	View and report on EPSDT claims as defined by ODJFS.			
7.3.1.101	Identify duplicate cross-over claims and edit processing or deny based on ODJFS defined criteria.			
7.3.1.102	Calculate and verify the amount of co-insurance on Medicare cross-over claims.			
7.3.1.103	Accept fully adjudicated pharmacy claims, including NCPDP reject/payment codes, directly into the payment cycle.			
7.3.1.104	Provide the capability to make payments directly to a Medicaid consumer (or authorized representative) or a fiscal agent using warrants, EFT, or other payment methods. (An example would be when retroactive Medicaid eligibility has been determined for a consumer who has already paid the bill).			
7.3.1.105	Maintain at the claim header and line level all accounting codes for payment distribution.			
7.3.1.106	Support edits based on tooth number.			
7.3.1.107	For Long Term Care, maintain and display data that reflects an entire calendar month's worth of services.			
7.4	**Claims Adjustments**			
7.4.1	Requirements			
7.4.1.1	Maintain three years of on-line claim history to be used for adjustment processing upon implementation (e.g., 3 years available on day one of implementation), including encounter data.			
7.4.1.2	Accept and process 837 adjustments and NCPDP transactions.			
7.4.1.3	Link adjustments or replacement claims to immediate predecessor or original claims.			
7.4.1.4	Associate all supporting documentation for gross adjustments to TCN assigned to the gross adjustment.			
7.4.1.5	~~Suspend and review eligibility changes for consumers enrolled in MCPs.~~			
7.4.1.6	Provide capability to easily turn suspend function off and on at a specific edit level.			
7.4.1.7	Crosswalk and store third party submitted control numbers (e.g., Medicare ICN) for cross-over claims.			
7.4.1.8	Copy a claim, manually enter data into the copied claims, and submit claims as an adjustment. This capability must be available for State staff and providers.			

MITS Business Requirement "Functional Fit" Survey				
Transactions, Claims, and Encounters				
Req Number	**Requirement**	**MITS Phase (1 or 2)**	**Response Code**	**Page Ref**
7.4.1.9	Track all incoming adjustment requests and claims regardless of input media and assign a unique tracking number and an adjustment type identifier.			
7.4.1.10	Image claim adjustments requests from providers (including faxes).			
7.4.1.11	Provide flexible reporting capability for analysis purposes (e.g., by provider, by reason, etc).			
7.4.1.12	Provide customizable workflow routing for adjustments.			
7.4.1.13	Provide management adjustments reporting capability for all adjustments requests, (e.g., aging, media type, provider).			
7.4.1.14	Process returned warrants or EFTs. Functionality should include: • Reestablishment of all claims into a to-be paid status • Be able to redistribute the funds to appropriate accounts • Reinstate units and dollars for prior authorized services.			
7.4.1.15	Automatically recognize if an adjustment is a prior-authorized claim and adjust units and dollars related to the PA record.			
7.4.1.16	Generate an alert to provider enrollment based on returned warrants (e.g., linked to auto payment stoppage) to reinstate the claims and adjust financial records.			
7.4.1.17	Receive and maintain all managed care retroactive and current eligibility enrollment spans and trigger retroactive adjustment claims.			
7.4.1.18	Pull paid claims history into adjustments record by multiple identifiers and assign a unique tracking number to each claim, as defined by the ODJFS (mass adjustments).			
7.4.1.19	Trigger take backs or payments and generate the content of 820 remittance advice for premium payments to providers, at ODJFS-defined intervals.			
7.4.1.20	Check for duplicate Medicare cross-over claims.			
7.4.1.21	Utilize workflow capability to route gross adjustments requests to optional customizable approval criteria.			
7.4.1.22	Provide on-line, role-based, approval for gross adjustments, as defined by ODJFS.			
7.4.1.23	Adjust claims both retroactively and prospectively (e.g., take back or not pay) based in consumer resource information.			
7.4.1.24	Allow adjustments for retroactive eligibility.			
7.4.1.25	Allow adjustments due to third party prior payment and alert the cost avoidance unit.			
7.4.1.26	Display both contracted agreement amount and actual payment amount.			
7.4.1.27	Provide the capability to easily modify the adjustment process to support one-time adjustments, such as Combined Proposed Adjudication Order (CPAO), or recurring adjustments to recoup Civil Monetary Penalties (CMP), other types of fines and liens.			

MITS Business Requirement "Functional Fit" Survey				
Transactions, Claims, and Encounters				
Req Number	**Requirement**	**MITS Phase (1 or 2)**	**Response Code**	**Page Ref**
7.4.1.28	Establish weekly payment reductions or increases based on the following including: IRS levy/lien, child support, as defined by ODJFS.			
7.4.1.29	Adjust a claim within a current month, (including re-billing).			
7.4.1.30	Accommodate adjustments across multiple providers.			
7.4.1.31	Provide for near real-time, on-line, mass adjustments, based on ODJFS-defined criteria			
7.4.1.32	Designate the release of payments related to adjustments.			
7.4.1.33	****Provide on-line**** ~~A~~access to the internal ~~or external~~ rate adjustment tables used in adjustment calculations.			
7.4.1.34	Find and replace claims by provider numbers.			
7.4.1.35	Provide easily customizable / parameter driven mass adjustment selection and review process.			
7.4.1.36	Establish and provide a sandbox environment that provides the functionality to create, test, modify and store fiscal impact scenarios.			
7.4.1.37	Provide internal communication capabilities (notification/explanation) tied to mass adjustments when necessary (e.g., policy initiated mass adjustments).			
7.4.1.38	Provide offline claim history back seven years. (This does not include claims requiring lifetime history.)			
7.4.1.39	Provide on-line reports for internal purposes such as credit balance.			
7.4.1.40	Deny or hold payments for review or release for immediate payment.			
7.4.1.41	Interface with Fiscal to accommodate warrant replacement, process liens and recoupments with MITS.			
7.5	**Premium Payment**			
7.5.1	Requirements			
7.5.1.1	Establish and maintain a flexible premium payment and adjustment system that incorporates to the following rate components: • Type of program • Geographic rate (region or other unit) • Type of Medicaid and /or Non-Medicaid eligibility within a specific care management program • Age and gender cohort • Disease and/or condition cohort, when applicable • Provision of optional services (e.g., dental, chiropractic, etc.) • Effective dates for rates including 7 year history • Premium production and payment on a program-specific frequency schedule as specified by ODJFS • Functional Level of Care or Nursing Home level of care • Medicare Status (including Parts A,B,C,D) • Specific premium rates per case management program			

MITS Business Requirement "Functional Fit" Survey				
Transactions, Claims, and Encounters				
Req Number	**Requirement**	**MITS Phase (1 or 2)**	**Response Code**	**Page Ref**
	• PACE (Medicaid only, dually eligible, Medicare only).			
7.5.1.2	Update consumer records to reflect premium payments made on his/her behalf.			
7.5.1.3	Process incentive/special payments to MCPs or other care management programs.			
7.5.1.4	Assess penalties including premium reductions, refundable fines and rate adjustments to MCPs or other care management programs.			
7.5.1.5	Calculate and remit monthly and daily, or as otherwise specified, premium payments to providers based on such criteria as monthly membership, benefit plan, and provider specific rate information.			
7.5.1.6	Provide a test environment to change rate structures for payments. Then provide ability to export rate structure into a file that can be imported to production by change management.			
7.5.1.7	Allow for on-line near real-time payment adjustments.			
7.5.1.8	Generate, and transmit to providers on a frequency specified by ODJFS, the content of HIPAA compliant automated premium payment reports (ASC-X12N 820) for members who are prospectively or retroactively enrolled in a care management plan.			
7.5.1.9	Maintain the capability to pay MCP premium payments directly or to reimburse a sub-recipient State agency.			
7.5.1.10	Adjust and track premium payments at the member level based on changing eligibility and membership status or other changes that affect the premium payment.			
7.5.1.11	Generate on-line and hard-copy balancing and control reports for specific programs as defined by ODJFS.			
7.5.1.12	Create and update rates on-line for effective dates as specified by program area.			
7.5.1.13	Case mix adjust based on claims data (both FFS and encounter data).			
7.5.1.14	Accept payments (EFT, inter-agency transfer payments, Warrants) from other entities.			
7.5.1.15	Generate additional care management program payments (e.g., delivery payments) from encounter data.			
7.5.1.16	Allow simultaneous membership in more than one care management program.			
7.5.1.17	Provide for review and oversight of mass rate changes after implementation.			
7.5.1.18	Generate a report identifying when retroactive rates changes have been initiated.			
7.5.1.19	Calculate and remit or recoup premium payments due to membership changes.			
7.6	**Encounter Data**			
7.6.1	Requirements			

MITS Business Requirement "Functional Fit" Survey				
Transactions, Claims, and Encounters				
Req Number	**Requirement**	**MITS Phase (1 or 2)**	**Response Code**	**Page Ref**
7.6.1.1	Accept encounter data, on-line or in batch form, in ANSI X 12 837 format or other ODJFS-defined format			
7.6.1.2	Accept encounter data daily.			
7.6.1.3	Edit encounter data against specific encounter edits using ODJFS-defined edit policies.			
7.6.1.4	Process encounter data and produce EDI 835 or unsolicited 277 or ODJFS defined error report per ODJFS specifications.			
7.6.1.5	Identify encounters by type of benefit package (e.g., waivers, care management programs, etc).			
7.6.1.6	Accept on a daily basis encounter data from Medicare Pharmacy benefit managers for eligible Medicaid consumers whose pharmacy coverage is through Medicare.			
7.6.1.7	Identify encounters by program (e.g., EPSDT).			
7.6.1.8	Assign category of service like FFS claims.			
7.6.1.9	Provide encounter data submission testing capabilities for care management plans as requested by ODJFS.			
7.6.1.10	Allow on-line modification to edits/audits as dictated by policy with a detailed audit trail.			
7.6.1.11	Provide the capability to update edits/audits in reference file.			
7.6.1.12	Utilize national code sets and update when changes are made to national code sets such as HCPCS, ICD-9 diagnosis and revenue service codes per benefit package.			
7.6.1.13	Identify encounter data versus FFS claims and maintain data for reporting purposes.			
7.6.1.14	Identify and store denied encounter data.			
7.6.1.15	Automate encounter data to SAS file formats.			
7.6.1.16	Trigger payments or recoupments for carved-out services (e.g., delivery payments) based on codes in the encounter or adjustment data, as designated by ODJFS.			
7.6.1.17	Generate an audit trail that identifies the specific encounter that triggered payment.			
7.6.1.18	Identify and generate an alert to specified State personnel for on-line encounter claims with TPL indicator requiring review.			
7.6.1.19	Generate a summary report that identifies changes being made to adjusted premium payments including codes for rejected encounter data.			
7.6.1.20	Produce and forward to specified ODJFS personnel a daily summary of encounter data mass revision submissions identifying data element changes.			
7.6.1.21	Maintain a complete history of encounter data and subsequent revisions thereto.			
7.6.1.22	Price encounter data based on FFS rates.			
7.6.1.23	Capture care management payments and denials by encounter and line item.			

MITS Business Requirement "Functional Fit" Survey				
Transactions, Claims, and Encounters				
Req Number	**Requirement**	**MITS Phase (1 or 2)**	**Response Code**	**Page Ref**
7.7	**Alternative Delivery System Model**			
7.7.1	Requirements			
7.7.1.1	Input and process PROGRAM specific financial and program eligibility information for PROGRAM program participation including the capability for different budgets for community and institutional living arrangements.			
7.7.1.2	Track the status of PROGRAM program applications from initial referral through approval/denial, including hearings and decisions, if applicable.			
7.7.1.3	Generate alerts to appropriate parties at each PROGRAM application decision point.			
7.7.1.4	Provide PROGRAM sites and other users approved by the State the ability to access PROGRAM financial and program eligibility data in accordance with ODJFS security rules.			
7.7.1.5	Provide on-line capability to capture and track data required for the determination of PROGRAM program eligibility.			
7.7.1.6	Provide the system capability to recommend level of care based on ODJFS-defined criteria and comparison to data regarding the individual diagnoses, functional ability to perform Activities of Daily Living (ADLs), IADLS, medication administration, treatments, etc. on assessment/level of care forms.			
7.7.1.7	Allow State specified staff to override the automated level of care recommendation.			
7.7.1.8	Capture and store data from PROGRAM sites including assessment data, level of care form, level of care plan, referral form, withdrawal form, enrollment agreement, and other forms as identified by the State.			
7.7.1.9	Generate alerts to staff that identifies case/applicant ready for program eligibility review.			
7.7.1.10	Provide on-line approval/denial of program eligibility.			
7.7.1.11	Generate alert if applicant is enrolled in other Medicaid programs.			
7.7.1.12	Generate alerts to appropriate staff identifying PROGRAM program participants that are due for annual review.			
7.7.1.13	Provide an on-line capability to modify re-determination dates and eligibility spans including initial and follow-up.			
7.7.1.14	Easily accommodate changes to re-determination period as defined by ODJFS.			
7.7.1.15	Capture both effective and begin dates for PROGRAM program.			
7.7.1.16	Provide the capability to accommodate partial month enrollment.			
7.7.1.17	Provide automated interfaces with Department of Aging and/or other sub-recipient State agencies as determined by ODJFS.			
7.7.1.18	Provide on-line role-based access to county and other users as determined by ODJFS.			
7.7.1.19	Provide on-line role-based access to enrollment agreement.			

MITS Business Requirement "Functional Fit" Survey				
Transactions, Claims, and Encounters				
Req Number	**Requirement**	**MITS Phase (1 or 2)**	**Response Code**	**Page Ref**
7.7.1.20	Maintain seven years of on-line history of PROGRAM program data as defined by ODJFS.			
7.7.1.21	Provide on-line notifications to PROGRAM site of approved enrollment agreement.			
7.7.1.22	Generate and distribute enrollment agreement and/or notification letters to participants and/or their guardians and/or authorized representatives.			
7.7.1.23	Generate and distribute ODJFS-defined denial of PROGRAM eligibility letters, including rights to fair hearings, to applicants and/or their guardians and/or authorized representatives.			
7.7.1.24	Generate notices to State defined staff of any PROGRAM eligibility denials.			
7.7.1.25	Provide the capability to request on-line dis-enrollment functionality.			
7.7.1.26	Provide on-line capability to complete and track PROGRAM financial eligibility data.			
7.7.1.27	Automatically close the PROGRAM referral and notify appropriate parties if the applicant chooses not to enroll.			
7.7.1.28	Track hearings, date of hearing, issues and outcomes, and linkage to hearing documents for PROGRAM program.			
7.7.1.29	Provide the capability to defer enrollment to a future date as determined by the State when participant is hospitalized in the effective date of the enrollment.			
7.7.1.30	Provide capability to re-establish eligibility spans using ODJFS defined criteria and automatically notify appropriate parties.			
7.7.1.31	Provide capability to pend an application for the consumer based on ODJFS defined-rules.			
7.7.1.32	Capture data through the use of a Programmable Digital Assistant (PDA) and the capability to upload that data to the system.			
7.7.1.33	Support acceptance of electronically submitted physical signatures.			
7.7.1.34	Generate and distribute PROGRAM program related reports including: • Length of stay • Enrollment/dis-enrollment • Census data by PROGRAM site • In home versus institutional care • Processing times • Reasons for dis-enrollment.			
7.7.1.35	Capture and track individual participant decisions regarding PROGRAM program enrollment and/or dis-enrollment.			
7.7.1.36	Capture and track individual PROGRAM participant enrollment in Medicare Part A and Part B and all necessary capitation fees and co-pays.			

MITS Business Requirement "Functional Fit" Survey				
Transactions, Claims, and Encounters				
Req Number	**Requirement**	**MITS Phase (1 or 2)**	**Response Code**	**Page Ref**
7.7.1.37	Identify and track PROGRAM participants by program (e.g., Medicaid, Medicare, Dual Eligible, or Private Pay).			
7.7.1.38	Provide for on-line completion of PROGRAM referral form 2398 by the CDJFS, the PROGRAM site, and other entities as specified by the State.			
7.7.1.39	Generate/send the referral to CDJFS and/or the PROGRAM site and notify the State Administering Agency (SAA) that the referral was made.			
7.7.1.40	Provide on-line access to referral form containing data elements specified by the ODJFS and form completion capability for State staff and other entities as specified by ODJFS.			
7.7.1.41	Identify PROGRAM participants and the date spans during which they are enrolled in PROGRAM to allow payment of claims only to the PROGRAM site and to prevent Medicaid payment to any other Medicaid providers during such periods of PROGRAM enrollment.			
7.7.1.42	Prevent payment of PROGRAM capitation payments (under either FFS claims or managed care monthly lump sum payment mechanism) to providers that are not approved PROGRAM sites or are not the specific PROGRAM site at which the individual is enrolled as a participant.			
7.7.1.43	Recognize attempts at enrollment to/from mutually exclusive benefit packages (e.g., HCBS waiver, accessing card services from providers other than PROGRAM site, NF vendor payments, etc) to prevent simultaneous enrollment/participations in mutually exclusive benefit packages, and alert the affected entities or program areas as identified by ODJFS.			
7.7.1.44	Recognize when a PROGRAM participant change of address is to an out-of-service location and alert the SAA, PROGRAM site, CDJFS caseworker, and/or other entity as specified by ODJFS.			
7.7.1.45	Provide capability to pay more than one rate per PROGRAM site/provider number when specified by ODJFS (e.g., Medicaid only and Medicaid/Medicare dual eligible PROGRAM rates based on the participant's eligibility status).			
7.7.1.46	Capture and record PROGRAM program eligibility for both Medicaid and non-Medicaid participants and only allow payment for those participants who are Medicaid eligible.			

MITS Business Requirement "Functional Fit" Survey				
Transactions, Claims, and Encounters				
Req Number	**Requirement**	**MITS Phase (1 or 2)**	**Response Code**	**Page Ref**
7.7.1.47	Ensure that PROGRAM sites are paid the appropriate rate based on both the Medicare and Medicaid eligibility status of the individual during the dates the participant is enrolled in PROGRAM (e.g., if a PROGRAM site bills the Medicaid-only rate for someone who is dually eligible for Medicare/Medicaid it would not pay but would notify the PROGRAM site that the wrong rate was billed and direct the site to either provide evidence that the person did not have Medicare coverage or resubmit a corrected claim in which the dually eligible rate was billed for the participant).			
7.7.1.48	Adjudicate claims to pay the appropriate PROGRAM capitation rate for the individual's eligibility status (e.g., Medicaid-only or Medicare/Medicaid dually eligible) minus the individual's patient liability amount, if applicable, to prevent overpayments to PROGRAM sites.			
7.7.1.49	Accept the PROGRAM site name/address as the participants mailing address for purposes of receiving the individual's Medicaid card in addition to the participant's actual residence address.			
7.7.1.50	Track outcomes of referrals, including voluntary withdrawals from the PROGRAM application process following completion of a 2398 form.			
7.7.1.51	Provide on-line access to PROGRAM site's staff/applications for completion of forms (e.g., voluntary withdrawal of PROGRAM application form) with electronic signature capability.			
7.7.1.52	Provide for on-line submission, routing, processing and provision of notice to parties as specified by ODJFS (e.g., CDJF caseworker/PROGRAM coordinator, SAA, PROGRAM site, when applicants voluntarily withdraw their applications).			
7.7.1.53	Provide the capability to receive on-line submission of PROGRAM applications including sufficient notes and comments space for explanations.			
7.7.1.54	Provide the capability to direct submitted application forms to appropriate worker at appropriate agency pursuant to criteria determined by ODJFS.			

MITS Business Requirement "Functional Fit" Survey				
Quality Management				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
8.1	**Provider Performance Management**			
8.1.1	Requirements			
8.1.1.1	Provide near real-time role-based HIPAA compliant access (updated in accordance with other business requirements) to electronic **** data **** ~~files~~ via the Medicaid Portal or other access channels. This access should be made available to medical service providers, other care manager professionals, and OHP staff, as permitted under State and Federal law using security protocols. Only information that is determined necessary to support informed, high-quality care management and best clinical practice in regard to the care provided to Medicaid consumers will be available. The system may need to provide access to service information at a stage in claims processing that precedes the claim's final adjudication and payment of the claim.			
8.1.1.2	~~Develop a Quality Management application for OHP to access and display the following information:~~ **** Provide role-based access to quality management supporting applications and information: **** • Service information **(Accessed via MITS Screen)** • Pharmacy benefit system ~~(if separate)~~ **(Accessed via Medicaid Portal)** • Encounter data **(Accessed via MITS Screen)** • Eligibility data **(Accessed via MITS Screen)** • Demographic data **(Accessed via MITS Screen)** • Census data **** stored in the data warehouse/DSS ** (Accessed via Medicaid Portal)** • Provider information **(Accessed via MITS Screen)** • Geographic location information **(Accessed via MITS Screen)** • Benefits packages associated with various programs **(Accessed via MITS Screen)** ~~• Electronic medical records~~ • Individualized waiver service plans **(Accessed via MITS Screen)** • Reports of major unusual incidents **(Accessed via MITS Screen)** • State Immunization Registry **** as stored in MITS ** (Accessed via MITS Screen)** • Clinical studies and recommendations **** stored in the data warehouse/DSS ** (Accessed via Medicaid Portal)** • Lead poisoning database **** as stored in MITS ** (Accessed via MITS Screen)** • Quality reviews **(Accessed via Medicaid Portal)** • Information from other stand alone systems including: **(Accessed via Medicaid Portal)** o data warehouse/DSS o Pegasus o Perseus			

MITS Business Requirement "Functional Fit" Survey				
Quality Management				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
	• Consumer satisfaction survey data, etc. **(Accessed via Medicaid Portal)** • **** HEDIS data within the data warehouse/DSS ** (Accessed via Medicaid Portal)**			
8.1.1.3	Phase 2 - **** Provide role-based access via links from the Medicaid Portal to data from the data warehouse/DSS that is used to **** ~~M~~monitor, measure, and compare the performance of individual medical service providers and care manager professionals, and comparisons of managed health care plans to variable pre-established standards of care for Medicaid consumers with particular diagnostic or demographic characteristics. This monitoring/comparison should be able to be aggregated according to specified reporting dimensions (e.g. county, MCPs, etc.). ~~Standards of care should include:~~ ~~• Considerations of the types of medical services~~ ~~• Health Plan Employer Data and Information Set (HEDIS), HEDIS-like, or other performance measures as defined by the state~~ ~~• Timeliness of specific medical services~~ ~~• Sequence of specific medical services~~ ~~• Venues through which particular medical services are provided~~ ~~• Other patterns of patient care and medical treatment or modalities, or outcomes.~~			
8.1.1.4	Phase 2 - **** Provide role-based access from the Medicaid Portal to monthly (at a minimum) provider scorecards or report cards, that include: **** ~~Produce monthly (at a minimum) a provider scorecard or report card, as defined by ODJFS, that calculates and presents provider information associated with specific performance measures, including:~~ **[Combined 8.1.1.12 with this requirement]** **• ** Information from MITS that provides a complete view of individual providers, including: **** o Information that clarifies their participation in various provider groups and practices o Services they provide or are qualified to provide o Their occurrence in various Medicaid groupings of provider types, specialization, or other qualifications o All tax IDs, provider numbers, and provider names under which they bill for Medicaid services, etc. **• ** Links to data in the data warehouse/DSS that presents specific provider performance measures, including: **** o Utilization measures o Quality of care measures o Comparisons across peer groups and relative to norms o Comparisons of performance over time o Outlier identification			

MITS Business Requirement "Functional Fit" Survey				
Quality Management				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
	o Comparisons to strategic targets o Information examples include lead testing rates, immunization rates, emergency department visits, and inpatient length of stay analysis.			
8.1.1.5	~~Phase 2 - Allow role-based access to information that includes clinical, utilization, financial and outcome based information in clear formats, with user-friendly query development, with flexible reporting capabilities, including fields and categories that can be selected on an ad hoc basis.~~			
8.1.1.6	Automate an alert system to be sent directly to medical care providers, care managers, Medicaid consumers, Medicaid Managed Care Plans and/or OHP staff, as authorized. Alerts will be generated based upon considerations of the types of medical services (e.g., diabetes exams, hospitalization), the timeliness of specific medical services (e.g., Healthchek exams, lead screening test), or the sequence of specific medical services (e.g., immunizations, pap smears).			
8.1.1.7	Include in the alert information the medical care that has been provided, medical care that may need to be provided, or in regard to other medical events, as defined by ODJFS, that are determined to be relevant to the quality or coordination of care provided to particular Medicaid consumers.			
8.1.1.8	Ability for the system to generate timely alerts based upon the following criteria: • Through the Medicaid Portal, automated telephone calls, and/or automatically generated and mailed hardcopy correspondence or delivery mechanisms as defined by ODJFS • Directly to medical care providers, care managers, Medicaid consumers, and/or OHP staff, as authorized • Relative to pre-established variable standards of medical care for consumers with particular diagnostic or demographic characteristics • To warn medical care providers, care manager professionals, Medicaid consumers, or OHP staff, as authorized, when the medical care that has been provided is determined by studies of clinical outcomes or the input provided to OHP by medical professionals, to potentially create adverse medical conditions or to otherwise increase the health risks of Medicaid consumers • In which "timely" is defined by ODJFS in terms of the timeframes within which particular alerts need to be issued in order to have a probable positive impact on the quality or coordination of care provided to Medicaid consumers			

MITS Business Requirement "Functional Fit" Survey				
Quality Management				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
	• In which "automated" infers devices that trigger alerts, on a variable rule defined basis, when information indicating that a particular service has been rendered or that a medical event as defined by ODJFS has occurred, or when other pre-defined situations are determined to exist or to have occurred by an algorithmic analytical capacity that exits in data warehouse/DSS, in an enhanced Medicaid claims processing system, or elsewhere.			
8.1.1.9	Phase 2 - Provide flexibility in MITS components to support pay for performance.			
8.1.1.10	Phase 2 - Interface with claims pricing to ~~prompt~~ **** trigger **** payment adjustment (increase/decrease) for specific services paid to individual providers and care manager professionals based on their performance relative to variable pre-established standards of care for Medicaid consumers with particular diagnostic or demographic characteristics. Standards of care should include: • Considerations of the types of medical services • Timeliness of specific medical services, the sequence of specific medical services • Venues through which particular medical services are provided • Other patterns of patient care and medical treatment or modalities.			
8.1.1.11	Phase 2 - Support the benefits and service administration business process to allow the potential of "rule-based" flexibility to manage incentive programs within provider groups (e.g., allow staff to view the top ten percent of providers within a certain category) and automatically assign or remove an incentive payment bonus to the reimbursement rate for a set period of time.			
8.1.1.12	~~Phase 2 - Generate and display, through Medicaid Portal and other media, provider scorecards and/or other particular provider performance information based on criteria as defined by ODJFS. This report/scorecard will provide a complete picture of individual providers including:~~ **[Merged this requirement into 8.1.1.4]** ~~• Information that clarifies their participation in various provider groups and practices~~ ~~• Services they provide or are qualified to provide~~ ~~• Their occurrence in various Medicaid groupings of provider types, specialization, or other qualifications~~ ~~• All tax ID, provider numbers, and provider names under which they bill for Medicaid services, etc.~~			
8.1.1.13	Automate interfaces with external public and private health care data sources (e.g., State Immunization Registry, Census information, lead poisoning database, and sub-recipient State agencies) to allow access to data that can be used to improve the quality or coordination of care provided to Medicaid consumers.			

MITS Business Requirement "Functional Fit" Survey				
Quality Management				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
8.1.1.14	~~Interface with MITS, data warehouse/DSS component to perform algorithmic and other analytical capability to analyze claims and/or multiple data sources in order to identify; A) individual or classes of Medicaid consumers or B) individual or classes of Medicaid providers to include the following:~~ ~~• Patterns of treatment and diagnosis~~ ~~• Relationships among peer providers or providers and consumers correlations~~ ~~• Consumers' age or gender~~ ~~• Types or costs of services delivered.~~			
8.1.1.15	Phase 2 - Through mechanisms as defined by ODJFS define, initiate, and track surveys of consumers and others in order to gather and generate performance information on individual or groupings of providers.			
8.1.1.16	Phase 2 - **** Provide role-based access via links from the Medicaid Portal to data in the data warehouse/DSS that display provider profile reports that support **** ~~Interface with MITS data warehouse/DSS component to generate provider profile reports using~~ on-line selection of providers from an exception report and ~~have the ability to do~~ **** that provide **** monthly aggregations of the data on units of service by provider type and category of service.			
8.1.1.17	~~Provide consolidation of health care information and services across all providers.~~			
8.2	**Quality Assurance**			
8.2.1	Requirements			
8.2.1.1	Phase 2 - **** Provide role-based access via links from the Medicaid Portal to data in the data warehouse/DSS that supports the analysis of **** ~~Analyze~~ multiple data sources ~~to include~~ **** including **** eligibility files and encounter/claims data **** in order **** to identify clinical and non-clinical areas of health care that need improvement. Examples of these areas are: • Asthma • Diabetes • Acute Myocardial Infarction (AMI) • Childhood immunization • Blood lead screening • Mental health services • Pap tests.			
8.2.1.2	Phase 2 - **** Provide role-based access via links from the Medicaid Portal to data in the data warehouse/DSS that display **** ~~Produce~~ quality and outcome review **** information **** ~~data~~, such as Health Plan Employer Data and Information Set (HEDIS) and other clinical performance measures as specified by ODJFS.			

MITS Business Requirement "Functional Fit" Survey				
Quality Management				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
8.2.1.3	Phase 2 - Through mechanisms as defined by ODJFS initiate and track surveys of Medicaid consumers and others in order to gather and generate performance information on individual or groupings of providers.			
8.2.1.4	Phase 2 - **** Provide role-based access via links from the Medicaid Portal to capabilities in the data warehouse/DSS that **** ~~P~~provide the flexibility to easily change the parameters that drive the performance measurement process.			
8.2.1.5	~~Phase 2 - Provide on-line role-based access to encounter/claims and eligibility data for vendors identified by ODJFS to generate samples for studies/surveys.~~			
8.2.1.6	~~Phase 2 - Perform a data import function to integrate and analyze data in various types of file formats such as Access, Excel, Text, Paradox, and Dbase external sources that are transmitted from external sources such as vendors and sub-recipient State agencies to ODJFS.~~			
8.2.1.7	Phase 2 - Link to Medicaid consumer level data from quality studies to service providers.			
8.2.1.8	Phase 2 - **** Provide role-based access via links from the Medicaid Portal to functions in the data warehouse/DSS that **** ~~C~~capture data extracted from medical record reviews **** in order **** to evaluate services provided to Medicaid consumers.			
8.2.1.9	Phase 2 - **** Provide role-based access via links from the Medicaid Portal to the data warehouse/DSS in order to **** ~~G~~generate reports and analytical finds for ODJFS staff on managed care plans, providers, county programs and other external stakeholders by addressing the following areas, at a minimum: • Complex analysis and reporting of health care utilization and expenditure patterns and trends primarily using health care claims data • Performance of specialized studies of access, quality, use and/or cost of health care • Comparative analysis and profiling of health care providers, including the profiling of the clinical and financial performance of health care providers • Complex clinically oriented analysis and reporting of access to and quality of health care • Detection, analysis, and reporting of patterns and trends in access, quality, use and cost of health care • Analysis of merged or multiple data sources (e.g. public health, lead data, immunization registration data).			
8.3	**Consumer Health and Safety**			
8.3.1	Requirements			

MITS Business Requirement "Functional Fit" Survey				
Quality Management				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
8.3.1.1	Provide the capability to interface, accept, retain, track, analyze and report on incidents and provider occurrences that occur within ODJFS-administered Medicaid programs (e.g. Ohio Home Care Waiver), using Consumer and Provider Occurrence Report Tracking System (C-PORTS) as the functional model.			
8.3.1.2	Convert data from C-PORTS to the applicable MITS component.			
8.3.1.3	Interface MITS components with any other ODJFS or external incident reporting systems (e.g. ODMR/DD's Major Unusual Incidence (MUI) database) as identified by ODJFS.			
8.3.1.4	Allow provider and/or care manager to complete on-line incident report.			
8.3.1.5	Generate notice of deficiencies or correction action plans to the provider.			
8.3.1.6	Issue timely alerts to medical care providers, care managers or OHP staff in regard to reports of health and safety related to incidents (e.g. e-mail, hardcopy letter).			
8.3.1.7	Accept and track information associated with health and safety related incidents reported by providers, field review staff, consumers, and/or other entities identified by ODJFS.			
8.3.1.8	Generate reports on health and safety incidents and related information by data such as provider or by Medicaid consumers.			
8.3.1.9	Perform waiver (or other) program field (i.e., remote) data gathering / transmission functions via hand held wireless technology, systems or other mechanisms as identified by ODJFS.			
8.4	**Consumer Satisfaction**			
8.4.1	Requirements			
8.4.1.1	Phase 2 - Generate a sampling frame or other types of a random sample, related to the eligible population and benefit package for the consumer satisfaction survey as specified by ODJFS. Provide flexibility to change the sampling frame used in analysis such as the eligible population and benefit package for the consumer satisfaction survey.			
8.4.1.2	Phase 2 - Import and accept survey data from multiple sources (e.g., External Quality Review Organization (EQRO) vendor, sub-recipient State agencies) via multiple media types such as CDs, Medicaid Portal, wireless technology, systems, or other mechanisms as identified by ODJFS.			
8.4.1.3	Phase 2 - Link survey data to the consumer and provider for use by OHP staff.			
8.4.1.4	Phase 2 - Send and store survey response data in data warehouse/DSS.			
8.4.1.5	Phase 2 - **** Provide role-based access via links from the Medicaid Portal to**** external data sources as defined by ODJFS, such as **** the **** National Committee for Quality Assurance (NCQA) database.			

MITS Business Requirement "Functional Fit" Survey				
Quality Management				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
8.4.1.6	Phase 2 - Produce quality management reporting related to the interaction and timely response to consumer contact (as defined by ODJFS).			
8.4.1.7	Phase 2 - Perform waiver (or other) program field (i.e., remote) data gathering / transmission functions via hand held wireless technology, systems or other mechanisms as identified by ODJFS.			
8.4.1.8	Phase 2 - Trigger, at a minimum, customer satisfaction surveys automatically based on ODJFS specified criteria within 6 months of waiver program enrollment.			
8.4.1.9	Phase 2 - Provide flexible parameter setting functionality to determine the frequency of various activities including: • Surveys • Reports.			
8.5	**Provider Satisfaction**			
8.5.1	Requirements			
8.5.1.1	Phase 2- Generate a "sample frame", or random sample, related to the specified provider population for the provider satisfaction survey, as specified by ODJFS every six months.			
8.5.1.2	Phase 2 - Import and accept survey data from multiple sources (e.g., External Quality Review Organization (EQRO) vendor and sub-recipient State agencies) via multiple media types such as CDs, Medicaid web portal, and wireless technology.			
8.5.1.3	Phase 2 - Link survey data to consumer and provider for use by OHP staff.			
8.5.1.4	Phase 2 - Send and store survey response data in the Decision Support System.			
8.5.1.5	Phase 2 - **** Provide role-based access via links from the Medicaid Portal to **** external data sources as identified by ODJFS (e.g. NCQA database, sub-recipient State agencies).			
8.5.1.6	Phase 2 - Produce quality management reporting related to the interaction and timely response to provide contact as defined by ODJFS.			
8.5.1.7	Phase 2 - Perform waiver (or other) program field (i.e., remote) data gathering / transmission functions via hand held wireless technology, systems or other mechanisms as identified by ODJFS.			
8.5.1.8	Phase 2 - Trigger, at a minimum, provider satisfaction surveys automatically based on ODJFS specified criteria within six months of waiver program enrollment.			
8.5.1.9	Phase 2 - Provide flexible parameter setting functionality to determine the frequency of various activities including: • Surveys • Reports.			
8.6	**Case Management**			
8.6.1	Requirements			

MITS Business Requirement "Functional Fit" Survey				
Quality Management				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
8.6.1.1	Provide the capability to accept, retain, track, analyze, and report on case management related quality of care and quality performance data in the aggregate, as well as at the individual case level.			
8.6.1.2	Accommodate varying needs of case management initiatives and programs and other ODJFS-administered community-based and institutional case management initiatives. Criteria and types of data will include: • Identification/screening results • Assessment results • Treatment/service plan development status • Level of intensity of services • ~~CMS quality standards and initiatives Accept case management data and interface with internal (e.g. CRIS-E, MITS) and external sources and in a variety of mediums, including data acceptance via the Medicaid Portal.~~			
8.6.1.3	Link case management performance data to the claims processing system (and/or other external interfaces, as defined by ODJFS) for purposes of monitoring and enforcing established case management contract expectations or performance standards including expectations, standards, or measures related to: • Return on Investment • Cost effectiveness of care • Other performance expectations.			
8.6.1.4	**** Provide role-based access via links from the Medicaid Portal to the data warehouse/DSS in order to **** ~~G~~generate case management reports by program, service, or provider in pre-established formats and on a flexible ad hoc basis.			
8.6.1.5	**** Provide role-based access via links from the Medicaid Portal to the data warehouse/DSS in order to **** ~~Provide variable role based~~ access ~~to~~ case management data for case managers. Information should include the following: claims data, historical case, claims, and enrollment data, eligibility information, benefit packages, case notes, case activity codes, and incident and provider occurrence reports. Case Managers can be defined as any of the following: • ODJFS staff • Nurses • Sub-recipient State agencies • Contractors • Social workers • Primacy care providers • Other entities as defined by ODJFS.			

MITS Business Requirement "Functional Fit" Survey				
Quality Management				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
8.6.1.6	**** Provide role-based access via links from the Medicaid Portal to the data warehouse/DSS in order to access **** ~~Accept, retain~~ and maintain financial information associated with variable, pre-established budget caps or spending limits associated with individual cases that are being case managed. This should include the capability to allow ongoing and immediate entry of and adjustments to this financial information by designated ODJFS staff.			
8.6.1.7	Automatically flag and send alerts to designated case managers or OHP staff, as designated, when the actual or expected cost of claims for services provided to individual Medicaid consumers exceed interim limits or caps, as defined by ODJFS.			
8.6.1.8	**** Phase 2 - Provide role-based access via links from the Medicaid Portal to the data warehouse/DSS in order to **** ~~G~~generate pre-defined data extracts and send the selected case management information (e.g., claims data and demographic information) to authorized entities at established intervals and/or upon request.			
8.6.1.9	**** Provide role-based access via links from the Medicaid Portal to the data warehouse/DSS in order to: **** ~~Provide variable role-based capability to~~ view ~~electronic files o~~f case management reports and other case management information from computer desktops in pre-established formats and on an ad hoc basis.			
8.6.1.10	**** Accept case management data and interface with internal (e.g. CRIS-E, MITS) and external sources and in a variety of mediums, including data acceptance via the Medicaid Portal. ****			

MITS Business Requirement "Functional Fit" Survey				
****Operational Reports** ~~Business Intelligence~~**				
Req Number	**Requirement**	**MITS Phase (1 or 2)**	**Response Code**	**Page Ref**
9.1	**External Reporting (Operational)**			
9.1.1	Clinical Reporting Requirements			
Blood Testing Reporting				
9.1.1.1	Interface with other systems to generate Blood Testing Reporting results as specified by ODJFS.			
Clinical Based Outcome Data Reporting				
9.1.1.2	****Provide operational reports based**** ~~Report~~ on data/information including preventive health indicators and screenings of waiver consumers.			
9.1.1.3	****Provide operational reports based**** ~~Report~~ on information including deaths & causes, vital statistics, and have the ability to identify cases of suspicious deaths.			
9.1.1.4	****Provide operational reports**** ~~Report~~ on waiver outcomes ****based**** on ~~County Medical Systems~~ participant experiences~~ and include data for benchmarking with other states~~.			
9.1.1.5	Track EPSDT referrals.			
****Patient Disease**** ~~Disease Patient~~ Registry				
9.1.1.6	****Provide the capability to generate operational reports based on clinical and disease-specific consumer information that is contained in**** ~~Include~~ a ~~Disease~~ Patient ****Disease**** Registry where the end user can easily extract consumer information ~~with specific condition~~ for targeted case management activities as specified by ODJFS~~ in a secure role-based access environment~~.			
Immunization Reporting				
9.1.1.7	Provide ~~the flexibility to~~ ****an**** interface (including receiving, storing and sending information) ****directly to the Ohio Department of Health Immunization Registry that will be used to populate a Patient Disease Registry within MITS****. ~~with immunization statistics and information/data regarding waiver consumers.~~			
9.1.1.8	Interface (including receiving, storing, and sending information/data) directly related to Minimum Data Sets (MDS). Information and data needed includes: • MDS summary data • Case mix calculations and reports • Policy updates • MDS reporting information by providers and reports.			
9.1.2	Federal/State/Other Agencies Reporting			
Federal Reporting				
9.1.2.1	Provide information to support Federal reporting requirements including: • CMS 64 report to identify recovery efforts • CMS 372 Cost Neutrality Assessment for Waivers • CMS 416 (Healthchek Report) • Medicaid Statistical Information System data reports.			

MITS Business Requirement "Functional Fit" Survey				
****Operational Reports** ~~Business Intelligence~~**				
Req Number	**Requirement**	**MITS Phase (1 or 2)**	**Response Code**	**Page Ref**
9.1.2.2	Compile and aggregate the necessary data for ODJFS and Federal Healthchek and EPSDT reporting including the CMS 416 report that uses both fee-for-service and encounter data.			
9.1.2.3	Generate the Medicaid Statistical Information System (MSIS) Data (formerly CMS-2082) according to CMS media requirements and timeframes and submit a copy to ODJFS on specified media for review and filing.			
County Department of Job and Family Services Reporting (CDJFS)				
9.1.2.4	Support the reporting needs of the counties and county boards including direct reporting interfaces with other sub-recipient State agencies including Mental Retardation and Developmental Disabilities (MR/DD), Department of Aging, etc.			
9.1.2.5	~~Provide a method to track and~~ Report on incident tracking, Medicaid services and quality assurance processes.			
9.1.2.6	Provide enhanced on-line, web-based reporting capabilities to CDJFS based upon a role-based security system.			
9.1.2.7	Provide the capability for CDJFS to generate external reports through the Medicaid Portal.			
Other State Agencies Reporting				
9.1.2.8	Provide a direct secure interface to other survey information as identified by ODJFS such as Quality Assurance (QA) survey data (e.g., authorized & provider-reported services) and to other agencies (e.g., Ohio Department of Health Outcome and Assessment Information Set (OASIS) data).			
9.1.3	Medicaid Reporting			
External Contractors/Partners Reporting				
9.1.3.1	Provide flexible reporting tools via the Medicaid Portal that interface directly to individual single providers, including: • Reports to home care agencies for benchmarking across Agencies • Reports to waiver case managers of independent providers • Agency provider caseloads, services & reimbursements.			
Contractors/Partners Reporting				
9.1.3.2	Provide business contractors/partners on-line access through the Medicaid Portal to ****operational**** reports as specified by ODJFS including: • Non-Claim business provider process information reporting • Cost report trends • Contract monitoring for waiver consumers.			
Managed Care Plans (MCPs)				
9.1.3.3	Interface directly with all MCPs and be able to provide on-line, web-based ****operational**** reporting information and data that includes: • Care management membership and premium payment reports			

MITS Business Requirement "Functional Fit" Survey				
Operational Reports ~~Business Intelligence~~				
Req Number	**Requirement**	**MITS Phase (1 or 2)**	**Response Code**	**Page Ref**
	• Performance measurement reports • MCP progress reports • Ad hoc reports as developed by ODJFS • Capability to convert MCP files to specified formats.			
9.1.3.4	Provide to MCPs the capability to access fee-for-service claims data utilization reports for their members as defined by ODJFS.			
9.1.3.5	Capability to report on-line aggregate and summary data and store information on benefit packages.			
9.2	**Operational/Administrative – Cost/Benefit Reporting**			
9.2.1	Business Intelligence Support For Financial Reporting			
Financial and Budget Reporting				
9.2.1.1	Provide a tool for use in financial and budget reporting, including: • Cost report trends • Rate to cost analyses • near real-time checking of budgets by Case Management • Budget development for waiver applications and renewals • Premium payment reports by Managed Care plans.			
9.2.1.2	Interface with authorized services to coordinate claims payment.			
9.2.1.3	Provide automatic alerts that are easily programmed by end users, to case managers if cost limit approached/exceeded.			
9.2.1.4	Provide trend reports of types and quantities of services authorized, such as: • Detailed financial transaction registers • Disbursement account control reports • Recoupment by amount and time period for providers • Aged accounts receivable, with flags on those that have no activity within a State-specified period of time.			
9.2.1.5	Report on costing information for LTC facilities, MCPs, and all other institutional providers.			
9.2.1.6	Generate ~~20~~ reports to identify various types of recoupment and collections, for example including fraud and abuse recoupment, account receivable collections, estate and casualty recovery cases, TPL, insurance collections, or other categories, as defined by ODJFS.			
9.2.1.7	Report COB activities that impact management reporting including cost avoidance amounts, insurance post payment billing and collection, copays and insurance premiums. This coordination includes history-only adjustments, gross adjustments, and mass adjustments.			
Claims Monitoring Reporting				
9.2.1.8	Provide data, including reports, on a real-time basis to include:Provide data, including reports, on a real-time basis to include: • Claims paid for State-funded programs			

MITS Business Requirement "Functional Fit" Survey				
Operational Reports ~~Business Intelligence~~				
Req Number	**Requirement**	**MITS Phase (1 or 2)**	**Response Code**	**Page Ref**
	• Claims & payments after each payment cycle • Finalized input into weekly claims payment cycle • Claims withheld from payment processing • Specially-handled or manually-processed claims • Monthly adjudicated claims file • Paid & denied claims • Summary report by adjustment and/or reason code • Direct bill reporting • Combined ~~Provider~~ **** Proposed**** Adjudication Order (CPAO) • Trends & analyses of expenditure patterns • Analyses of budget variances • Generation of Federal cost neutrality reports for waivers. ▪ Lag factors between date of service and date of payment based on expenditures to determine cash flow trends.			
Contract Monitoring Reporting				
9.2.1.9	Receive, store and provide reporting capabilities for Ohio Department of Health (and other sub-recipient State agencies) survey and certification data.			
9.2.1.10	Provide information on cumulative data sets requiring periodic reports from waiver contractors for example, benefit plans.			
Provider Measurement Reporting				
9.2.1.11	Generate report of billing lags and processing time statistics by provider categories.			
9.2.1.12	Generate claims processing summary reports that report expenditures by claim type, edit failures, percent of denials, and "input media".			
Consumer Measurement Reporting				
9.2.1.13	Generate reports identifying claims paid under both Medicaid and State-funded programs when a client has switched program eligibility to monitor payment under the proper program.			
9.2.2	Business Intelligence Support for Clinical Reporting			
Case Management Reporting				
9.2.2.1	Electronically provide community resource manuals in an on-line format that is easily accessible to case managers and consumers.			
9.2.2.2	Generate clinical paths for tracking treatments versus clinical guidelines based upon claim data.			
Breast & Cervical Cancer Program (BCCP) Reporting				
9.2.2.3	Provide reporting to track and report on BCCP hearings and BCCP hearing results.			
Clinical Based Outcome Reporting				
9.2.2.4	Provide Identification and notification to case managers of multi-pharmacy abuse by consumers or providers.			
9.2.2.5	Report on death certificates to consumers for identification of suspicious deaths.			

MITS Business Requirement "Functional Fit" Survey				
****Operational Reports** ~~Business Intelligence~~**				
Req Number	**Requirement**	**MITS Phase (1 or 2)**	**Response Code**	**Page Ref**
Disease / Patient Registry (including Well Care)				
9.2.2.6	Provide reports to allow case managers to review preventative assessments for consumers, managed care plans and their providers regarding care needed by members.			
Incident Tracking Reporting				
9.2.2.7	Ability to report on data relating to ocmplaints and incidents.			
9.2.2.8	Summarize and provide trend analyses regarding incident tracking and resolution outcomes.			
9.2.2.9	Report on provider incident profiles, including termination of providers.			
9.2.2.10	Generate Notification of Death and Cease and Desist letters.			
9.2.2.11	Provide report cards and reports of provider sanctions, including automatic alerts to end-users.			
Provider Measurement Reporting				
9.2.2.12	Provide reporting feedback to providers and ODJFS including: • LTC Beds Reporting • MDS based audit risk analysis • Maintenance of approved agency/provider type lists for waiver consumers • Checking of provider licensures and Bureau of Criminal Investigation (BCI) status • Identification of high reimbursement providers and those with "surges" in reimbursements • Tracking of investigation/audit of outliers • Linkage of provider investigative work to that by AG and provider licensure boards • Monitoring of provider turnover for consumers.			
Waiver Monitoring Reporting				
9.2.2.13	Provide reporting for quality assurance administration.			
9.2.2.14	Report movement of consumers in and out of waiver programs and to report on waiver trends.			
9.2.2.15	Provide performance measure reporting capability.			
9.3	**Program Analysis and Development**			
9.3.1	MITS Support of General DSS Capabilities			
9.3.1.1	****Supply data through data feeds and the Medicaid Portal to**** ~~Integrate with~~ the ****ODJFS data**** warehouse/DSS ****architecture****, which is based on a singular ****relational**** database ~~and technical~~ platform, which supports waiver program planning and evaluation, financial reporting, medical policy development, utilization management, eligibility analysis, actuarial rate setting, managerial-level program performance measurement, fraud and abuse detection and investigation, and a variety of other Medicaid healthcare reporting as defined by ODJFS.			

MITS Business Requirement "Functional Fit" Survey				
****Operational Reports** ~~Business Intelligence~~**				
Req Number	**Requirement**	**MITS Phase (1 or 2)**	**Response Code**	**Page Ref**
9.3.1.2	~~Interoperate with the warehouse/DSS data model which is based on a Medicaid-proven and expandable design concept that is specialized for on-line analytical processing.~~			
9.3.1.3	Supply data to the ****ODJFS data**** warehouse/DSS ****architecture through flat file extracts or other methods to**** ~~which~~ integrate~~s~~ data from the following sources into a single analytically-ready database that supports rapid and efficient population-based reporting across all systems and programs including: • Multiple eligibility systems • Capitation systems • Claims systems (paid and denied claims, as well as claim adjustments in bulk and in detail) • Managed care encounter data • Carve-out contractors, such as pharmacy benefit managers, behavioral health plans, chip contractors • Prior-authorization data			
9.3.1.4	Supply data to the ****ODJFS data**** warehouse/DSS ****architecture**** to support features such as the Medstat Episode Grouper (MEG) or other Episode Grouper, CMS DRG, Diagnostic Cost Grouper (DxCG).			
9.3.1.5	Supply ****detail**** data to the ****ODJFS data**** warehouse/DSS ****architecture**** to support ~~its true~~ drill-down capabilities ~~that enable a user to drill-down~~ to the lowest level of detail.			

MITS Business Requirement "Functional Fit" Survey				
Program Integrity				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
10.1	**Provider Utilization Management/Fraud Waste and Abuse Prevention (FWAP)**			
10.1.1	Profiling and Claims Analysis			
10.1.1.1	Interface ****with the ODJFS Data Warehouse architecture to provide detail data for profiling and claims analysis**** ~~and interoperate with the data warehouse/DSS~~.			
10.1.1.2	Maintain up-to-date clinical summaries for consumers including diagnosis and services information. ~~(Interface with the data warehouse/DSS)~~			
10.1.1.3	Analyze, identify, report, and alert on hit-and-run provider schemes and spike billings as defined by ODJFS. For example, these schemes involve a significant or sudden high volume of submitted claims by an individual or group of providers compared to their previous claim activity or to their peers for a given time period. ~~(Interface with the data warehouse/DSS)~~			
10.1.1.4	Associate individual providers with their practice affiliation, such as a group practice or MCP. ~~(Interface with the data warehouse/DSS)~~			
10.1.1.5	Cross-reference all provider ID numbers, including NPIs as identified by CMS, to a single ID number (e.g., individual provider numbers for their group practice affiliation(s)), track a single provider ID across various sub-recipient State agencies, and report selectively and collectively on provider utilization.			
10.1.1.6	Associate services furnished in a clinic setting to both the clinic and servicing provider.			
10.1.1.7	Where appropriate, integrate near real-time algorithms into MITS to detect aberrant billing patterns and/or other anomalies while claims are being processed.			
10.1.2	Communication, Tracking, and Alerts			
10.1.2.1	Track report and information request deadlines and generate alerts to appropriate staff when deadlines are past due.			
10.1.2.2	Provide role-based access to enter complaints and referrals from outside parties and agencies about consumers or providers into the on-line tracking system for fraud and abuse investigations, and track dispute resolutions and referrals.			
10.1.2.3	Link provider enrollment with the payment system to automatically generate a message when an amount is due because of an audit or review finding.			
10.1.2.4	Generate an alert to the appropriate staff/business area when it is required to place a provider's claims payment on "hold and review" status.			
10.1.2.5	Provide the capability to track and document compliance with the applicable Federal regulations for specific time periods to be defined by ODJFS and produce compliance reports, both summary and detailed, to include the number and percentage of: • Cases referred and to which agency the referral			

MITS Business Requirement "Functional Fit" Survey				
Program Integrity				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
	• Full scope reviews conducted • Cases on “hold and review” status • Other parameters as defined by ODJFS.			
10.1.2.6	Develop and maintain an automated case tracking and alert system as defined by ODJFS to accommodate internal and external program integrity audit-related data and activities including: • Audit time period • Initiating agency • Reason for audit • Providers placed on a hold and review status, the reason for hold and review status, and dates of hold and review. • Outcomes including monetary recoveries • Required actions and alerts, such as to re-review alerts, education activities • Tracking of the repayment activities including the date of overpayment discovery, amount of overpayment, and amount of recovered overpayment. • Chronology of significant case activity, such as date of opening letter sent to the provider; dates of phone calls to providers; dates of records/information received by the provider • Significant case documentation, such as case findings and recommendations; exception code key; summary of exceptions; and phone memos • Listing of case contacts • Electronic storage of the supporting documents for the case review including significant case documentation as defined by the ODJFS and records received from the providers.			
10.1.3	Support for Payment Error Rate Measurement (PERM) System			
10.1.3.1	Comply with Federal (CMS) requirements in support of PERM.			
10.1.3.2	In compliance with CMS quarterly claims sample frequency requirements, send the required data to the Statistical Contractor (SC) according to the claims extract approach using CMS-approved formats, media, and security procedures. Only claims that have not been adjusted during the quarter are to be included. The required fields are: • Unique claim identifier • Date of payment • Paid amount ($0 for denied claims) • Provider type or similar variable • Strata assignment (1 through 8) or MSIS category.			

MITS Business Requirement "Functional Fit" Survey				
Program Integrity				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
10.1.3.3	Receive the file of sample claims selected by the SC (including the fields submitted in the claims extract) and send to the SC for each claim (or claim line) in the list of samples, the claim history and all other supporting information including the sample claim itself and any adjustments made within 60 days of the original paid date. For each claim or adjustment, the following information is required: • Unique claim identifier (Identification Claim Number or other State-assigned number) • Strata assignment (1 through 8) or MSIS category • Dates for original payment, adjustments, and for denials, adjudication • Provider type or similar variable • Patient information (e.g., name, date of birth, gender, program enrollment indicators impacting claim processing rules, eligibility information including spend-down indicator, if applicable • Provider number and name for both billing provider and servicing provider • Provider specialty of both billing provider and servicing provider • Servicing provider address • Servicing provider phone number • Claim type • All diagnosis codes • DRG code, if applicable • Service from date • Service to date • Prior authorization • Place of service • Number of line items • Procedure codes (CPT, HCPCS, etc.) and units of service for all line items associated with the claim • ype of service • Include at both the line item and claim levels, if applicable: o Submitted charge o Allowed charge o Third party liability information o Patient co-payment responsibility o Paid amount ($0 for denied claims).			
10.2	**Consumer Utilization Management/FWAP**			
10.2.1	Requirements			
10.2.1.1	Identify the specific PACT exception criteria for each Medicaid consumer that has been identified for potential PACT participation.			

MITS Business Requirement "Functional Fit" Survey				
Program Integrity				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
10.2.1.2	Implement and maintain an automated tracking system to accommodate PACT data and activities including: • PACT category (e.g., physician, drug, etc.) • Medicaid provider number • PACT primary care physician name, address and telephone number • Pact pharmacy, address, and telephone number • PACT starting and end dates • Appeals and status • Hearings, date of hearing, issues and outcomes, and linkage to hearing documents for the PACT program. • Letters to providers • Letters to PACT Medicaid consumers • Note taking functionality.			
10.2.1.3	Generate the following PACT related letters to consumers and providers including: • Notice of enrollment to consumers • Welcome letter and designated provider form to provider • State hearing and appeals information to consumer • Primary care physician name, address, selected pharmacy name and address • Additional brochures, newsletters, fact sheets, and other PACT related materials.			
10.2.1.4	Automate correspondence to the provider and/or consumer via the CRM and EDMS systems.			
10.2.1.5	Image documentation and correspondence from consumers and providers regarding the PACT program.			
10.2.1.6	Provide on-line role-based access to information including: • PACT data and imaged documentation • Consumer information, such as hospitalizations, LTC facility, pharmacy, PA information, State Plan services • Provider information, such as outpatient services, waiver services by type, waiver services by provider and by consumer • Waiver services by procedure code • Waiver services by day.			
10.2.1.7	Generate automatic alerts to appropriate PACT staff. Alerts are identified by ODJFS and include: • Notification of pending review • State hearings • 9- and 18-month report due dates for consumer reviews.			
10.2.1.8	Identify and view on-line all Medicaid consumers currently restricted to PACT for the month, and new PACT consumers, applying all changes to reflect updates made during the month as directed by ODJFS.			

MITS Business Requirement "Functional Fit" Survey				
Program Integrity				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
10.2.1.9	Send PACT consumer enrollment information to the eligibility system to drive PACT card issuance.			
10.2.1.10	Generate an automatic notification to the appropriate staff when the Medicaid card is issued for consumers identified as PACT consumers. Include in this notification, the name of the consumer and the type of card that was generated.			
10.2.1.11	Pay case management fees on a monthly basis to primary care physicians who serve PACT consumers. See the claims adjudication sub-process for managed care payments.			
10.2.1.12	Identify conflicting and complementary services by consumer during the same time period (i.e., nursing facility stays and waiver services billed simultaneously).			
10.2.1.13	Maintain a history of actions, edits, and changes made to a PACT consumer profile and the staff person who made the changes. Actions, edits, and changes including: re-opening a PACT case; release of a PACT consumer; change in PACT primary care provider or pharmacy.			
10.3	**Retrospective Drug Utilization Review (DUR)**			
10.3.1	Requirements			
10.3.1.1	Generate, track, acknowledge, and archive letters, including responses from providers. Letters should include provider name, date mailed, and findings.			
10.3.1.2	Track and notify providers of: • The need to respond to letters sent according to a time period defined by ODJFS • Review dates • Re-review dates.			
10.3.1.3	Image, access, archive and maintain incoming correspondence utilizing electronic document management system technology.			
10.3.1.4	Refer providers to appropriate licensing board using criteria to be defined by ODJFS.			
10.3.1.5	Develop a tickler file with all DUR reviews and alert ODJFS staff when re-views are due. Tickler file criteria and time intervals of re-views will be defined by ODJFS.			
10.4	**Sub-recipient State Agency Reviews**			
10.4.1	Requirements			
10.4.1.1	Identify the following information for contracts including: • Catalog of Federal Domestic Assistance (CFDA) Number • Vendor vs. sub-recipient State agency • Fiscal year for vendor and sub-recipient State agency.			
10.4.1.2	Match period expenditures to inter-agency agreement amounts.			
10.4.1.3	Generate a report identifying vendor vs. sub-recipient State agency and a report of all sub-recipient State agencies.			
10.4.1.4	Generate accounts payable information to track status of sanctions.			

MITS Business Requirement "Functional Fit" Survey				
Program Integrity				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
10.4.1.5	Track original amount owed, settled amounts and recouped funds, and once paid.			
10.4.1.6	Generate reports on expenditures by sub-recipient State agency, by program.			
10.4.1.7	Generate and create letters to sub-recipient State agencies.			
10.4.1.8	Identify whether an A-133 audit report was required (based upon expenditure information received from MITS, $500,000 or more in known expenditures) and if the report was received.			
10.4.1.9	Generate a report that identifies exceptions on single audits and notifies designated staff as defined by ODJFS.			
10.4.1.10	Track the status of issues/exceptions (Cost Allocation Plan (CAP), Sanctions) and report to designated ODJFS staff including: • Audited entity • Time period audited • Status of issues/exceptions • Disposition of issues/exceptions • Date of and amounts remitted to the State of: o Initial finding o Adjudicated amount o Actual amount collected.			
10.4.1.11	Generate a report on services authorized vs. services received.			
10.4.1.12	Generate reports based upon ODJFS specified date parameters (e.g., dates needed for audit rather than set time periods).			
10.4.1.13	Report on claims that were not paid to utilize in completing a risk assessment for the providers to determine who to audit in a given time period			
10.4.1.14	Capture proposed cost adjustments and alert program staff of proposed cost adjustments.			
10.4.1.15	Notify ODJFS of final settlement amount.			
10.4.1.16	Generate an A-133 report with Medicaid funding listed by sub-recipient State agencies and potentially by county, by CFDA number, and by discrete entity.			
10.5	**Provider State Hearing Rights**			
10.5.1	Requirements			
10.5.1.1	Provide case management tracking capabilities / functionality that tracks case activity related audits and reviews completed by internal and external entities on behalf of Medicaid.			
10.5.1.2	Provide complaint identification tracking.			
10.5.1.3	Generate Report of Examination (ROE) documentation.			
10.5.1.4	Distribute case and ROE documentation in a format that cannot be altered by the notification recipient.			
10.5.1.5	Provide flexible status and activity reporting, as defined by ODJFS including: • Process status			

MITS Business Requirement "Functional Fit" Survey				
Program Integrity				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
	• Adjudication results/amounts • Date ROE is issued • Universe dollar amount • Finding amounts • Dollars set for recoveries • Actual recoveries.			
10.5.1.6	Generate alerts to ODJFS from the Office of Fiscal Services when a provider defaults on repayment.			
10.5.1.7	Update provider history and provider profiles with audit/review findings as defined by ODJFS.			
10.5.1.8	Track the collection of repayments by providers, either timed payments or lump sum payments.			
10.5.1.9	Accept, retain and track report findings from: • Auditor of State • Hospital reviews • SURS.			
10.5.1.10	Track and report on reviews performed by ODJFS and provide results to outside entities as defined by ODJFS.			
10.5.1.11	Track cases referred to law enforcement (e.g., Medicaid Fraud Control Unit from the Attorney General, local / State law enforcement, etc.).			
10.5.1.12	Accept, retain and track Hospital Submissions for Appeals.			
10.5.1.13	Alert ODJFS when appeals are received from peer review organizations.			
10.5.1.14	Produce on-line performance reports related to pre-admission review based on ODJFS defined criteria.			
10.5.1.15	Track outside legal proceedings and decisions in a format as defined by ODJFS.			

MITS Business Requirement "Functional Fit" Survey				
Privacy and Security				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
11.1	**Privacy Requests Management**			
11.1.1	Requirements			
11.1.1.1	Provide functionality to receive, log, track and report on individual requests related to PHI.			
11.1.1.2	Track the following data pertaining to the management of PHI requests: • Consumer identification numbers, including: Medicaid Billing Number, Social Security Number, and CRIS-E/BEN Number • Consumer demographic data • Accounting for disclosures of PHI – including when released, for what purpose, and to whom • Restrictions requested by the consumer and what actions ODJFS has taken • Individual or personal representative (what was used as proof – legal needs a scanned copy if they are making the call; caseworkers sometimes make call w/o documentation and load into eligibility systems) requesting the data • Consumer requests for corrections to PHI data and the action taken • Consumer objections to PHI data if changes were not made • Authorizations for releases of data other than payment, treatment or healthcare operations • Complaints and dispositions • A record of the PHI that was requested • The date the request was received • The date the response was generated • The detailed information that was provided • How the request came in (e.g., Consumer Hotline, Legislature, or P.O. Box).			
11.1.1.3	Automatically populate PHI screen or window with demographic data and previous disclosure requests and the request dispositions.			
11.1.1.4	Pull personal representative data from the eligibility system (currently CRIS-E and FACSIS).			
11.1.1.5	Provide ability to perform ad hoc queries to obtain PHI data. Example search fields include: • Dates of service • Provider name • HCPCS codes • Search results would populate the PHI data fields in the PHI screen.			
11.1.1.6	Automatically generate response letters to the requestor.			
11.1.1.7	Provide the capability for the user to choose from multiple form letters and customize them as needed.			
11.1.1.8	Retain an archived copy of letters that are sent out.			

MITS Business Requirement "Functional Fit" Survey				
Privacy and Security				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
11.1.1.9	Generate on-line canned and ad hoc reports on privacy related activity. Examples include: • Number of complaints filed • Disposition of complaints.			
11.1.1.10	Allow the use of alternate mailing address to send PHI, upon individual request, as approved and directed by the State.			
11.1.1.11	Continue to interface with the eligibility systems (currently CRIS-E and SACWIS) to obtain privacy-related consumer eligibility data.			
11.1.1.12	Track and process written correspondence from individuals exercising their right to access information under the privacy rule.			
11.1.1.13	Respond to an individual's request for a copy of their PHI, as directed by ODJFS.			
11.1.1.14	Maintain a record of restrictions, per individual request, on certain uses and disclosures of PHI, as approved and directed by ODJFS.			
11.1.1.15	Track and provide an accounting of anyone who sent and/or received PHI relating to an individual.			
11.1.1.16	Interface electronically with other systems which contain PHI.			
11.1.1.17	Log and track PHI requests and responses wherever they occur in MITS or other Medicaid processes.			
11.2	**Security Management**			
11.2.1	Requirements			
11.2.1.1	MITS must interface with an Identity Management System - An enterprise wide security system designed to help entities to simplify, strengthen, and track access to information across an organization's digital assets and physical infrastructure.			
11.2.1.2	MITS must seamlessly integrate with the Single Sign On (SSO) solution within ODJFS.			
11.2.1.3	Ensure that all applications operate in accordance with all State and Federal security rules including the final and amended rules adopted under HIPAA for security and privacy incorporating appropriate National Institute of Standards and Technology (NIST) and International Standards Organization (ISO) standards.			
11.2.1.4	Access roles should be defined at the individual data element.			
11.2.1.5	Utilize the primary security tool (Identity Management System) implemented with Novell's eDirectory as a single identity vault for security protocols and access control.			
11.2.1.6	Requests for access must come from an authoritative source(s) as defined by ODJFS.			
11.2.1.7	Support on-line, near real-time updating of security information if this functionality is not included in the Identity Management System.			

MITS Business Requirement "Functional Fit" Survey				
Privacy and Security				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
11.2.1.8	Provide ad hoc reporting capabilities that can correlate security metrics such as profile e.g. user id/number), privileges (e.g. role based), environment (e.g. test/development), last successful login, failed logins. and password resets.			
11.2.1.9	Protect all systems from anticipated threats or hazards to data and restrict the availability of data to appropriate State staff or other designated individuals and organizations through standardized system applications and data security capabilities.			
11.2.1.10	Implement and maintain a secure environment for both on-line and batch access to State data through the use of a fully functional and documented security software package.			
11.2.1.11	Provide three types of controls to maintain the integrity, availability, and confidentiality of PHI data contained within the system: These controls shall be in place at all appropriate points of processing. • Preventive Controls: Controls designed to prevent errors and unauthorized events from occurring • Detective Controls: Controls designed to identify errors and unauthorized transactions which have occurred in the system • Corrective Controls: Controls to ensure that the problems identified by the detective controls are corrected.			
11.2.1.12	Ensure various levels of security within MITS on-line applications including the following features: • Unique log-on for each user • Required passwords that will expire on a staggered schedule and that can be reset at any time by appropriate personnel and/or automated system reset • Restriction of application and/or function within an application through role-based security. Role assignments are used to determine which user categories have permission to access which application and/or function within an application. • Audit trails of all updates to the security system (add/change/delete) by log-on ID (or batch update identifier), date and time of the change, and source of entry (workstation ID), including all attempted updates.			
11.2.1.13	Access control to all data and to the applications software; the system shall employ a security system that restricts access to varying hierarchical levels of data, including functions, screens and individual data fields; the security system must restrict access to data on a “minimum necessary” basis and restrict functions based on an individual user profile, including inquiry only capabilities; global access to all functions must be restricted to specified staff.			

MITS Business Requirement "Functional Fit" Survey				
Privacy and Security				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
11.2.1.14	Maintain a list of users and their security profiles, if this functionality is not included in the State's Identity Management System, including updating security files with State approved additions of new staff, changes to existing security profiles and be able to support audits of security profiles against currently approved roles as required by the State.			
11.2.1.15	Automatically remove individual security profile upon notification of termination, but save profile for archival purposes.			
11.2.1.16	Ensure that all applications comply and are compatible with existing State and Federal guidelines preventing unauthorized access.			
11.2.1.17	Prohibit display of passwords on the sign-on screen when entered by the user.			
11.2.1.18	Log and report all unauthorized access attempts by terminal ID, user ID, date, and time.			
11.2.1.19	Log a user off a system if there is no activity within a 30 minute period of time.			
11.2.1.20	Terminate access if there is no activity on a user account within ninety (90) days, or other period designated by ODJFS.			
11.2.1.21	Immediately disable access to any user or user group after a predetermined number of attempts to log-on.			
11.2.1.22	Follow ODJFS guidelines for the restriction of override capabilities of the Identity Management System.			
11.2.1.23	Implement audit trails to allow information on source documents to be traced through the processing stages to the point where the information is finally recorded.			
11.2.1.24	Trace data from the final place of recording back to its source of entry. Audit trail functionality must include Medicaid Portal, IVR system, CRM system, listings, transactions reports, update reports, transaction logs, error logs, downloads, and file transfers.			
11.2.1.25	Ensure that the integrity and confidentiality of consumer and all other data is protected by safeguards to assure that information is not released without proper consent.			
11.2.1.26	Comply with the HIPAA-mandated Accounting for Disclosures requirements.			
11.2.1.27	Identify the source of any request to add, change, or delete data on the system.			
11.2.1.28	Amend the data and associate a note with that amendment as required by the HIPAA Privacy Amendment requirement.			
11.2.1.29	Ensure all application design, development, and implementation and operations are in accordance with State and Federal regulations and guidelines related to security, confidentiality, and auditing.			

MITS Business Requirement "Functional Fit" Survey				
Privacy and Security				
Req Number	**Requirement**	**Phase (1 or 2)**	**Response Code**	**Page Ref**
11.2.1.30	Provide for the same hierarchical password protection, as well as a system-inherent mechanism for recording any change to a software module or subsystem. The contractor shall propose procedures for safeguarding ODJFS from unauthorized modifications to the MITS.			
11.2.1.31	Generate and distribute all ODJFS-defined security reports.			
11.2.1.32	Anticipate and provide a flexible solution that is positioned to effectively meet the requirements of current and future HIPAA security regulations.			
11.2.1.33	Include a notification matrix that will escalate notification of security issues, including breaches and attempted breaches, to the ODJFS chief security official and others as designated.			

Supplement 10

Technical Requirements Matrix Amendment Replacement Pages

Supplement 10

Technical Requirements Matrix Amendment Replacement Pages

Instructions for Completing the Technical Requirements Self-Scoring Worksheet

1. The Contractor must self-score each MITS Technical Requirement in the "Response Code" column using only the values that appear in the drop-down list.

2. The "Response Code" values are:

D – Available as delivered without configuration, extension, or modification
P – Partially available as delivered without configuration, extension, or modification. ****A row may be added below the requirement in the Supplement 10 spreadsheet that contains the description or the offeror may use the Proposal Reference column to point back to that description in the Proposal.****
C – Available with configuration
M – Requires a modification. ****When "M" is used in responding to a requirement, the offeror must provide a description explaining the modification needed to meet the requirement. A row may be added below the requirement in the Supplement 10 spreadsheet that contains the description or the offeror may use the Proposal Reference column to point back to that description in the Proposal. ****
N – Not available/Not met

3. Each requirement must contain one of the scoring values identified in Item #2 above. Any requirement without a scoring value will be considered to be "Not Met" ("N").

~~4. Comments **must** be included in the required narrative section of the Contractor's RFP reponse and the applicable narrative reference page number **must** be inserted in the Page Reference ("Page Ref")column for all requirements that are coded "P" (Requirement will be partially met with the delivered software without configuration, code extensions, or modification). These narrative comments must explan how the requirement will be partially met and which areas will not be met.~~

Instructions for Completing the Proposed Technologies Self-Scoring Worksheet

1. For each Technology Solution area, the Contractor must briefly identify (no more than 20 words) the proposed technology solution.

2. The Contractor must self-score each proposed technology in the "Preferred, Supported, or Other" column using only the values that appear in the drop down list. The drop-down list values are:

P - Preferred solution
S - Supported solution
O - Other solution

3. Each proposed technology solution must contain one of the scoring values identified in Item #2. Any technology solution without a scoring value will be considered non-compliant and no score will be calculated.

4. Comments **must** be included the required narrative section of the Contractor's RFP response and the applicable narrative reference page number **must** be inserted in the Page Reference ("Page Ref") column for each Technology Solution coded as "O" (Other). These narrative comments must explain the proposed techology and the standards and/or best practices that will be employed with the technology.