REQUEST FOR PROPOSALS

Utilization Management/Quality Improvement Organization
UM/QIO

RFP# 20170811

RFx # 3120001211

Contact:
Matthew Nassar
Procurement Officer
Procurement@medicaid.ms.gov
Phone: (601) 359-6189

Due Dates:
Questions & Letter of Intent
E-MAIL or MAIL or HAND DELIVERY
5:00 PM Central Standard Time, August 31, 2017

Answers Posted to Internet www.medicaid.ms.gov
5:00 PM Central Standard Time, September 6, 2017

Sealed Proposals
MAIL or HAND DELIVERY ONLY

5:00 PM Central Standard Time, Wednesday, September 13, 2017

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1 SCOPE of WORK

1.1. Purpose

The Mississippi Division of Medicaid (DOM) issues this Request for Proposals, hereafter referred to as the RFP, requesting competitive written proposals from qualified contractors to provide Utilization Management (UM) and Quality Improvement Organization (QIO) services to DOM. This RFP is being issued in accordance with the 42 C.F.R. § 456.1(b)(1), the State Plan must provide methods and procedures to safeguard against unnecessary utilization of care and services. The Offeror must be a QIO under contract with the Centers for Medicaid and Medicare Services (CMS) or a CMS designated QIO-like entity, thereby enabling the State of Mississippi to qualify for the 75 percent Federal Financial Participation (FFP) as established in 42 C.F.R. § 433.15(b)(6)(i). The Offeror must have certification as a Utilization Review Resource for the State of Mississippi as defined in Section 41-83-1, *et seq.* of the Mississippi Code of 1972, as amended.

DOM requests proposals from experienced, responsive, responsible, and financially sound entities prepared to carry out the requirements detailed in the Scope of Work of this RFP. DOM will contract with a single contractor to provide the following:

- Medical Services Utilization Management
- Behavioral Health Services Utilization Management
- Dental Services Utilization Management
- Peer Review Services
- Focused Studies
- Clinical/Medical Consultations
- Quality Improvement Services
- Care Management Services

Offerors will be directed to DOM's website throughout this procurement. Please note that all historic data referenced in this RFP may be found on DOM's website https://medicaid.ms.gov/resources/procurement/.

1.2. Background

It is DOM's responsibility to be a prudent purchaser of quality health care and to ensure that benefits are provided for medically necessary services. To comply with this responsibility; DOM contracts with a UM/QIO. DOM contracts with a UM/QIO to administer Medical Services Utilization Management, Behavioral Health Utilization Management and Dental Services Utilization Management. The current contract ends August 31, 2018.

Mississippi Coordinated Access Network Program

On January 1, 2011, DOM implemented the MississippiCAN Program for selected high-risk beneficiaries. MississippiCAN is a coordinated care program for Mississippi Medicaid beneficiaries. Beneficiaries were enrolled with one of two current CCOs, Magnolia Health Plan and UnitedHealth Care Community Plan, through which they access covered MississippiCAN Program services.

After successfully implementing this initial phase of the MississippiCAN Program and receiving Legislative approval in the Spring of 2012 to enroll up to 45% of Medicaid beneficiaries in managed care delivery systems, DOM expanded MississippiCAN to include additional populations and services. In 2014, and again in 2015, Mississippi received approval to further expand the program to cover all Medicaid services for eligible beneficiaries, including inpatient hospital care. Additionally, in December 2015, residents of PRTFs were included in MississippiCAN covered services. Beginning in July 2018, the 1915(i) Intellectual/Developmental Disabilities Community Support Program (IDD CSP) and MYPAC will also be included in MississippiCAN covered services. The CCOs are responsible for processing all prior authorizations for UM services for beneficiaries in the MississippiCAN program.

Figure 1: Populations Who Have the Option to Disenroll

Eligible Populations Who Have the Option to Disenroll	**Age Categories**
SSI	0-19
Disabled Child Living at Home	0-19
DHS-Foster Care Children	0-19
DHS-Foster Care Children (Adoption Assistance)	0-19
Native Americans	0-65
*The hyphen denotes "up to" the age listed.	

Figure 2: Populations Who May Not Disenroll

Populations Who May Not Disenroll	**Age Categories**
SSI	19-65
Working Disabled	19-65
Breast and Cervical Cancer	19-65
Pregnant Women	8-65
Parent/Caretakers	0-19
Medical Assistance Children	
*The hyphen denotes "up to" the age listed.	

The CCOs may require notification from the Contractor of certain authorizations. The contractor shall have the capability to provide on a daily basis a secure file identifying any Prior Authorizations that have been approved/or denied.

1.3. Procurement Overview

The following timetable is the estimated and anticipated timetable for the RFP and procurement process.

Table 1: RFP and Procurement Timetable

Date	Process
August 11, 2017	Release RFP for Bids
August 31, 2017	Deadline for Letter of Intent and Written Questions
September 6, 2017	Response to Questions Posted
September 13, 2017 (5:00 p.m.	Proposal Deadline

CDT)	
September 18, 2017	Evaluation of Technical Proposal
September 28-29, 2017	WebEx Oral Presentations
October 2, 2017	Evaluation of Business Proposal
October 3, 2017	Executive Review and Award
November 14, 2017	Personal Service Contract Review Board (PSCRB) Meeting (proposed)
January 1, 2018	Contract Start – (Implementation begins)
August 1, 2018	Operational Phase begins

1.3.1. Mandatory Letter of Intent

The Offeror is required to submit a Letter of Intent to bid. The Offeror should indicate whether it is a QIO or QIO-like entity. The Letter of Intent is due by 5:00 p.m. CDT, August 31, 2017, and should be sent to:

Matt Nassar
Procurement Officer
Division of Medicaid
Walter Sillers Building
550 High Street, Suite 1000
Jackson, Mississippi 39201
Email: procurement@medicaid.ms.gov

The Letter of Intent shall be on the official business letterhead of the Offeror and must be signed by an individual authorized to commit the Offeror to the work proposed. Submission of the Letter of Intent shall not be binding on the prospective Offeror to submit a proposal. However, an Offeror that does not submit a Letter of Intent by 5:00 p.m. CDT, August 31, 2017, will not thereafter be eligible for the procurement.

Prior to August 31, 2017, all RFP amendments will be sent to all organizations that request an RFP and will be posted on DOM's procurement website, medicaid.ms.gov/resources/procurement/. After August 31, 2017, RFP amendments will only be distributed to Offerors that have submitted a Letter of Intent.

1.3.2. Procedure for Submitting Questions

Questions may be submitted using the Question and Answer template found at https://medicaid.ms.gov/resources/procurement. Written answers will be available no later than 5:00 PM CDT, Wednesday, September 6, 2017, via DOM's procurement website, https://medicaid.ms.gov/resources/procurement/. Questions and answers will become part of the final Contract as an attachment. Written answers provided for the questions are binding.

Questions should be sent to:

Matt Nassar
Procurement Officer
Division of Medicaid
Walter Sillers Building
550 High Street, Suite 1000

Jackson, Mississippi 39201
Email: procurement@medicaid.ms.gov

1.3.3. Proposal Submission Requirements

Proposals must be in writing and must be submitted in two parts: 1) Technical Proposal; and 2) Business Proposal. The format and content of each proposal are specified in Sections 5 and 6, respectively, of this RFP.

Technical Proposals for the RFP must be submitted in durable; three-ring binders with components of the RFP clearly tabbed and labeled using the RFP section titles and terminology. Tabs should protrude from the pages to be easily identified. An original and eight (8) copies of the Technical Proposal under sealed cover and an original and three (3) copies of the Business Proposal under separate sealed cover must be received by DOM no later than 5:00 p.m. CDT, on Wednesday, September 13, 2017. The Offeror must also submit one (1) copy of the Technical Proposal on CD in a single document in a searchable Microsoft Word or Adobe Acrobat (PDF) format.

Offerors shall also submit one (1) full copy of the Technical Proposal in a single document in a searchable Microsoft Word or Adobe Acrobat (PDF) format through MAGIC. Do not include pricing data in any section of the MAGIC submission or entry page. MAGIC is the State of Mississippi's Accountability System for Governmental Information and Collaboration. Registering as a supplier with the State of Mississippi allows businesses to register for upcoming RFx # **3120001211**opportunity notifications by the products they supply, search the system for upcoming RFxs, respond to a RFx # **3120001211**electronically, and receive purchase orders by email. In order to register, please go to the following website: http://www.dfa.ms.gov/dfa-offices/mmrs/mississippi-suppliers-vendors/supplier-self-service/.

Proposals exceeding the typed page length limitations as outlined in this RFP will be redacted by DOM Office of Procurement prior to evaluation.

Any proposal received after this date and time will be rejected and returned unopened to the Offeror. Proposals should be delivered to:

Matthew Nassar
Procurement Officer
Division of Medicaid
Walter Sillers Building
550 High Street, Suite 1000
Jackson, Mississippi 39201

The outside cover of the package containing the Technical Proposal shall be marked:

RFP # 201708011
Technical Proposal
(Name of Offeror)

The outside cover of the package containing the Business Proposal shall be marked:

RFP # 20170811
Business Proposal
(Name of Offeror)

As the proposals are received, the sealed proposals will be date-stamped and recorded by DOM. The Offeror is responsible for ensuring that the sealed competitive proposal is delivered by the required time and to the required location and assumes all risks of delivery. A facsimile proposal will not be accepted. Each proposal must be signed in blue ink by an official authorized to bind the Offeror to the proposal provisions. Proposals and modifications thereof received by DOM after the time set for receipt or at any location other than that set forth above will be considered late and will not be considered for award.

1.4. Technical Requirements

1.4.1. General Utilization Management Requirements

1. The Contractor shall demonstrate high quality administrative and clinical leadership in UM/QIO services, which must comply with Federal and State laws and regulations, DOM policies and formal memorandums. DOM will provide assistance as needed with interpretation and clarification of DOM policy and will notify the Contractor as changes are made that affect the program. Any instances of discrepancies in interpretation of the contract, policies or program requirements between the Contractor and DOM will be decided at the discretion of DOM. The requirements in this section are applicable to all UM/QIO review functions.

2. The Contractor shall have established procedures and sufficient staffing to receive all review requests, supporting medical documentation and adhere to specific processing requirements, regardless of the mode of receipt. Staffing requirements must be in accordance with Section 1.6 of this RFP.

3. The Contractor shall conduct authorization, prior authorization and prepayment review processes that include two (2) levels of review. The first level of review is conducted by a qualified health professional licensed in the State of Mississippi with clinical knowledge and experience in utilization review. Requests not approved at the first level of review for not meeting criteria shall be referred for a second level review by an appropriate health care professional (physician, dentist, orthodontist, etc.).

4. Completion of a first level determination is one (1) of the following:

    a. Authorization of services by the first level reviewer;

    b. Authorization through the automated rules system, when appropriate;

    c. Referral to second level review;

    d. Pending of the review based on a request for additional information from the provider; or

    e. Technical denial of the request due to administrative policy rules, as defined by DOM.

5. Completion of a second level determination is one (1) of the following:

    a. Authorization of services by the second level reviewer;

    b. Denial, modification or reductions of services by the second level reviewer;

    c. Pending the review based on Contractor request for additional information from the provider; or

d. Technical denial of the request due to Federal and State laws and regulations, DOM policies and/or formal memorandums.

6. The Contractor shall ensure denials, modifications, or reductions in services by the second level reviewer are made by a physician reviewer licensed in the State of Mississippi and of the same specialty as a result of the second level review.

7. The Contractor shall have the capability and established procedures to receive retrospective review requests by web-based submission, facsimile, or mail. A retrospective review is performed when a service has been provided and no authorization is obtained, or at the discretion of DOM. (DOM provides retroactive eligibility review for a beneficiary that was not eligible for Medicaid benefits at the time of service.)

8. The Contractor shall pend a service authorization review request if the provider submits a request for authorization with incomplete, inadequate, or ambiguous information. The Contractor shall seek clarification or request that the provider submit all required information, including additional supporting clinical information as necessary. The Contractor shall initiate a process of placing a request on hold (pending) until additional information has been received.

9. The Contractor shall suspend a review for services when the review has been pended because additional information is required and the requested information is not submitted by the due date. If the requested information is not submitted by the due date, the Contractor must have a process for technically denying the services for failure to submit additional information required to perform the review.

10. The Contractor shall issue a technical denial for services when the case does not meet Federal and State laws and regulations, DOM policies and/or formal memorandums or is technically insufficient.

11. In accordance with 42 C.F.R. Subpart E, the Contractor shall have the capability and established procedures to ensure all ordering and referring physicians or other professionals providing services under the State plan are enrolled as a participating Medicaid provider, prior to authorizing review requests.

12. The Contractor shall generate a TAN when a case meets all policy and medical criteria necessary for authorization of the services requested.

13. Except as otherwise noted, the Contractor shall notify Medicaid beneficiaries of the denied requests in writing via certified U.S. Mail, and shall ensure that the beneficiary notice contains the medical and/or technical basis for the denial. The notice shall set forth the Flesch-Kincaid, or other approved standard, readability scores at or below sixth (6th) grade reading level and the Contractor shall certify compliance therewith. The notice shall use easily understood language and format in a font no smaller than 12-point. The notice shall be available in English and such other language as DOM may require at any time with proper notice to the Contractor; and shall be available in alternative formats as required for the special needs of beneficiaries.

14. The Contractor shall provide written notices to providers through an online web-based system and via facsimile notifications. The Contractor shall also allow verbal notification of pended reviews to providers unable to receive written facsimile notification. The Contractor shall have a process to document verbal notifications. DOM may request the documentation at any time with proper notice to the Contractor.

15. The Contractor's written notice of denials, modifications, or reductions shall include a statement that a provider, attending physician, or beneficiary/representative/responsible party who is dissatisfied with the

review determination is entitled to a reconsideration of the review outcome. The written notice shall also explain the method by which a provider, attending physician, or beneficiary/representative/responsible party can request a reconsideration of the review outcome.

16. The Contractor shall conduct reconsiderations and make determinations upholding, modifying, or reversing the review outcome by taking into consideration all pertinent information, including any additional or new information that may be presented during the reconsideration.

17. The Contractor must provide, at a minimum, a reconsideration process for reviews in which the decision is a:

    a. Denial, modification, or reduction of services/items based on medical necessity;

    b. Denial based on Federal and State laws and regulations, DOM policies and/or formal memorandums that excludes coverage;

    c. Certain technical denials as defined by DOM;

    d. Quality issue, or

    e. Other adverse decisions as defined by DOM.

18. The Contractor shall have the capability to accept and document reconsideration requests by web-based submission, telephone, facsimile, or mail, and shall have dedicated telephone and facsimile numbers for reconsiderations.

19. The Contractor shall have established procedures to notify individuals that the reconsideration- request was received by the Contractor and the individual has the opportunity to provide additional information within 10 business days from the date on the Contractor's notification letter.

20. The Contractor shall ensure that a second physician not involved in the initial decision reviews the reconsideration request, the original information, and any additional information submitted with the reconsideration request and make a determination. The second physician or reconsideration physician reviewer shall be licensed in the state of Mississippi and of the same specialty as the attending physician.

21. The Contractor shall provide written notification of reconsideration determinations within 10 business days of receipt of the request for a standard reconsideration.

22. If the reconsideration determination was upheld or any portion was not approved as requested, the Contractor's written notice shall include a statement explaining the beneficiary, representative, or responsible party has the right to request a an administrative hearing conducted by DOM. The notice shall set forth the Flesch-Kincaid, or other approved standard, readability scores at or below sixth (6th) grade reading level and the Contractor shall certify compliance therewith. The notice shall use easily understood language and format in a font no smaller than 12-point. The notice shall be available in English and such other language as DOM may require at any time with proper notice to the Contractor; and shall be available in alternative formats as required for the special needs of beneficiaries.

23. The Contractor shall maintain an office location within Hinds, Madison or Rankin County. The Office shall include at least one (1) statewide toll-free telephone number for receipt of medical and behavioral health authorization requests and a separate statewide toll-free telephone number for inpatient hospital

medical/surgical services. The numbers shall be answered by live operators located at the office location within Hinds, Madison or Rankin County at minimum Monday through Friday, 8:00 a.m. to 5:00 p.m. Central Standard Time including State holidays except for New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day and Christmas Day. Calls placed during hours that the office is not open shall receive a voice message, in English, stating the hours of operation and advising the caller to dial "911", or the appropriate emergency number, if there is an emergency. The Contractor may also route calls placed during hours that the office is not required by DOM to be open to any office operated by Contractor staff in any location in the United States of America. The Contractor may never route calls outside of the United States of America. The Contractor shall train staff on using services offered by Mississippi Relay for callers who are deaf, hard-of-hearing, deaf-blind or speech disabled. The Contractor shall propose an alternate protocol for non-English speaking or non-verbal beneficiaries. The Project Manager, Assistant Project Manager, Medical Director, Education Manager; shall conduct UM/QIO business and be physically located within the office location.

24. The Contractor shall have the capability to conduct Retroactive Eligibility Reviews, a review conducted after services are provided to a Beneficiary and the Beneficiary is retroactively determined to be eligible for Medicaid. The Contractor shall allow the provider 90 calendar days from the date of eligibility determination to submit authorizations for service rendered on or after the retroactive eligibility date. (Example: John Doe applies for Medicaid on January 1, 2017 and DOM determines eligibility on April 1, 2017. John Doe is retroactively eligible for Medicaid effective January 1, 2017. As a result of the retroactive eligibility, the provider shall be allowed 90 calendar days from the date of eligibility determination (April 1, 2017) to submit authorization requests for dates of services on or after January 1, 2017. For dates of service on or after April 1, 2017, the provider should obtain a prior authorization for services and in some instances obtain a retrospective authorization.)

1.4.2. Authorization Requirements

1.4.2.1 Medical Services Technical Requirements

This section describes the requirements for the development, implementation, and operation of a UM/QIO program for medical services including but not limited to:

- Inpatient Hospital Medical/Surgical Services
- Outpatient Services and Surgical Procedures
- Maternity Admissions for Delivery/Early Elective Delivery and Reporting
- Organ Transplant Services
- Hospice Services
- Durable Medical Equipment, Medical Supplies, Appliances and Orthotics and Prosthetics
- Vision Services
- Hearing Services
- Outpatient Physical Therapy, Occupational Therapy and Speech Therapy Services
- Expanded EPSDT benefits
- Expanded Physician Services/Office Visits

- Expanded Home Health Services
- Private Duty Nursing Services
- Prescribed Pediatric Extended Care Services
- DCLH Level of Care Determinations
- Long-Term Care Clinical Eligibility Determinations
- PAD and Implantable Drug System Devices
- Molecular (Genetic) Testing
- Continuous Glucose Monitoring Service and Remote Patient Monitoring Services
- Diabetes Self-Management Training
- Cardiac Rehabilitation Services
- Innovative Programs, Services and Items

The Methodology section of the Technical Proposal shall provide information on the Offeror's experience providing UM/QIO services and a detailed description of how the Offeror shall meet requirements outlined in this RFP. The Offeror shall describe in detail the Offeror's experience administering similar UM/QIO programs for medical services for commercial health care programs. The Offeror shall describe in detail the Offeror's experience administering similar UM/QIO programs for medical services for government health care programs.

A. Inpatient Hospital Medical/Surgical Services Authorization

1. DOM covers inpatient medical/surgical services for eligible beneficiaries. For additional information on coverage, see Administrative Code Title 23 Medicaid.

   As a condition for reimbursement, DOM requires that all inpatient hospital admissions receive authorization. Failure to obtain the authorization will result in denial of payment to all providers billing for services, including the hospital and the attending physician. Currently, DOM's contract UM/QIO conducts authorization of hospital admissions. Historic information on the volume of authorizations is provided on DOM's website.

2. The Contractor shall develop, implement, and maintain a UM/QIO program that includes authorization, prior authorization and prepayment review of inpatient medical and surgical service requests.

3. The Contractor shall have established procedures to receive authorizations and prepayment review requests and supporting information via web-based submissions, telephone, facsimile, and mail from hospital providers under the direct/order of the attending physicians as required by 42 C.F.R. §456.60 and §456.80.

   a. The Contractor shall establish and maintain a telephone number, toll-free in Mississippi, solely dedicated for the receipt of prior authorization requests for inpatient medical/surgical services submitted by telephone.

   b. The Contractor shall establish and maintain a facsimile number, toll-free in Mississippi, solely dedicated for the receipt of prior authorization and prepayment review requests for inpatient medical/surgical services submitted by facsimile.

c. The Contractor shall establish and maintain a physical mailing address in Hinds, Rankin or Madison County for the receipt of all prior authorization and prepayment review requests for inpatient medical/surgical services submitted by mail.

d. The Contractor shall establish and maintain a web-based system for receipt of prior authorization and prepayment review requests for inpatient medical/surgical services submitted electronically. This web-based system must comply with the requirements in Section 1.6 of this RFP.

4. Regardless of the mode of receipt, the Contractor shall have established procedures and sufficient capacity to receive review forms and additional medical documentation required for authorization and prepayment review of inpatient medical/surgical services.

5. The Contractor shall determine the medical necessity for urgent and non-emergency inpatient admission authorizations, continued stays, and retrospective reviews for inpatient medical/surgical services to eligible Mississippi Medicaid beneficiaries utilizing Federal and State laws and regulations, DOM policies and/or formal memorandums.

   a. Urgent Admission Reviews: Urgent admissions are defined as admissions to an inpatient hospital setting resulting from the sudden onset of a medical condition or injury requiring acute care and manifesting itself by acute symptoms of sufficient severity that the absence of immediate inpatient hospital care could result in:

      1) Permanently placing the beneficiary's health in jeopardy;

      2) Serious impairment to bodily function; or

      3) Serious and permanent dysfunction of any bodily organ or part, or other serious medical consequence.

      The Contractor shall have the capability and established procedures to receive retrospective urgent admission reviews that are not planned or elective and conduct authorizations when the beneficiary has not been discharged. The Contractor shall ensure determinations for urgent admission reviews are completed 98% of the time within one (1) business day of receipt.

   b. Non-Emergency Admission Reviews: Non-emergency admissions are for planned or elective admissions and the beneficiary has not been hospitalized. The Contractor shall have the capability and established procedures to receive non-emergency admission review requests and conduct prior authorizations before the planned date of admission. The Contractor shall ensure determinations for non-emergency admission reviews are completed 98 percent of the time within one (1) business day of receipt.

   c. Weekend and Holiday Admission Reviews: Weekend admissions are when the beneficiary was admitted on a weekend. Holiday admissions are defined as those admissions where a beneficiary is admitted on a state-observed holiday. The Contractor shall have the capability and established procedures to receive weekend and holiday admission review requests and conduct authorizations post-admission when the beneficiary has not been discharged. The Contractor shall ensure determinations for weekend and holiday admission reviews are completed 98 percent of the time within one (1) business day of receipt.

d. Continued Stay Reviews: Continued stays reviews are subsequent reviews performed to determine if continuation of services is medically necessary and appropriate. The Contractor shall have the capability and established procedures to receive continued stay review requests for additional inpatient days of care for admissions previously approved and conduct prior authorizations on or before the next review point (i.e. the last approved day). The Contractor shall have the capability and established procedures to provide all hospital providers with a daily listing of beneficiaries whose authorization expires within 48 hours. The Contractor shall ensure determinations for continued stay reviews are completed 98 percent of the time within one (1) business day of receipt when beneficiaries remain hospitalized and within one (1) business day when beneficiaries have been discharged.

e. Retrospective Short Stay Review: A retrospective short stay review is defined as a review performed when the admission length of stay was eight days or less and the admission was not previously authorized. The Contractor shall have the capability and established procedures to receive retrospective short stay review requests and conduct prepayment reviews as such conditions are identified. The Contractor shall ensure determinations for retrospective short stay reviews are completed 98 percent of the time within ten (10) business days of receipt.

f. Retrospective Reviews: Retrospective review is defined as a review performed when a service has been provided and no authorization had been given. Retrospective reviews cover those admissions where the beneficiary was admitted and discharged, authorization was not obtained while the beneficiary was hospitalized, and the length of stay is greater than eight (8) days. The Contractor shall have the capability and established procedures to receive retrospective review requests and conduct prepayment reviews. The Contractor shall ensure determinations for retrospective reviews are completed 98 percent of the time within ten (10) business days of receipt. (DOM provides retroactive Medicaid eligibility for a beneficiary that was not eligible for Medicaid benefits at the time of hospitalization.)

6. The Contractor shall develop and maintain a web-based, electronic review request system for authorization, prior authorization and prepayment review of inpatient hospital services that allows for data input by the requesting providers. The Contractor's system shall have the capability for automated criteria/rules-based authorization system. The Contractor shall manually review each authorization, prior authorization and prepayment review request received that is not authorized by the Contractor's rules-based system, along with any required supporting documentation to support the need for inpatient medical/surgical services.

7. The Contractor shall provide a first level review conducted by a complement of qualified staff, which must include registered nurses licensed in the state of Mississippi, to apply Federal and State laws and regulations, DOM policies and/or formal memorandums and DOM approved medical necessity criteria in order to approve inpatient medical/surgical services based on authorization policy and criteria or refer requests that cannot be approved to a second level review.

8. If request is not approved at the first level, the Contractor shall provide a second level review conducted by physicians licensed in the state of Mississippi to make review determinations for: 1) inpatient medical/surgical services based on documentation that supports the medical necessity and appropriateness of setting; 2) consideration of unique factors associated with each patient care episode; 3) local healthcare delivery system infrastructure; and 4) clinical experience, judgment, and generally accepted standards of healthcare.

a. The Contractor shall have the capability and established procedures for verbal consultation by the physician reviewer with the attending physician to obtain additional information when the documentation submitted does not clearly support medical necessity.

b. The Contractor shall ensure that authorization requests not meeting medical necessity criteria for inpatient medical/surgical services are reviewed by a physician licensed in the state of Mississippi and of the same specialty as the case under review.

9. The Contractor shall have the capability and established procedures for verbal and written notification to the requesting provider of a pended review and for informing the provider of the information needed along with a time frame for submission. Notification to providers of pended reviews shall not exceed the following:

Table 2: Notification of Pended Reviews for Inpatient Medical/Surgical Services

Review Type	Contractor Action	Time Standard
Urgent Admission Reviews	Verbal Notification to Provider	Within four (4) hours past due date for requested information
Non-Emergency Admission Reviews Weekend and Holiday Admission Reviews Continued Stay Reviews	Written Notification to Provider	Within one (1) business day past due date for requested information
Retrospective Short Stay Reviews	Written Notification to Provider	Within three (3) business days past due date for requested information
Retrospective Reviews	Written Notification to Provider	Within three (3) business days past due date for requested information

10. The Contractor shall establish and maintain a procedure for the attending physician to contact the Contractor's Medical Director to discuss inpatient medical/surgical services cases that have been denied, modified, reduced or considered for denial.

11. The Contractor shall notify providers and beneficiaries or legal guardians/representatives of review determinations for inpatient medical/surgical services requests.

a. The Contractor shall issue verbal and written notification of approved authorization results to the hospital provider and attending physician.

b. The Contractor shall issue verbal and written notification of denial, modification or reduction to the hospital provider, attending physician, and beneficiary or, if a child, the legal guardian/representative.

c. Time frames for notification to providers and beneficiaries of review outcomes for prior authorization and prepayment review of inpatient medical/surgical services shall not exceed the following standards:

Table 3: Notification of Review Outcomes for Inpatient Hospital Medical/Surgical Services

Review Type	Contractor Action	Time Standard
Urgent Admission Reviews	Verbal Approval to Provider	Within one (1) business day from review determination
Non-Emergency Admission Reviews	Written Approval to Provider	Within one (1) business day from review determination
Weekend and Holiday Admission Reviews	Verbal Denial to Provider	Within one (1) business day from review determination
Continued Stay Reviews	Written Denial to Provider	Within one (1) business day from review determination
	Written Denial to Beneficiary/ Parent/Representative	Within one (1) business day from review determination
Retrospective Short Stay Reviews	Written Approval to Provider	Within three (3) business days from review determination
Retrospective Reviews	Written Denial to Provider	Within three (3) business days from review determination
	Written Denial to Beneficiary/ Parent/Representative	Within three (3) business days from review determination

12. The Contractor shall have the capability and established procedures to perform prepayment reviews to include, but not limited to, the review of additional medical information, contacting third parties and analyzing past beneficiary and/or provider claim history to ensure proper adjudication and compliance with Federal and State laws and regulations, DOM policies and/or formal memorandums and procedures.

13. The Contractor shall have the capability and established procedures to perform post-payment review for Medical Necessity and Independent Verification and Validation (IV&V):

    a. DOM defines review for Medical Necessity and/or Independent Verification and Validation (IV&V) as the review for services of Medicaid FFS beneficiaries and CCO members in an inpatient setting including, but not limited to, the following:

        1) Meeting clinical guidelines for medical necessity. [Refer to Part 200, Rule 5.1 for definition of medical necessity],

        2) Appropriateness of setting and quality of care,

        3) Appropriate lengths of stay and services, and

        4) Correct All Patient Refined Diagnosis Related Groups (APR-DRG) assignment.

        5) DOM covers inpatient medical/surgical services for eligible beneficiaries. For additional information on coverage, see Administrative Code Title 23 Medicaid.

B. Outpatient Services and Surgical Procedures Authorization

1. DOM covers certain outpatient surgical procedures for eligible beneficiaries. For additional information on coverage, see Administrative Code Title 23 Medicaid. As a condition for reimbursement, DOM may require authorization for certain outpatient services and surgical procedures. Failure to obtain the authorization will result in denial of payment to all providers billing for services.

2. The Contractor shall develop, implement, and maintain a UM/QIO program that includes authorization, prior authorization and prepayment review of outpatient services and surgical procedures service requests.

3. The Contractor shall have established procedures to receive authorization, prior authorizations and prepayment review requests and supporting information via web-based submissions, facsimile, and mail from outpatient services and surgical providers.

    a. The Contractor shall establish and maintain a dedicated facsimile number, toll-free in Mississippi, for the receipt of prior authorization and prepayment review requests for outpatient services and surgical procedures submitted by facsimile.

    b. The Contractor shall establish and maintain a physical mailing address in Hinds, Rankin or Madison County for the receipt of all prior authorization and prepayment review requests for outpatient services and surgical procedures submitted by mail.

    c. The Contractor shall establish and maintain a web-based system for receipt of prior authorization and prepayment review requests for outpatient services and surgical procedures submitted electronically. This web-based system must comply with the requirements in Section 1.6 of this RFP.

4. Regardless of the mode of receipt, the Contractor shall have established procedures and sufficient capacity to receive review forms and additional medical documentation required for authorization, prior authorization and prepayment review of outpatient services and surgical procedures.

5. The Contractor shall determine the medical necessity for authorization, prior authorization, prepayment review and retrospective reviews for outpatient services and surgical procedures to eligible Mississippi Medicaid beneficiaries utilizing Federal and State laws and regulations, DOM policies and/or formal memorandums.

    a. Prior Authorization Reviews: The Contractor shall have the capability and established procedures to ensure determinations for prior authorization of outpatient services and surgical procedures are completed 98 percent of the time within two (2) business days of receipt.

    b. Retrospective Reviews: The Contractor shall have the capability and established procedures to ensure determinations for retrospective reviews of outpatient services and surgical procedures are completed 98 percent of the time within ten (10) business days of receipt. (DOM provides retroactive Medicaid eligibility for a beneficiary that was not eligible for Medicaid benefits at the time of service.)

6. The Contractor shall develop and maintain a web-based, electronic review request system for authorization, prior authorization and prepayment review of outpatient services and surgical procedures that allows for data input by the submitting providers. The Contractor's system shall have the capability for automated criteria/rules-based authorization system. The Contractor shall manually review each authorization, prior authorization and prepayment review request received that is not authorized by the Contractor's rules-based

system, along with any required supporting documentation to support the need for inpatient medical/surgical services.

7. The Contractor shall provide a first level review conducted by a complement of qualified staff, which must include registered nurses licensed in the state of Mississippi, to apply Federal and State laws and regulations, DOM policies and/or formal memorandums and DOM approved medical necessity criteria in order to outpatient services and surgical procedures based on authorization policy and criteria or refer requests that cannot be approved to a second level review.

8. If request is not approved at the first level, the Contractor shall provide a second level review conducted by physicians licensed in the state of Mississippi to make review determinations for: 1) outpatient services and surgical procedures based on documentation that supports the medical necessity and appropriateness of setting; 2) consideration of unique factors associated with each patient care episode; 3) local healthcare delivery system infrastructure; and 4) clinical experience, judgment, and generally accepted standards of healthcare.

9. The Contractor shall have the capability and established procedures for verbal consultation by the physician reviewer with the attending physician to obtain additional information when the documentation submitted does not clearly support medical necessity.

10. The Contractor shall ensure that denials, modifications, or reductions not meeting medical necessity criteria for outpatient surgical procedures are reviewed by a physician licensed in the state of Mississippi and of the same specialty as the case under review.

11. The Contractor shall have the capability and established procedures for verbal and written notification to the requesting provider of a pended review and for informing the provider of the information needed along with a time frame for submission.

C. Maternity Admissions for Delivery/Early Elective Delivery and Reporting

1. DOM covers maternity services including, but not limited to, delivery services, the care involved in the actual birth, and continued care for sixty (60) calendar days following the birth of the newborn. Hospitals must report admissions for deliveries, both vaginal and Cesarean section, as required by DOM. DOM policy exempts certain maternity admissions for delivery from the reporting requirement and providers are not required to submit reports for these situations. No report is required if the beneficiary has Medicare Part A and Part B coverage for the hospitalization time frame and the Medicare benefits are not exhausted. No review is required if the beneficiary's Medicaid eligibility is only for the Family Planning Waiver.

2. The Contractor shall develop, implement, and maintain a maternity admission reporting process for delivery and early elective delivery and conduct continued stay reviews in accordance with the requirements of section 1.4.2.1.A, Inpatient Medical/Surgical Services Authorization.

3. The Contractor shall have established procedures to receive maternity admission for delivery and early elective delivery reports via web-based submissions, telephone, facsimile, and mail from hospital providers under the directive/orders of the attending physicians.

    a. The Contractor shall establish and maintain a telephone number, toll-free in Mississippi, for the receipt of maternity admission for delivery reports by phone.

b. The Contractor shall establish and maintain a facsimile number, toll-free in Mississippi, for the receipt of maternity admission for delivery reports submitted by facsimile.

c. The Contractor shall establish and maintain a physical mailing address in Hinds, Rankin or Madison County for the receipt of maternity admission for delivery reports submitted by mail.

d. The Contractor shall establish and maintain a web-based system for receipt of prior authorization and prepayment review requests for hospital services submitted electronically. This web-based system must comply with the requirements in Section 1.6 of this RFP.

4. Regardless of the mode of receipt, the Contractor shall have established procedures and sufficient capacity to receive review forms and additional medical documentation required for authorization, prior authorization and prepayment review of maternity admission for delivery services.

5. The Contractor shall issue a written notification for issuance of a TAN to the hospital provider and attending physician within one (1) business day from receipt of completed report.

D. Organ Transplant Services Authorization

1. DOM covers organ transplant services for eligible beneficiaries. For additional information on coverage, see Administrative Code Title 23 Medicaid. As a condition for reimbursement, DOM requires that heart, lung, liver, and small bowel transplants receive authorization. No authorization is required for kidney, cornea, and bone marrow/peripheral stem cell transplants. Failure to obtain the authorization will result in denial of payment to all providers billing for services, including the hospital and the attending physician. Currently, DOM's contract UM/QIO conducts authorization of organ transplants that require authorization. Historic information on the volume of authorizations for organ transplant services is provided on DOM's website.

2. The Contractor shall develop, implement, and maintain a UM/QIO program, which includes authorization, prior authorization and retrospective review of application requests for organ transplant services.

3. The Contractor shall have the established procedures to receive authorization requests and supporting information via web-based submissions, facsimile and mail submissions from transplant facilities and attending physicians.

   a. The Contractor shall establish and maintain a dedicated facsimile number, toll-free in Mississippi, for the receipt of review requests for transplant services submitted by facsimile.

   b. The Contractor shall establish and maintain a physical mailing address in Hinds, Rankin or Madison County for the receipt of review requests for transplant services submitted by mail.

   c. The Contractor may establish and maintain a web-based system for receipt of review requests for transplant services submitted electronically. Any web-based system must comply with the requirements in Section 1.6 of this RFP.

4. Regardless of the mode of receipt, the Contractor shall have established procedures and sufficient capacity to receive applications, supporting clinical documentation, and other forms or documentation required for authorization of transplant services.

5. The Contractor shall determine the medical necessity of transplant requests for authorization, prior authorization, extension of benefits and/or retrospective reviews for eligible Mississippi Medicaid beneficiaries utilizing DOM approved criteria and policies. The Contractor shall ensure determinations of transplant request for authorization, prior authorization and extensions of benefits are completed 98 percent of the time within three (3) business days of receipt. The Contractor shall ensure determinations for retrospective reviews are completed 98 percent of the time within ten (10) business days of receipt.

6. The Contractor shall develop and maintain a web-based, electronic review request system for authorization and prior authorization of transplant services that allows for data input by the submitting providers. The Contractor's system may have the capability for automated criteria/rules-based authorization system. The Contractor shall manually review each prior authorization request not authorized by the Contractor's rules-based system for transplant services.

7. The Contractor shall provide a first level review conducted by qualified staff, which must include registered nurses licensed in the state of Mississippi to apply Federal and State laws and regulations, DOM policies and/or formal memorandums and approved medical necessity criteria.

8. If request is not approved at the first level, the Contractor shall provide a second level review conducted by physicians licensed in the state of Mississippi to make review determinations for transplant based on: 1) documentation that supports the medical necessity of transplant; 2) consideration of unique factors associated with each patient care episode; and 3) clinical experience, judgment, and generally accepted standards of healthcare.

    a. The Contractor shall have the capability and established procedures for verbal consultation by the physician reviewer with the attending physician to obtain additional information when the documentation submitted does not clearly support medical necessity.

    b. The Contractor shall ensure that authorization requests not meeting medical necessity criteria for transplant services are reviewed by a physician licensed in the state of Mississippi and of the same specialty as the case under review.

9. The Contractor shall have the capability and established procedures to verify Medicare approval of the transplant facility and determine the existence of other financial resource available.

10. The Contractor shall have the capability and established procedures for verbal and written notification to the requesting provider of a pended review and informing the provider of the information needed along with a time frame for submission that shall not exceed ten (10) business days.

11. The Contractor shall have the capability and established procedures for verbal and written notification to the requesting provider of a suspended review. Notification to providers of suspended reviews shall occur within one (1) business day of the past due date for information requested.

12. The Contractor shall establish and maintain a procedure for the attending physician to contact the Contractor's Medical Director to discuss transplant cases that have been denied, or considered for denial.

    a. For transplant denials, the Contractor issues a written notification of outcome to the attending physician, transplant facility, beneficiary or, if a child, the legal guardian/representative and DOM.

b. For transplant approvals, the Contractor issues a written notification of outcome to DOM. DOM issues the notification to the requesting physician or transplant facility.

c. Time frames for notification to DOM of review outcomes for authorizations, prior authorizations, extension of benefits and retrospective reviews shall not exceed one (1) business day from the review determination.

E. Hospice Services Authorization

1. DOM covers hospice services in accordance with 42 C.F.R. § 418 for eligible beneficiary certified as being terminally ill with a life expectancy of six (6) months or less, and with a documented diagnosis consistent with a terminal stage of six (6) months or less. According to the Patient Protection and Affordable Care Act of 2010 for Hospice, EPSDT eligible beneficiaries may receive hospice benefits including curative treatment upon the election of the hospice benefit without foregoing any other service to which the child is entitled under Medicaid. Beneficiaries enrolled in Mississippi Medicaid's Home and Community Based Waiver programs can receive hospice benefits simultaneously. For additional information on coverage, see Administrative Code Title 23 Medicaid.

   As a condition for reimbursement, DOM requires that hospice services receive authorization. Authorization may occur before or after admission to a hospice facility however, failure to obtain authorization will result in denial of payment to hospice providers billing for services. Currently, DOM's contract UM/QIO conducts authorization of hospice services. Historic information on the volume of authorizations for hospice services is provided on DOM's Website.

2. The Contractor shall develop, implement, and maintain a UM/QIO program, which includes authorization, prior authorization and prepayment review of hospice services requests.

3. The Contractor shall have the capability and established procedures to receive authorization requests and supporting information via web-based submissions and facsimile from hospice providers.

   a. The Contractor shall establish and maintain a dedicated facsimile number, toll-free in Mississippi, for the receipt of review requests for hospice services submitted by facsimile.

   b. The Contractor shall establish and maintain a web-based system for receipt of review requests for hospice services submitted electronically. Any web-based system must comply with the requirements in Section 1.6 of this RFP.

4. The Contractor shall have established procedures and sufficient capacity to receive requests for review, required forms, history and physical, additional medical documentation and other forms or documentation required for prior authorization of hospice services.

5. The Contractor shall determine the medical necessity of prior authorization and recertification requests for eligible Medicaid only beneficiaries, as well as admission and continued stay reviews for dual eligible (Medicare/Medicaid) beneficiaries electing hospice services to eligible Mississippi Medicaid beneficiaries utilizing DOM approved criteria and policies.

   a. Prior Authorization Requests (Medicaid Only Beneficiaries): The Contractor shall have the capability and established procedures to receive authorization reviews for the initiation of a hospice enrollment period for a beneficiary with Medicaid only benefits. The Contractor shall have the capability to track election

periods as defined in 42 C.F.R. § 418. The Contractor shall ensure determinations for authorization requests are completed 98 percent of the time within three (3) business days of receipt.

b. Admission Reviews (Dual Eligible Beneficiaries): The Contractor shall have the capability and established procedures to receive admission reviews for the initiation of a hospice enrollment period for a beneficiary with Medicare and Medicaid benefits. The Contractor shall ensure determinations for admission reviews are completed 98 percent of the time within three (3) business days of receipt.

c. Recertification Requests (Medicaid Only Beneficiaries): The Contractor shall have the capability and established procedures to receive recertification requests to determine if continuation of a hospice benefit period is medically necessary for a beneficiary with Medicaid only coverage. The Contractor shall ensure determinations for recertification requests are completed 98 percent of the time within three (3) business days of receipt.

d. Continued Stay Reviews (Dual Eligible Beneficiaries): The Contractor shall have the capability and established procedures to receive continued stay reviews to determine if continuation of a hospice benefit period is medically necessary for a beneficiary with Medicare and Medicaid benefits. The Contractor shall ensure determinations for continued stay reviews are completed 98 percent of the time within three (3) business days of receipt.

6. The Contractor shall develop and maintain a web-based, electronic review request system for authorization of hospice services that allows for data input by the submitting providers. The Contractor's system shall have the capability for an automated criteria/rules-based authorization system. The Contractor shall manually review each authorization request received that is not authorized by the Contractor's rules-based system, along with any required supporting documentation to support the need for hospice services.

7. The Contractor shall provide a first level review conducted by a complement of qualified staff, which must include registered nurses licensed in the state of Mississippi, to apply Federal and State laws and regulations, DOM policies and/or formal memorandums and DOM approved medical necessity criteria in order to approve hospice services based on authorization policy and criteria or refer requests that cannot be approved to a second level review.

8. If request is not approved at the first level, the Contractor shall provide a second level review conducted by physicians licensed in the state of Mississippi to make review determinations for hospice services based on: 1) documentation that supports the prognosis and medical appropriateness of setting; 2) evidence-based guidelines; 3) consideration of unique factors associated with each patient care episode; 4) local healthcare delivery system infrastructure; and 5) clinical experience, judgment, and generally accepted standards of healthcare.

   a. The Contractor shall have the capability and established procedures for verbal consultation by the physician reviewer with the attending physician and/or hospice medical director to obtain additional information when the documentation submitted does not clearly support medical necessity.

   b. Contractor shall ensure that authorization requests not meeting medical necessity criteria for Hospice services are reviewed by a physician licensed in the state of Mississippi and of the same specialty as the case under review.

9. The Contractor shall have the capability and established procedures for verbal and written notification to the requesting provider of a pended review and informing the provider of the information needed along with a time frame for submission that shall not exceed one (1) business day.

    a. Contractor shall pend incomplete submissions for no more than ten (10) business days.

    b. Contractor shall issue a technical denial on day eleven (11), if request is still incomplete.

    c. Contractor shall issue verbal and written notification of denials, modifications or reductions to the hospice provider and beneficiary or, if a child, the legal guardian/representative.

10. The Contractor shall establish and maintain a procedure for the attending physician or hospice medical director to contact the Contractor's Medical Director to discuss hospice services cases that have been denied, modified, reduced or considered for denial.

11. The Contractor shall notify providers and beneficiaries or legal guardians/representatives of review determinations for hospice services requests.

    a. The Contractor shall issue verbal and written notification of approved certification results to the hospice provider.

    b. The Contractor shall issue verbal and written notification of denials, modifications or reductions to the hospice provider and beneficiary or, if a child, the legal guardian/representative.

    c. Time frames for notification to providers and beneficiaries of review outcomes for authorization of hospice services shall not exceed one (1) business day from the review determination.

Table 4: Notification of Review Outcomes for Hospice Services

Review Type	Contractor Action	Time Standard
Prior Authorization	Notification of Pended Status to Provider	Within one (1) business day from technical review
	Written Approval to Provider	Within one (1) business day from review determination
	Written Denial to Provider	Within one (1) business day from review determination
	Written Denial to Beneficiary/ Parent/Representative	Within one (1) business day from review determination
Admission Review	Notification of Pended Status to Provider	Within one (1) business day from technical review
	Written Approval to Provider	Within one (1) business day from review determination
	Written Denial to Provider	Within one (1) business day from review determination
	Written Denial to Beneficiary/ Parent/Representative	Within one (1) business day from review determination
Recertification Requests	Notification of Pended Status to Provider	Within one (1) business day from technical review
	Written Approval to Provider	Within one (1) business day from review determination
	Written Denial to Provider	Within one (1) business day from review determination

	Written Denial to Beneficiary/ Parent/Representative	Within one (1) business day from review determination
Continued Stay Review	Notification of Pended Status to Provider	Within one (1) business day from technical review
	Written Approval to Provider	Within one (1) business day from review determination
	Written Denial to Provider	Within one (1) business day from review determination
	Written Denial to Beneficiary/ Parent/Representative	Within one (1) business day from review determination

F. Durable Medical Equipment, Medical Supplies, Appliances and Orthotics and Prosthetics Authorization

1. DOM covers durable medical equipment (DME), supplies, appliances and orthotics, and prosthetics for eligible beneficiaries. For additional information on coverage, see Administrative Code Title 23 Medicaid. As a condition for reimbursement, DOM requires authorization for certain DME, supplies, appliances and orthotics and prosthetics. Specific items requiring authorization, as well as the service limits, are identified in the DME-Orthotic-Prosthetic Fee Schedules which can be accessed at: http://www.medicaid.ms.gov/FeeScheduleLists.aspx. Failure to obtain authorization will result in denial of payment to providers billing for services. Currently, DOM's contract UM/QIO conducts authorization of DME, supplies, appliances and orthotics and prosthetics. Historic information on the volume of prior authorizations for DME, supplies, appliances and orthotics and prosthetics is provided on DOM's Website.

2. The Contractor shall develop, implement, and maintain a UM/QIO program, which includes authorization, prior authorization and prepayment review of DME, supplies, appliances and orthotics and prosthetics requests.

3. The Contractor shall have the capability and established procedures to receive authorizations, prior authorizations and prepayment review requests and supporting information via web-based submissions, facsimile and mail submissions from DME, supplies, appliances and orthotics and prosthetics providers.

   a. The Contractor shall establish and maintain a facsimile number, toll-free in Mississippi, for the receipt of review requests for DME, supplies, and orthotics and prosthetics submitted by facsimile.

   b. The Contractor shall establish and maintain a physical mailing address in Hinds, Rankin or Madison County for the receipt of review requests for DME, supplies, and orthotics and prosthetics submitted by mail.

   c. The Contractor may establish and maintain a web-based system for receipt of review requests for DME, supplies, and orthotics and prosthetics submitted electronically. Any web-based system must comply with the requirements in Section 1.6 of this RFP.

4. Regardless of the mode of receipt, the Contractor shall have established procedures and sufficient capacity to receive review requests, physician's orders, prescriptions, plans of care, and other forms or documentation, including itemized invoices for manually-priced procedures required for authorization, prior authorization and prepayment review of DME, supplies, appliances and orthotics and prosthetics.

5. The Contractor shall determine the medical necessity of authorizations, prior authorization reviews and retrospective reviews for DME, supplies, appliances and orthotics and prosthetics to eligible Mississippi Medicaid beneficiaries utilizing DOM approved criteria and policies.

    a. Prior Authorization Reviews: The Contractor shall ensure determinations for prior authorization reviews are completed 98 percent of the time within two (2) business days of receipt. In some cases delivery of DME, supplies, appliances and orthotics and prosthetics may occur prior to prior authorization review requests.

    b. Retrospective Reviews: The Contractor shall ensure determinations for retrospective reviews are completed 98 percent of the time within ten (10) business days of receipt. (DOM provides retroactive Medicaid eligibility for a beneficiary that was not eligible for Medicaid benefits at the time of service.)

6. The Contractor may develop and maintain a web-based, electronic review request system for authorization, prior authorization and prepayment review of DME, supplies, appliances and orthotics and prosthetics that allows for data input by the submitting providers. The Contractor's system may have the capability for automated criteria/rules-based authorization system. The Contractor shall manually review each authorization, prior authorization and prepayment review request received that is not authorized by the Contractor's rules-based system for DME, supplies, appliances and orthotics and prosthetics.

7. The Contractor shall provide a first level review conducted by a complement of qualified staff, which must include registered nurses licensed in the state of Mississippi, to apply Federal and State laws and regulations, DOM policies and/or formal memorandums and DOM approved medical necessity criteria in order to approve DME, supplies, appliances and orthotics and prosthetics based on authorization policy and criteria or refers requests that cannot be approved to a second level review. Manual pricing does not need to be conducted by a licensed health professional.

8. If request is not approved at the first level, the Contractor shall provide a second level review conducted by a physician licensed in the state of Mississippi to make review determinations for DME, supplies, appliances and orthotics and prosthetics based on: 1) documentation that supports the medical necessity and appropriateness; 2) consideration of unique factors associated with each patient care episode; 3) local healthcare delivery system infrastructure; 4) clinical experience, judgment, and generally accepted standards of healthcare; and 5) evidence-based guidelines.

    a. The Contractor shall have the capability and established procedures for verbal consultation by the physician reviewer with the ordering provider to obtain additional information when the documentation submitted does not clearly support medical necessity.

    b. Contractor shall ensure that authorization requests not meeting medical necessity criteria for DME, supplies, appliances and orthotics and prosthetics are reviewed by a physician licensed in the state of Mississippi and of the same specialty as the case under review.

9. The Contractor shall have the capability and established procedures for verbal and written notification to the requesting provider of a pended review and informing the provider of the information needed along with a time frame for submission that shall not exceed three (3) business days for prior authorization and ten (10) business days for retrospective reviews.

10. The Contractor shall have the capability and established procedures for verbal and written notification to the requesting provider of a suspended review. Notification to providers of suspended reviews shall occur within one (1) business day of the past due date for information requested.

11. The Contractor shall establish and maintain a procedure for the DME, supplies, appliances and orthotics and prosthetics provider, the ordering provider, and the attending physician to contact the Contractor's Medical Director to discuss DME, supplies, appliances and orthotics and prosthetics cases that have been denied, modified, or reduced or considered for denial.

12. The Contractor shall notify providers and beneficiaries or legal guardians/representatives of review determinations for DME requests. Notifications to providers and beneficiaries or legal guardians shall occur ninety-eight percent of the time within one (1) business day of the final review determination.

    a. The Contractor shall issue a written notification of approved certification results to the DME, supplies, appliances and orthotics and prosthetics provider and the ordering provider.

    b. The Contractor shall issue a written notification of denials, modifications or reductions to the DME, supplies, appliances and orthotics and prosthetics provider, the ordering provider, and beneficiary or, if a child, the legal guardian/representative.

    c. Time frames for notification to providers and beneficiaries of review outcomes for prior authorization and prepayment review of DME, supplies, appliances and orthotics and prosthetics shall not exceed the following standards:

Table 5: Notification of Review Outcomes for DME, supplies, appliances and orthotics and prosthetics

Review Type	Contractor Action	Time Standard
Prior Authorization Review	Written Approval to Provider	Within one (1) business day from review determination
	Written Denial to Provider	Within one (1) business day from review determination
	Written Denial to Beneficiary/ Parent/Representative	Within one (1) business day from review determination
Retrospective Review	Written Approval to Provider	Within three (3) business days from review determination
	Written Denial to Provider	Within three (3) business days from review determination
	Written Denial to Beneficiary/ Parent/Representative	Within three (3) business days from review determination

G. Vision Services Authorization

1. Vision service is an optional benefit under the state's Medicaid program. For additional information on coverage, see Administrative Code Title 23 Medicaid. Specific procedures requiring prior authorization are identified in the Vision Fee Schedule which can be accessed at: http://www.medicaid.ms.gov/FeeScheduleLists.aspx. As a condition for reimbursement, DOM requires authorization for certain vision services. Failure to obtain the authorization for certain vision services will result in denial of payment to providers billing for services. Currently, DOM's contract UM/QIO conducts

authorization of vision services. Historic information on the volume of authorizations is provided on DOM's website.

2. The Contractor shall develop, implement, and maintain a UM/QIO program, which includes authorization, prior authorization and prepayment review of vision services requests.

3. The Contractor shall have the capability and established procedures to receive authorizations, prior authorizations and prepayment review requests and supporting information via web-based submissions, facsimile, and mail from vision services providers.

   a. The Contractor shall establish and maintain a facsimile number, toll-free in Mississippi, for the receipt of review requests for vision services submitted by facsimile.

   b. The Contractor shall establish and maintain a physical mailing address in Hinds, Rankin or Madison County for the receipt of review requests for vision services submitted by mail.

   c. The Contractor shall establish and maintain a web-based system for receipt of review requests for vision services submitted electronically. This web-based system must comply with the requirements in Section 1.6 of this RFP.

4. Regardless of the mode of receipt, the Contractor shall have established procedures and sufficient capacity to receive review request and other forms or documentation required, including itemized invoices for manually-priced procedures for authorization, prior authorization and prepayment review of vision services.

5. The Contractor shall determine the medical necessity of authorizations, prior authorizations and retrospective reviews for vision services to eligible Mississippi Medicaid beneficiaries utilizing DOM approved criteria and policies.

   a. Prior Authorization Reviews: The Contractor shall ensure determinations for prior authorization reviews are completed 98 percent of the time within two (2) business days of receipt.

   b. Retrospective Reviews: The Contractor shall ensure determinations for retrospective reviews are completed 98 percent of the time within ten (10) business days of receipt. (DOM provides retroactive Medicaid eligibility for a beneficiary that was not eligible for Medicaid benefits at the time of service.)

6. The Contractor shall develop and maintain a web-based, electronic review request system for authorization, prior authorization and prepayment review of vision services that allows for data input by the submitting providers. The Contractor's system shall have the capability for automated criteria/rules-based authorization system. The Contractor shall manually review each authorization, prior authorization and prepayment review request received that is not authorized by the Contractor's rules-based system, along with any required supporting documentation to support the need for vision services.

7. The Contractor shall provide a first level review conducted by a complement of qualified staff, which must include registered nurses licensed in the state of Mississippi, to apply Federal and State laws and regulations, DOM policies and/or formal memorandums and DOM approved medical necessity criteria in order to approve vision services based on authorization policy and criteria or refer requests that cannot be approved to a second level review. Manual pricing does not need to be conducted by a vision professional.

8. If request is not approved at the first level, the Contractor shall provide a second level review conducted by physicians licensed in the state of Mississippi to make review determinations for vision services based on: 1) documentation that supports the medical necessity and appropriateness of setting; 2) consideration of unique factors associated with each patient care episode; 3) local healthcare delivery system infrastructure; and 4) clinical experience, judgment and generally accepted standards of healthcare.

    a. The Contractor shall have the capability and established procedures for verbal consultation by the physician reviewer with the vision services provider to obtain additional information when the documentation submitted does not clearly support medical necessity.

    b. The Contractor shall ensure that authorization requests not meeting medical necessity criteria for vision services are reviewed by a physician licensed in the state of Mississippi and of the same specialty as the case under review.

9. The Contractor shall have the capability and established procedures for verbal and written notification to the requesting provider of a pended review and informing the provider of the information needed along with a time frame for submission that shall not exceed three (3) business days for prior authorization and ten (10) business days for retrospective reviews.

10. The Contractor shall have the capability and established procedures for written notification to the requesting provider of a suspended review. Notification to providers of suspended reviews shall occur within one (1) business day of the past due date for information requested.

11. The Contractor shall establish and maintain a procedure for the vision service provider and attending physician to contact the Contractor's Medical Director to discuss vision services cases that have been denied, reduced or modified.

12. The Contractor shall notify providers and beneficiaries or legal guardians/representatives of review determinations for vision services requests.

    a. The Contractor shall issue a written notification of approved authorization results to the vision services provider.

    b. The Contractor shall issue a written notification of denials, modifications, or reductions to the vision services provider and beneficiary or, if a child, the legal guardian/representative.

    c. Time frames for notification to providers and beneficiaries of review outcomes for authorization, prior authorization and prepayment review of vision services shall not exceed the following standards:

Table 6: Notification of Review Outcomes for Vision Services

Review Type	Contractor Action	Time Standard
Prior Authorization Review	Written Approval to Provider	Within one (1) business day from review determination
	Written Denial to Provider	Within one (1) business day from review determination
	Written Denial to Beneficiary/ Parent/Representative	Within one (1) business day from review determination

Retrospective Review	Written Approval to Provider	Within three (3) business days from review determination
	Written Denial to Provider	Within three (3) business days from review determination
	Written Denial to Beneficiary/ Parent/Representative	Within three (3) business days from review determination

H. Hearing Services Authorization

1. DOM covers hearing aids for beneficiaries eligible for EPSDT expanded services. For additional information on coverage, see Administrative Code Title 23 Medicaid. As a condition for reimbursement, DOM requires authorization for certain hearing services. Specific procedures requiring prior authorization are identified in the Hearing Fee Schedule which can be accessed at: http://www.medicaid.ms.gov/FeeScheduleLists.aspx. Failure to obtain authorization will result in denial of payment to providers billing for services. Currently, DOM's contract UM/QIO conducts authorization of hearing services. Historic information on the volume of authorizations is provided on DOM's website.

2. The Contractor shall develop, implement and maintain a UM/QIO program, which includes authorization, prior authorization and prepayment review of hearing services requests.

3. The Contractor shall have the capability and established procedures to receive authorizations, prior authorizations and prepayment review requests and supporting information via web-based submissions, facsimile, and mail from hearing services providers.

   a. The Contractor shall establish and maintain a facsimile number, toll-free in Mississippi, for the receipt of review requests for hearing services submitted by fax.

   b. The Contractor shall establish and maintain a physical mailing address, in Hinds, Rankin or Madison County, Mississippi for the receipt of review requests for hearing services submitted by mail.

   c. The Contractor shall establish and maintain a web-based system for receipt of review requests for hearing services submitted electronically. This web-based system must comply with the requirements in Section 1.6 of this RFP.

4. Regardless of the mode of receipt, the Contractor shall have established procedures and sufficient capacity to receive review request and other forms or required documentation, including itemized invoice for manually-priced procedures and other forms or documentation required for authorization, prior authorization and prepayment review of hearing services.

5. The Contractor shall determine the medical necessity of prior authorization and retrospective reviews for hearing services to eligible Mississippi Medicaid beneficiaries utilizing DOM approved criteria and policies.

   a. Prior Authorization Reviews: The Contractor shall ensure determinations for prior authorization reviews are completed 98 percent of the time within two (2) business days of receipt.

   b. Retrospective Reviews: The Contractor shall ensure determinations for retrospective reviews are completed 98 percent of the time within ten (10) business days of receipt. (DOM provides retroactive Medicaid eligibility for a beneficiary that was not eligible for Medicaid benefits at the time of service.)

6. The Contractor shall develop and maintain a web-based, electronic review request system for authorization, prior authorization and prepayment review of hearing services that allows for data input by the submitting providers. The Contractor's system shall have the capability for automated criteria/rules-based authorization system. The Contractor shall manually review each prior authorization and prepayment review request received that is not authorized by the Contractor's rules-based system, along with any required supporting documentation to support the need for hearing services.

7. The Contractor shall provide a first level review conducted by a complement of qualified staff, which must include registered nurses licensed in the state of Mississippi, to apply Federal and State laws and regulations, DOM policies and/or formal memorandums and DOM approved medical necessity criteria in order to approve hearing services based on authorization policy and criteria or refer requests that cannot be approved to a second level review. Manual pricing does not need to be conducted by a licensed health professional.

8. If request is not approved at the first level, the Contractor shall provide a second level review conducted by physicians licensed in the state of Mississippi to make review determinations for hearing services based on: 1) documentation that supports the medical necessity and appropriateness of setting; 2) consideration of unique factors associated with each patient care episode; 3) local healthcare delivery system infrastructure; and 4) clinical experience, judgment and generally accepted standards of healthcare.

    a. The Contractor shall have the capability and established procedures for verbal consultation by the physician reviewer with the hearing service provider to obtain additional information when the documentation submitted does not clearly support medical necessity.

    b. The Contractor shall ensure that authorization requests not meeting medical necessity criteria for hearing services are reviewed by a physician licensed in the state of Mississippi and of the same specialty as the case under review.

9. The Contractor shall have the capability and established procedures for and written notification to the requesting provider of a pended review and informing the provider of the information needed along with a time frame for submission three (3) business days for prior authorization and ten (10) business days for retrospective reviews.

10. The Contractor shall have the capability and established procedures for verbal and written notification to the requesting provider of a suspended review. Notification to providers of suspended reviews shall occur within one (1) business day of the past due date for information requested.

11. The Contractor shall establish and maintain a procedure for the hearing service provider and attending physician to contact the Contractor's Medical Director to discuss hearing services cases that have been denied, reduced or modified.

12. The Contractor shall notify providers and beneficiaries or legal guardians/representatives of review determinations for hearing services requests.

    a. The Contractor shall issue a written notification of approved authorization results to the hearing provider and attending physician.

    b. The Contractor shall issue a written notification of denials, modifications, or reductions to the hearing provider, attending physician, and beneficiary or, if a child, the legal guardian/representative.

c. Time frames for notification to providers and beneficiaries of review outcomes for authorization, prior authorization and prepayment review of hearing services shall not exceed the following standards:

Table 7: Notification of Review Outcomes for Hearing Services

Review Type	Contractor Action	Time Standard
Prior Authorization Review	Written Approval to Provider	Within one (1) business day from review determination
	Written Denial to Provider	Within one (1) business day from review determination
	Written Denial to Beneficiary/ Parent/Representative	Within one (1) business day from review determination
Retrospective Review	Written Approval to Provider	Within three (3) business days from review determination
	Written Denial to Provider	Within three (3) business days from review determination
	Written Denial to Beneficiary/ Parent/Representative	Within three (3) business days from review determination

I. Outpatient Physical, Occupational, and Speech Therapy Authorization

1. DOM covers outpatient physical, occupational, and speech therapy services for eligible beneficiaries. The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Administrative Code Title 23, without regard to service limitations and with prior authorization. For additional information on coverage, see Administrative Code Title 23 Medicaid. As a condition for reimbursement, DOM requires authorization for certain outpatient therapy services receive authorization. Failure to obtain authorization will result in denial of payment to providers billing for services. Currently, DOM's contracted UM/QIO conducts authorization of outpatient therapy services. Historic information on the volume of authorizations for outpatient therapy services is provided on DOM's Website.

2. The Contractor shall develop, implement, and maintain a UM/QIO program, which includes authorization, prior authorization and prepayment review of therapy services requests.

3. The Contractor shall have the capability and established procedures to receive authorizations, prior authorizations and prepayment review requests and supporting information via web-based submissions, facsimile, and mail from therapy services providers.

   a. The Contractor shall establish and maintain a telephone facsimile, toll-free in Mississippi, for the receipt of review requests for therapy services submitted by facsimile.

   b. The Contractor shall establish and maintain a physical mailing address in Hinds, Rankin or Madison County, Mississippi for the receipt of review requests for therapy services submitted by mail.

   c. The Contractor shall establish and maintain a web-based system for receipt of requests for therapy services submitted electronically. This web-based system must comply with the requirements in Section 1.6 of this RFP.

4. Regardless of the mode of receipt, the Contractor shall have established procedures and sufficient capacity to receive review requests, physician's orders, plans of care, evaluations, and other forms or documentation required for authorization, prior authorization and prepayment review of therapy services.

5. The Contractor shall determine the medical necessity of authorization, prior authorization, recertification, and retrospective reviews for therapy services to eligible Mississippi Medicaid beneficiaries utilizing Federal and State laws and regulations, DOM policies and/or formal memorandums.

    a. Prior Authorization Reviews: The Contractor shall ensure determinations for precertification reviews are completed 98 percent of the time within two (2) business days of receipt.

    b. Recertification Reviews: The Contractor shall ensure determinations for recertification reviews are completed 98 percent of the time within two (2) business days of receipt.

    c. Retrospective Reviews: The Contractor shall ensure determinations for retrospective reviews are completed 98 percent of the time within ten (10) business days of receipt. (DOM provides retroactive Medicaid eligibility for a beneficiary that was not eligible for Medicaid benefits at the time of service.)

6. The Contractor shall develop and maintain a web-based, electronic review request system for authorization, prior authorization and prepayment review of therapy services that allows for data input by the submitting providers. The Contractor's system shall have the capability for automated criteria/rules-based authorization system. The Contractor shall manually review each authorization, prior authorization and prepayment review request received that is not authorized by the Contractor's rules-based system, along with any required supporting documentation to support the need for therapy services.

7. The Contractor shall provide a first level review conducted by a complement of qualified staff, which must include registered nurses licensed in the state of Mississippi, to apply Federal and State laws and regulations, DOM policies and/or formal memorandums and DOM approved medical necessity criteria in order to approve therapy services based on authorization policy and criteria or refer requests that cannot be approved to a second level review.

8. If request is not approved at the first level, the Contractor shall provide a second level review conducted by physicians licensed in the state of Mississippi to make review determinations for therapy services based on: 1) documentation that supports the medical necessity and appropriateness of setting; 2) consideration of unique factors associated with each patient care episode; 3) local healthcare delivery system infrastructure; and 4) clinical experience, judgment, and generally accepted standards of healthcare.

    a. The Contractor shall have the capability and established procedures for verbal consultation by the physician reviewer with the therapy service provider to obtain additional information when the documentation submitted does not clearly support medical necessity.

    b. The Contractor shall ensure that first and second level reviews have access to physical therapists, occupational therapists, and speech and language pathologists, for authorization requests not meeting medical necessity criteria.

9. The Contractor shall have the capability and established procedures for verbal and written notification to the requesting provider of a pended review and informing the provider of the information needed along with a time

frame for submission that shall not exceed three (3) business days for admission/precertification and ten (10) business days for retrospective reviews.

10. The Contractor shall have the capability and established procedures for verbal and written notification to the requesting provider of a suspended review. Notification to providers of suspended reviews shall occur within one (1) business day of the past due date for information requested.

11. The Contractor shall establish and maintain a procedure for the therapy service provider and the attending physician to contact the Contractor's Medical Director to discuss therapy services cases that have been denied, reduced or modified.

12. The Contractor shall notify providers and beneficiaries or legal guardians/representatives of review determinations for therapy requests.

    a. The Contractor shall issue a written notification of approved certification results to the therapy provider and the attending physician.

    b. The Contractor shall issue a written notification of denials, modifications, or reductions to the therapy provider, attending physician, and beneficiary or, if a child, the legal guardian/representative.

    c. Time frames for notification to providers and beneficiaries of review outcomes for prior authorization and prepayment review of therapy shall not exceed the following standards:

Table 8: Notification of Review Outcomes for Physical, Occupational, and Speech Therapy

Review Type	Contractor Action	Time Standard
Prior Authorization Review Recertification Review	Written Approval to Provider	Within one (1) business day from review determination
	Written Denial to Provider	Within one (1) business day from review determination
	Written Denial to Beneficiary/ Parent/Representative	Within one (1) business day from review determination
Retrospective Review	Written Approval to Provider	Within three (3) business days from review determination
	Written Denial to Provider	Within three (3) business days from review determination
	Written Denial to Beneficiary/ Parent/Representative	Within three (3) business days from review determination

J. Expanded Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Benefits Authorization

1. DOM covers any medically necessary Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) diagnostic and treatment services required to correct or ameliorate physical, mental, psychosocial, and/or behavioral health conditions discovered by a screening, whether or not such services are covered under any Medicaid Administrative Rule or the State Plan for EPSDT-eligible beneficiaries and, if required, prior

authorized by the UM/QIO. As a condition for reimbursement, DOM requires authorization for expanded EPSDT service. Failure to obtain authorization will result in denial of payment to all providers billing for services. Currently, DOM's UM/QIO conducts authorization of reviews of expanded EPSDT benefits.

2. The Contractor shall develop, implement, and maintain a UM/QIO program, which includes authorization, prior authorization and prepayment review of expanded EPSDT benefits.

3. The Contractor shall have the capability and established procedures to receive authorizations, prior authorizations and prepayment review requests and supporting information via web-based submissions, facsimile, and mail from attending physicians.

    a. The Contractor shall establish and maintain a dedicated facsimile number, toll-free in Mississippi, for the receipt of review requests for expanded EPSDT benefits submitted by facsimile.

    b. The Contractor shall establish and maintain a physical mailing address in Hinds, Rankin or Madison County, Mississippi for the receipt of review requests for expanded EPSDT benefits submitted by mail.

    c. The Contractor shall establish and maintain a web-based system for receipt of review requests for expanded EPSDT benefits submitted electronically. This web-based system must comply with the requirements in Section 1.6 of this RFP.

4. Regardless of the mode of receipt, the Contractor shall have established procedures and sufficient capacity to receive review request, supporting clinical documentation, and other forms or documentation required for authorization, prior authorization and prepayment review of expanded EPSDT benefits.

5. The Contractor shall determine the medical necessity of authorizations, prior authorizations and retrospective reviews utilizing Federal and State laws and regulations, DOM policies and/or formal memorandums for expanded EPSDT benefits to eligible Mississippi Medicaid beneficiaries.

    a. Prior Authorization Reviews: The Contractor shall ensure determinations for prior authorization reviews are completed 98 percent of the time within two (2) business days of receipt.

    b. Retrospective Reviews: The Contractor shall ensure determinations for retrospective reviews are completed 98 percent of the time within ten (10) business days of receipt. (DOM provides retroactive Medicaid eligibility for a beneficiary that was not eligible for Medicaid benefits at the time of service.)

6. The Contractor shall develop and maintain a web-based, electronic review request system for authorization, prior authorization and prepayment review of expanded EPSDT benefits that allows for data input by the submitting providers. The Contractor's system shall have the capability for automated criteria/rules-based authorization system. The Contractor shall manually review each authorization, prior authorization and prepayment review request received that is not authorized by the Contractor's rules-based system, along with any required supporting documentation to support the need for expanded EPSDT benefits.

7. The Contractor shall provide a first level review conducted by a complement of qualified staff, which must include registered nurses licensed in the state of Mississippi, to apply Federal and State laws and regulations, DOM policies and/or formal memorandums and DOM approved medical necessity criteria in order to approve expanded EPSDT benefits based on authorization policy and criteria or refer requests that cannot be approved to a second level review.

8. If request is not approved at the first level, the Contractor shall provide a second level review conducted by physicians licensed in the state of Mississippi to make review determinations for expanded EPSDT benefits based on: 1) documentation that supports the medical necessity and appropriateness of setting; 2) consideration of unique factors associated with each patient care episode; 3) local healthcare delivery system infrastructure; and 4) clinical experience, judgment, and generally accepted standards of healthcare.

    a. The Contractor shall have the capability and established procedures for verbal consultation by the physician reviewer with the attending physician to obtain additional information when the documentation submitted does not clearly support medical necessity.

    b. The Contractor shall ensure that authorization requests not meeting medical necessity criteria for expanded EPSDT benefits are reviewed by a physician of the same specialty as the case under review.

9. The Contractor shall have the capability and established procedures for written notification to the requesting provider of a pended review and informing the provider of the information needed along with a time frame for submission shall not exceed three (3) business days for prior authorization and ten (10) business days for retrospective reviews.

10. The Contractor shall have the capability and established procedures for written notification to the requesting provider of a suspended review. Notification to providers of suspended reviews shall occur within one (1) business day of the past due date for information

11. The Contractor shall establish and maintain a procedure for the attending physician to contact the Contractor's Medical Director to discuss expanded EPSDT benefits cases that have been denied, reduced or modified.

12. The Contractor shall notify providers and beneficiaries or legal guardians/representatives of review determinations for expanded EPSDT benefits requests.

    a. The Contractor shall issue a written notification of approved authorization results to the attending physician.

    b. The Contractor shall issue a written notification of denials, modifications, or reductions to the attending physician and beneficiary or, if a child, the legal guardian/representative.

    c. Time frames for notification to providers and beneficiaries of review outcomes for authorization, prior authorization and prepayment review of expanded EPSDT benefits shall not exceed the following standards:

Table 9: Notification of Review Outcomes for expanded EPSDT benefits

Review Type	Contractor Action	Time Standard
Prior Authorization Review	Written Approval to Provider	Within one (1) business day from review determination
	Written Denial to Provider	Within one (1) business day from review determination
	Written Denial to Beneficiary/ Parent/Representative	Within one (1) business day from review determination
Retrospective	Written Approval to Provider	Within three (3) business days from review

Review		determination
	Written Denial to Provider	Within three (3) business days from review determination
	Written Denial to Beneficiary/ Parent/Representative	Within three (3) business days from review determination

K. Expanded Physician Services/Office Visits Authorization

1. DOM covers a total of twelve (12) physician office visits per state fiscal year as a State Plan benefit. DOM covers any medically necessary Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) diagnostic and treatment services required to correct or ameliorate physical, mental, psychosocial, and/or behavioral health conditions discovered by a screening, whether or not such services are covered under any Medicaid Administrative Rule or the State Plan for EPSDT-eligible beneficiaries and, if required, prior authorized by the UM/QIO. As a condition for reimbursement, DOM requires authorization for office visits that exceed service limits. Failure to obtain authorization will result in denial of payment to all providers billing for services. Currently, DOM's UM/QIO conducts authorization of reviews of expanded physician/office visit services.

2. The Contractor shall develop, implement, and maintain a UM/QIO program, which includes authorization, prior authorization and prepayment review of expanded physician services requests.

3. The Contractor shall have the capability and established procedures to receive authorizations, prior authorizations and prepayment review requests and supporting information via web-based submissions, facsimile, and mail from attending physicians.

    a. The Contractor shall establish and maintain a dedicated facsimile number, toll-free in Mississippi, for the receipt of review requests for expanded physician visits submitted by facsimile.

    b. The Contractor shall establish and maintain a physical mailing address in Hinds, Rankin or Madison County, Mississippi for the receipt of review requests for expanded physician visits submitted by mail.

    c. The Contractor shall establish and maintain a web-based system for receipt of review requests for expanded physician visits submitted electronically. This web-based system must comply with the requirements in Section 1.6 of this RFP.

4. Regardless of the mode of receipt, the Contractor shall have established procedures and sufficient capacity to receive review request, supporting clinical documentation, and other forms or documentation required for authorization, prior authorization and prepayment review of expanded physician services.

5. The Contractor shall determine the medical necessity of authorizations, prior authorizations and retrospective reviews utilizing DOM approved criteria and policies for extended physician visits to eligible Mississippi Medicaid beneficiaries who are children from birth to 21 years of age.

    a. Prior Authorization Reviews: The Contractor shall ensure determinations for prior authorization reviews are completed 98 percent of the time within two (2) business days of receipt.

    b. Retrospective Reviews: The Contractor shall ensure determinations for retrospective reviews are completed 98 percent of the time within ten (10) business days of receipt. (DOM provides retroactive Medicaid eligibility for a beneficiary that was not eligible for Medicaid benefits at the time of service.)

6. The Contractor shall develop and maintain a web-based, electronic review request system for authorization, prior authorization and prepayment review of expanded physician services that allows for data input by the submitting providers. The Contractor's system shall have the capability for automated criteria/rules-based authorization system. The Contractor shall manually review each authorization, prior authorization and prepayment review request received that is not authorized by the Contractor's rules-based system, along with any required supporting documentation to support the need for expanded physician visits.

7. The Contractor shall provide a first level review conducted by a complement of qualified staff, which must include registered nurses licensed in the state of Mississippi, to apply Federal and State laws and regulations, DOM policies and/or formal memorandums and DOM approved medical necessity criteria in order to approve expanded physician visits based on authorization policy and criteria or refer requests that cannot be approved to a second level review.

8. If request is not approved at the first level, the Contractor shall provide a second level review conducted by physicians licensed in the state of Mississippi to make review determinations for expanded physician services based on: 1) documentation that supports the medical necessity and appropriateness of setting; 2) consideration of unique factors associated with each patient care episode; 3) local healthcare delivery system infrastructure; and 4) clinical experience, judgment, and generally accepted standards of healthcare.

    a. The Contractor shall have the capability and established procedures for verbal consultation by the physician reviewer with the attending physician to obtain additional information when the documentation submitted does not clearly support medical necessity.

    b. The Contractor shall ensure that authorization requests not meeting medical necessity criteria for expanded physician visits are reviewed by a physician of the same specialty as the case under review.

9. The Contractor shall have the capability and established procedures for written notification to the requesting provider of a pended review and informing the provider of the information needed along with a time frame for submission shall not exceed three (3) business days for prior authorization and ten (10) business days for retrospective reviews.

10. The Contractor shall have the capability and established procedures for written notification to the requesting provider of a suspended review. Notification to providers of suspended reviews shall occur within one (1) business day of the past due date for information

11. The Contractor shall establish and maintain a procedure for the attending physician to contact the Contractor's Medical Director to discuss expanded physician services cases that have been denied, reduced or modified.

12. The Contractor shall notify providers and beneficiaries or legal guardians/representatives of review determinations for expanded physician visits requests.

    a. The Contractor shall issue a written notification of approved authorization results to the attending physician.

    b. The Contractor shall issue a written notification of denials, modifications, or reductions to the attending physician and beneficiary or, if a child, the legal guardian/representative.

c. Time frames for notification to providers and beneficiaries of review outcomes for authorization, prior authorization and prepayment review of expanded physician visits shall not exceed the following standards:

Table 10: Notification of Review Outcomes for Expanded Physician Services/Office Visits

Review Type	Contractor Action	Time Standard
Prior Authorization Review	Written Approval to Provider	Within one (1) business day from review determination
	Written Denial to Provider	Within one (1) business day from review determination
	Written Denial to Beneficiary/ Parent/Representative	Within one (1) business day from review determination
Retrospective Review	Written Approval to Provider	Within three (3) business days from review determination
	Written Denial to Provider	Within three (3) business days from review determination
	Written Denial to Beneficiary/ Parent/Representative	Within three (3) business days from review determination

L. Expanded Home Health Services Authorization

1. DOM covers home health services for beneficiaries, limited to a combined total of twenty-five (25) visits per state fiscal year. Home health services must be provided to a beneficiary at the beneficiary's place of residence defined as any setting in which normal life activities take place, other than: a hospital, Nursing facility, Intermediate care facility for individuals with intellectual disabilities except when the facility is not required to provide the home health service; or Any setting in which payment is or could be made under Medicaid for inpatient services that include room and board. Home health services must be provided in accordance with the beneficiary's physician's orders as part of a written plan of care, which must be reviewed every sixty (60) days. The beneficiary's attending physician, must document that a face-to-face encounter occurred no more than ninety (90) days before or thirty (30) days after the start of home health services. The face-to-face encounter must be related to the primary reason the beneficiary requires the home health service. The home health agency providing home health services must be certified to participate as a home health agency under Title XVIII (Medicare) of the Social Security Act, and comply with all applicable state and federal laws and requirements. DOM covers any medically necessary Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) diagnostic and treatment services required to correct or ameliorate physical, mental, psychosocial, and/or behavioral health conditions discovered by a screening, whether or not such services are covered under any Medicaid Administrative Rule or the State Plan for EPSDT eligible beneficiaries and, if required, prior authorized by the UM/QIO. For additional information on coverage, see Administrative Code Title 23 Medicaid. As a condition for reimbursement, DOM requires that all home health services receive authorization for EPSDT eligible beneficiaries for home health services beyond the 25th visit per fiscal year. Failure to obtain the authorization will result in denial of payment to home health providers billing for services. Currently, DOM's contract UM/QIO conducts authorization of home health services. Historic information on the volume of authorizations for home health services is provided on DOM's Website.

2. The Contractor shall develop, implement, and maintain a UM/QIO program, which includes authorization, prior authorization and prepayment review of expanded home health services requests.

3. The Contractor shall have the capability and established procedures that allow for receipt of authorizations, prior authorizations and prepayment review requests and supporting information via web-based submissions, facsimile, and mail, from home health agencies (HHAs).

    a. The Contractor shall establish and maintain a facsimile number, toll-free in Mississippi, for the receipt of review requests for expanded home health services submitted by facsimile.

    b. The Contractor shall establish and maintain a physical mailing address in Hinds, Rankin or Madison County, Mississippi for the receipt of review requests for expanded home health services submitted by mail.

    c. The Contractor shall establish and maintain a web-based system for receipt of review requests for expanded home health services submitted electronically. This web-based system must comply with the requirements in Section 1.6 of this RFP.

4. Regardless of the mode of receipt, the Contractor shall have established procedures and sufficient capacity to receive review requests, physician's orders, plans of care, assessments, and other forms or documentation required for authorization, prior authorization and prepayment review of expanded home health services.

5. The Contractor shall have the capability and established procedures for determining the medical necessity of prior authorization, concurrent stay, and retrospective reviews utilizing DOM approved criteria and policies for expanded home health services to eligible EPSDT beneficiaries.

    a. Prior Authorization Reviews: The Contractor shall have the capability and established procedures to ensure determinations for prior authorization reviews are completed 98 percent of the time within two (2) business days of receipt.

    b. Continued Stay Reviews: The Contractor shall have the capability and established procedures to ensure determinations for continued stay reviews are completed 98 percent of the time within two (2) business days of receipt.

    c. Retrospective Reviews: The Contractor shall have the capability and established procedures to ensure determinations for retrospective reviews are completed 98 percent of the time within ten (10) business days of receipt. (DOM provides retroactive Medicaid eligibility for a beneficiary that was not eligible for Medicaid benefits at the time of service.)

6. The Contractor shall develop and maintain a web-based, electronic review request system for prior authorization and prepayment review of expanded home health services that allows for data input by the submitting providers. The Contractor's system shall have the capability for automated criteria/rules-based authorization system. The Contractor shall manually review each authorization, prior authorization and prepayment review request received that is not authorized by the Contractor's rules-based system, along with any required supporting documentation to support the need for expanded home health services.

7. The Contractor shall have the capability and established procedures that allow for a first level review conducted by a complement of qualified staff, which must include registered nurses licensed in the state of Mississippi, to apply Federal and State laws and regulations, DOM policies and/or formal memorandums and DOM approved medical necessity criteria in order to approve expanded home health services based on authorization policy and criteria or refer requests that cannot be approved to a second level review.

8. The Contractor shall have the capability and established procedures that allow for a second level review conducted by physicians licensed in the state of Mississippi to make review determinations for expanded home health services based on: 1) documentation that supports the medical necessity and appropriateness of setting; 2) consideration of unique factors associated with each patient care episode; 3) local healthcare delivery system infrastructure; and 4) clinical experience, judgment, and generally accepted standards of healthcare.

    a. The Contractor shall have the capability and established procedures for verbal consultation by the physician reviewer with the HHA and attending physician to obtain additional information when the documentation submitted does not clearly support medical necessity.

    b. The Contractor shall ensure that authorization requests not meeting medical necessity criteria for expanded physician visits are reviewed by a physician of the same specialty as the case under review.

9. The Contractor shall have the capability and established procedures for written notification to the requesting provider of a pended review and informing the provider of the information needed along with a time frame for submission shall not exceed three (3) business days for prior authorization and ten (10) business days for retrospective reviews.

10. The Contractor shall have the capability and established procedures for written notification to the requesting provider of a suspended review. Notification to providers of suspended reviews shall occur within one (1) business day of the past due date for information requested.

11. The Contractor shall establish and maintain a procedure for the HHA and attending physician to contact the Contractor's Medical Director to discuss expanded home health services cases.

12. The Contractor shall have the capability and established procedures for notification to providers and beneficiaries or legal guardians/representatives of review determinations for expanded home health services requests.

    a. The Contractor shall have the capability and established procedures for issuing a written notification of approved authorization results to the HHA and attending physician.

    b. The Contractor shall have the capability and established procedures for issuing a written notification of denials, modifications, or reductions to the HHA, attending physician, and beneficiary or, if a child, the legal guardian/representative.

    c. Time frames for notification to providers and beneficiaries of review outcomes for authorization, prior authorization and prepayment review of home health services shall not exceed one (1) business day from review determination for prior authorization and three (3) business days from review determination for retrospective reviews.

M. Private Duty Nursing Services Authorization

1. DOM covers Private Duty Nursing (PDN) services through the EPSDT expanded Program for EPSDT eligible beneficiaries who require more individual and continuous care than is available under the home health benefit. As a condition for reimbursement, DOM requires that all PDN services receive authorization. Failure to obtain authorization will result in denial of payment to providers billing for services. Currently, DOM's contract

UM/QIO conducts authorization of PDN services. Historic information on the volume of authorizations for PDN services is provided on DOM's Website.

2. The Contractor shall develop, implement, and maintain a UM/QIO program, which includes authorization, prior authorization and prepayment review of PDN service requests.

3. The Contractor shall have the capability and established procedures to receive authorizations, prior authorizations and prepayment review requests and supporting information via web-based submissions, facsimile and mail from PDN agencies.

   a. The Contractor shall establish and maintain a facsimile number, toll-free in Mississippi, for the receipt of review requests for PDN services submitted by facsimile.

   b. The Contractor shall establish and maintain a physical mailing in Hinds, Rankin or Madison County, Mississippi for the receipt of review requests for PDN services submitted by mail.

   c. The Contractor shall establish and maintain a web-based system for receipt of requests for PDN services submitted electronically. This web-based system must comply with the requirements in Section 1.6 of this RFP.

4. Regardless of the mode of receipt, the Contractor shall have established procedures and sufficient capacity to receive review requests, physician's orders, plans of care, assessments, and other forms or documentation required for authorization, prior authorization and prepayment review of PDN services.

5. The Contractor shall determine the medical necessity of prior authorization, concurrent stay, and retrospective reviews utilizing DOM approved criteria and policies for PDN services to eligible EPSDT beneficiaries.

   a. Prior Authorization Reviews: The Contractor shall ensure determinations for prior authorization reviews are completed 98 percent of the time within ten (10) business days of receipt.

   b. Continued Stay Reviews: The Contractor shall ensure determinations for continued stay reviews are completed 98 percent of the time within ten (10) business days of receipt.

   c. Retrospective Reviews: The Contractor shall ensure determinations for retrospective reviews are completed 98 percent of the time within ten (10) business days of receipt. (DOM provides retroactive Medicaid eligibility for a beneficiary that was not eligible for Medicaid benefits at the time of service.)

6. The Contractor may develop and maintain a web-based, electronic review request system for authorization, prior authorization and prepayment review of PDN services that allows for data input by the submitting providers. The Contractor's system may have the capability for automated criteria/rules-based authorization system. The Contractor shall manually review each authorization, prior authorization and prepayment review request not authorized by the Contractor's rules-based system for PDN services.

7. The Contractor shall provide a first level review conducted by a complement of qualified staff, which must include registered nurses licensed in the state of Mississippi, to apply Federal and State laws and regulations, DOM policies and/or formal memorandums and DOM approved medical necessity criteria in order to approve PDN services based on authorization policy and criteria or refer requests that cannot be approved to a second level review.

8. If request is not approved at the first level, the Contractor shall provide a second level review conducted by physicians licensed in the state of Mississippi to make review determinations for PDN services based on: 1) documentation that supports the medical necessity and appropriateness of setting; 2) consideration of unique factors associated with each patient care episode; 3) local healthcare delivery system infrastructure; and 4) clinical experience, judgment, and generally accepted standards of healthcare.

    a. The Contractor shall have the capability and established procedures for verbal consultation by the physician reviewer with the PDN agency to obtain additional information when the documentation submitted does not clearly support medical necessity.

    b. The Contractor shall ensure that authorization requests not meeting medical necessity criteria for PDN services are reviewed by a physician licensed in the state of Mississippi and of the same specialty as the case under review.

9. The Contractor shall have the capability and established procedures for verbal and written notification to the requesting provider of a pended review and informing the provider of the information needed along with a time frame for submission shall not exceed three (3) business days.

10. The Contractor shall have the capability and established procedures for verbal and written notification to the requesting provider of a suspended review. Notification to providers of suspended reviews shall occur within one (1) business day of the past due date for information requested.

11. The Contractor shall establish and maintain a procedure for the PDN agency and attending physician to contact the Contractor's Medical Director to discuss PDN services cases that have been denied, reduced or modified.

12. The Contractor shall notify providers and beneficiaries or legal guardians/representatives of review determinations for PDN services requests.

    a. The Contractor shall issue a written notification of approved authorization results to the PDN agency and attending physician.

    b. The Contractor shall issue a written notification of denials, modifications, or reductions to the PDN agency, attending physician, and beneficiary or, if a child, the legal guardian/representative.

    c. Time frames for notification to providers and beneficiaries of review outcomes for authorization review of PDN Services shall not exceed one (1) business day from review determination.

N. Prescribed Pediatric Extended Care Services Authorization

1. DOM covers Prescribed Pediatric Extended Care (PPEC) services through the EPSDT expanded Program for EPSDT eligible beneficiaries who require more individual and continuous care than is available under the home health benefit. As a condition for reimbursement, DOM requires that all PPEC services receive authorization. Failure to obtain authorization will result in denial of payment to providers billing for services. Currently, DOM's contract UM/QIO conducts authorization of PPEC services. Historic information on the volume of authorizations for PPEC services is provided on DOM's Website.

2. The Contractor shall develop, implement, and maintain a UM/QIO program, which includes authorization, prior authorization and prepayment review of PPEC service requests.

3. The Contractor shall have the capability and established procedures to receive authorizations, prior authorizations and prepayment review requests and supporting information via web-based submissions, facsimile and mail from PPEC agencies.

    a. The Contractor shall establish and maintain a facsimile number, toll-free in Mississippi, for the receipt of review requests for PPEC services submitted by facsimile.

    b. The Contractor shall establish and maintain a physical mailing in Hinds, Rankin or Madison County, Mississippi for the receipt of review requests for PPEC services submitted by mail.

    c. The Contractor shall establish and maintain a web-based system for receipt of requests for PPEC services submitted electronically. This web-based system must comply with the requirements in Section 1.6 of this RFP.

4. Regardless of the mode of receipt, the Contractor shall have established procedures and sufficient capacity to receive review requests, physician's orders, plans of care, assessments, and other forms or documentation required for authorization, prior authorization and prepayment review of PPEC services.

5. The Contractor shall determine the medical necessity of prior authorization, concurrent stay, and retrospective reviews utilizing DOM approved criteria and policies for PPEC services to eligible EPSDT beneficiaries.

    a. Prior Authorization Reviews: The Contractor shall ensure determinations for prior authorization reviews are completed 98 percent of the time within ten (10) business days of receipt.

    b. Continued Stay Reviews: The Contractor shall ensure determinations for continued stay reviews are completed 98 percent of the time within ten (10) business days of receipt.

    c. Retrospective Reviews: The Contractor shall ensure determinations for retrospective reviews are completed 98 percent of the time within ten (10) business days of receipt. (DOM provides retroactive Medicaid eligibility for a beneficiary that was not eligible for Medicaid benefits at the time of service.)

6. The Contractor may develop and maintain a web-based, electronic review request system for authorization, prior authorization and prepayment review of PPEC services that allows for data input by the submitting providers. The Contractor's system may have the capability for automated criteria/rules-based authorization system. The Contractor shall manually review each authorization, prior authorization and prepayment review request not authorized by the Contractor's rules-based system for PPEC services.

7. The Contractor shall provide a first level review conducted by a complement of qualified staff, which must include registered nurses licensed in the state of Mississippi, to apply Federal and State laws and regulations, DOM policies and/or formal memorandums and DOM approved medical necessity criteria in order to approve PPEC services based on authorization policy and criteria or refer requests that cannot be approved to a second level review.

8. If request is not approved at the first level, the Contractor shall provide a second level review conducted by physicians licensed in the state of Mississippi to make review determinations for PPEC services based on: 1) documentation that supports the medical necessity and appropriateness of setting; 2) consideration of unique factors associated with each patient care episode; 3) local healthcare delivery system infrastructure; and 4) clinical experience, judgment, and generally accepted standards of healthcare.

a. The Contractor shall have the capability and established procedures for verbal consultation by the physician reviewer with the PPEC agency to obtain additional information when the documentation submitted does not clearly support medical necessity.

b. The Contractor shall ensure that authorization requests not meeting medical necessity criteria for PPEC services are reviewed by a physician licensed in the state of Mississippi and of the same specialty as the case under review.

9. The Contractor shall have the capability and established procedures for verbal and written notification to the requesting provider of a pended review and informing the provider of the information needed along with a time frame for submission shall not exceed three (3) business days.

10. The Contractor shall have the capability and established procedures for verbal and written notification to the requesting provider of a suspended review. Notification to providers of suspended reviews shall occur within one (1) business day of the past due date for information requested.

11. The Contractor shall establish and maintain a procedure for the PPEC agency and attending physician to contact the Contractor's Medical Director to discuss PPEC services cases that have been denied, reduced or modified.

12. The Contractor shall notify providers and beneficiaries or legal guardians/representatives of review determinations for PPEC services requests.

a. The Contractor shall issue a written notification of approved authorization results to the PPEC agency and attending physician.

b. The Contractor shall issue a written notification of denials, modifications, or reductions to the PPEC agency, attending physician, and beneficiary or, if a child, the legal guardian/representative.

c. Time frames for notification to providers and beneficiaries of review outcomes for authorization review of PPEC Services shall not exceed one (1) business day from review determination.

O. Disabled Child Living at Home (DCLH) or "Katie Beckett" group Level of Care Determinations

1. DOM provides Medicaid benefits to children, age eighteen (18) or under, living at-home who qualify as disabled individuals using Social Security disability rules and provided certain conditions are met. These children would not be otherwise eligible for Medicaid due to deeming of parental income or resources. The specific statutory provisions establishing this option are contained in Section 1902(e) of the Social Security Act. State enabling legislation established authority for coverage of Disabled Children Living At-Home (DCLH) effective July 1, 1989. This program is in compliance with federal regulations: 42 C.F.R. §§ 435.225, 409.31-409.34, 440.10, 440.150, and 483.440.

2. The Contractor shall make Level of Care (LOC) determinations for eligibility in the DCLH category of eligibility.

3. The Contractor shall have established procedures and sufficient capacity to receive requests from Medicaid Regional Eligibility Offices via web-based submissions; and supporting clinical documentation, and other

forms or documentation required for LOC determinations for eligibility in the DCLH category of eligibility from physicians and others via web-based submissions, facsimile, and mail.

4. The Contractor shall determine the institutional LOC utilizing DOM approved criteria and policies for the DCLH category of eligibility. The Contractor shall ensure determinations for level of care decisions are completed 98 percent of the time within twenty (20) calendar days of receipt.

    a. Hospital LOC: Is appropriate for children who require continuous skilled care by licensed professionals 24 hours per day with risk of rapid deterioration in health status, continued need for use of medical technology, complex medical equipment or invasive techniques to sustain life, etc.

    b. ICF/IID LOC: Is appropriate for individuals who require continuous active treatment program, direct assistance from a professional for special rehabilitative or developmental intervention for conditions that significantly interfere with mental age appropriate activities, requires assistance and presence of another person for performance of at least three activities of daily living that are not appropriate for the child's age, daily skilled nursing services by licensed professional including direct observation, management, frequent monitoring and documentation of condition, evaluation by a clinical psychologist or physician who has determined that the child is intellectually/developmentally disabled.

    c. Nursing Facility LOC: Is appropriate for children who require daily skilled nursing services by a licensed professional including direct observation, management, frequent monitoring and documentation of condition, requires assistance and presence of another person for performance of at least three activities of daily living that are not appropriate for the child's age, and regularly scheduled skilled therapy services not less than once a week.

5. The Contractor shall provide a first level review conducted by a complement of qualified staff, which must include registered nurses licensed in the state of Mississippi, to apply Federal and State laws and regulations, DOM policies and/or formal memorandums and DOM approved institutional LOC criteria in order to approve LOC determinations for eligibility in the DCLH category of eligibility or refer requests that cannot be approved to a second level review. Face to face assessment will be required before denial of a request within thresholds established by DOM.

6. The Contractor shall provide a second level review conducted by physician licensed in the state of Mississippi and of the same specialty as the provider requesting the service to make review determinations for LOC determinations for eligibility in the DCLH category of eligibility. Only a physician may deny the LOC for eligibility in the DCLH category of eligibility.

7. The Contractor shall establish and maintain a procedure for providers to contact the Contractor's Medical Director to discuss LOC determinations for the DCLH category of eligibility that have been denied.

8. The Contractor shall notify providers and beneficiaries or legal guardians/representatives of review determinations for LOC determinations for eligibility in the DCLH category of eligibility.

P. Long-Term Care Clinical Eligibility Determinations

1. The Contractor shall make Level of Care (LOC) determinations for Long Term Care (LTC) applicants referred by DOM.

2. The Contractor shall have established procedures and sufficient capacity to receive requests and supporting clinical documentation for LOC determinations of LTC applicants from DOM.

3. The Contractor shall determine LOC of LTC applicants utilizing Federal and State laws and regulations, DOM policies and/or formal memorandums.

4. The Contractor shall ensure determinations for level of care decisions are completed 98 percent of the time within two (2) business days of requests from DOM.

5. The Contractor shall provide physician review and clinical determination for level of care determinations of LTC applicants.

6. The Contractor shall establish and maintain a procedure for DOM to contact the Contractor's Medical Director to discuss LOC determinations for LTC applicants that have been denied.

7. The Contractor shall notify DOM of review determinations for LOC determinations for LTC applicants.

Q. Physician Administered Drugs (PAD) Authorization and Implantable Drug System Devices

1. DOM covers medically necessary physician-administered drugs and implantable drug system devices as defined in DOM's Administrative Code. Physician administered drugs and implantable drug system devices, requiring authorization, are identified in the downloadable fee schedule at https://medicaid.ms.gov/providers/fee-schedules-and-rates/#. Failure to obtain authorization will result in denial of payment to providers billing for PADs that require authorization. Currently, DOM's UM/QIO contractor does not provide authorization of PAD and implantable drug system devices, historical information is not available.

2. The Contractor shall develop, implement, and maintain a UM/QIO program, which includes authorization, prior authorization and prepayment review of PAD and implantable drug system devices.

3. The Contractor shall have the capability and established procedures to receive authorizations, prior authorizations and prepayment review requests and supporting information via web-based submissions, facsimile and mail submissions for PAD and implantable drug system devices.

4. Regardless of the mode of receipt, the Contractor shall have established procedures and sufficient capacity to receive review requests, physician's orders, plans of care, and other forms or documentation, including itemized invoices for manually-priced procedures required for prior authorization and prepayment review of PAD and implantable drug system devices. Review must include validation and verification that the submitted HCPCS PAD may be billed with the corresponding NDC utilizing valid, updated HCPCS to NDC crosswalk. The crosswalk must be maintained at a minimum no less than once per month to ensure accuracy of prior authorizations submitted and proper claims adjudication

5. The Contractor shall determine the medical necessity of authorizations, prior authorizations and retrospective reviews for PAD and implantable drug system devices to eligible Mississippi Medicaid beneficiaries utilizing DOM approved criteria and policies.

a. Prior Authorization Reviews: The Contractor shall ensure determinations for prior authorization reviews are completed 98 percent of the time within two (2) business days of receipt.

b. Retrospective Reviews: The Contractor shall ensure determinations for retrospective reviews are completed 98 percent of the time within ten (10) business days of receipt. (DOM provides retroactive Medicaid eligibility for a beneficiary that was not eligible for Medicaid benefits at the time of service.)

6. The Contractor shell develop and maintain a web-based, electronic review request system for authorization, prior authorization and prepayment review of PAD and implantable drug system devices that allows for data input by the submitting providers. The Contractor's system may have the capability for automated criteria/rules-based authorization system. The Contractor shall manually review each authorization, prior authorization and prepayment review request not authorized by the Contractor's rules-based system for PAD and implantable drug system devices.

7. The Contractor shall provide a first level review conducted by qualified staff, which must include registered nurses licensed in the state of Mississippi, and/or pharmacists, to apply Federal and State laws and regulations, DOM policies and/or formal memorandums and DOM approved medical necessity criteria in order to approve PAD and implantable drug system devices based on certification policy and criteria or refers requests that cannot be approved to a second level review. Manual pricing does not need to be conducted by a licensed health professional. The first level of review must also include validation and verification that the submitted HCPCS PAD may be billed with the corresponding NDC utilizing valid, updated HCPCS to NDC crosswalk.

8. If request is not approved at the first level, the Contractor shall provide a second level review conducted by physicians licensed in the state of Mississippi to make review determinations for PAD and implantable drug system devices based on: 1) documentation that supports the medical necessity and appropriateness of setting; 2) consideration of unique factors associated with each patient care episode; 3) local healthcare delivery system infrastructure; and 4) clinical experience, judgment, and generally accepted standards of healthcare.

   a. The Contractor shall have the capability and established procedures for verbal consultation by the physician reviewer with the requesting provider to obtain additional information when the documentation submitted does not clearly support medical necessity.

   b. The Contractor shall ensure that authorization requests not meeting medical necessity criteria for PAD services are reviewed by a physician licensed in the state of Mississippi and of the same specialty as the case under review.

9. The Contractor shall have the capability and established procedures for verbal and written notification to the requesting provider of a pended review and informing the provider of the information needed along with a time frame for submission that shall not exceed three (3) business days for precertification and ten (10) business days for retrospective reviews.

10. The Contractor shall have the capability and established procedures for verbal and written notification to the requesting provider of a suspended review. Notification to providers of suspended reviews shall occur within one (1) business day of the past due date for information requested.

11. The Contractor shall establish and maintain a procedure for the requesting provider, and the attending physician to contact the Contractor's Medical Director to discuss PAD and implantable drug system device cases that have been denied, reduced or modified.

12. The Contractor shall notify providers and beneficiaries or legal guardians/representatives of review determinations for PAD and implantable drug system devices requests.

    a. The Contractor shall issue a written notification of approved authorization results to the PAD and implantable drug system devices requesting provider.

    b. The Contractor shall issue a written notification of denials, modifications, or reductions to the PAD and implantable drug system devices provider, the requesting provider, and beneficiary or, if a child, the legal guardian/representative.

    c. Time frames for notification to providers and beneficiaries of review outcomes for prior authorization and prepayment review of PAD and implantable drug system devices shall not exceed the following standards:

Table 11: Notification of Review Outcomes for Physician Administered Drugs

Review Type	Contractor Action	Time Standard
Prior Authorization Review	Written Approval to Provider	Within one (1) business day from review determination
	Written Denial to Provider	Within one (1) business day from review determination
	Written Denial to Beneficiary/ Parent/Representative	Within one (1) business day from review determination
Retrospective Review	Written Approval to Provider	Within three (3) business days from review determination
	Written Denial to Provider	Within three (3) business days from review determination
	Written Denial to Beneficiary/ Parent/Representative	Within three (3) business days from review determination

R. Molecular (Genetic) Testing

1. DOM covers molecular testing for eligible beneficiaries when medically necessary to establish a diagnosis of an inheritable disease(s). For comprehensive information about molecular testing, see Mississippi Administrative Code, Title 23. Specific information concerning which molecular tests requires prior authorization can be found on DOM's fee schedule, accessed at https://medicaid.ms.gov/providers/fee-schedules-and-rates/#. As a condition for reimbursement, DOM requires that all molecular testing receive authorization. Failure to obtain the authorization will result in denial of payment to all providers billing for services. Currently, DOM's contract UM/QIO conducts authorization of molecular testing. Historic information on the volume of authorizations is provided on DOM's website.

2. The Contractor shall develop, implement, and maintain a UM/QIO program, which includes authorization, prior authorization and prepayment review of molecular testing.

3. The Contractor shall have the capability and established procedures to receive authorizations, prior authorizations and prepayment review requests and supporting information via Web based submissions, facsimile and mail from DOM, providers and attending physicians.

4. Regardless of the mode of receipt, the Contractor shall have established procedures and sufficient capacity to receive review requests and other forms or documentation, including itemized invoices for manually-priced procedures or items required for authorization, prior authorization and prepayment review.

    a. Prior Authorization: The Contractor shall have the capability and established procedures to ensure determinations for authorization, prior authorization and prepayment reviews of molecular testing are completed 98 percent of the time within three (3) business days of receipt.

    b. Retrospective Reviews: The Contractor shall have the capability and established procedures to ensure determinations for retrospective reviews for molecular testing are completed 98 percent of the time within ten (10) business days of receipt. (DOM provides retroactive Medicaid eligibility for a beneficiary that was not eligible for Medicaid benefits at the time of service.)

5. The Contractor may develop and maintain a web-based, electronic review request system for authorization, prior authorization and prepayment review that allows for data input by the submitting providers. The Contractor's system may have the capability for automated criteria/rules-based authorization system. The contractor shall manually review each authorization, prior authorization and pre-payment review request that is not authorized by the Contractor's rules-based system, along with any required supporting documentation to support the need for services.

6. The Contractor shall provide a first level review conducted by a complement of qualified staff, which must include registered nurses licensed in the state of Mississippi, to apply Federal and State laws and regulations, DOM policies and/or formal memorandums and DOM approved medical necessity criteria in order to approve the request based on certification policy and criteria or refer requests that cannot be approved to a second level review.

7. If request is not approved at the first level, the Contractor shall provide a second level review conducted by physicians licensed in the state of Mississippi to make review determinations based on: 1) documentation that supports the medical necessity and appropriateness of setting; 2) consideration of unique factors associated with each patient care episode; 3) local healthcare delivery system infrastructure; and 4) clinical experience, judgment, and generally accepted standards of healthcare.

    a. The Contractor shall have the capability and established procedures for verbal consultation by the physician reviewer with the requesting provider to obtain additional information when the documentation submitted does not clearly support medical necessity.

    b. The Contractor shall ensure that authorization requests not meeting medical necessity criteria for services are reviewed by a physician licensed in the state of Mississippi and of the same specialty as the case under review.

8. The Contractor shall have the capability and established procedures for verbal and written notification to the requesting provider of a pended review and informing the provider of the information needed along with a time

frame for submission that shall not exceed three (3) business days for precertification and ten (10) business days for retrospective reviews.

9. The Contractor shall have the capability and established procedures for verbal and written notification to the requesting provider of a suspended review. Notification to providers of suspended reviews shall occur within one (1) business day of the past due date for information requested.

10. The Contractor shall establish and maintain a procedure for the provider, the requesting provider, and the attending physician to contact the Contractor's Medical Director to discuss cases that have been denied, reduced or modified.

11. The Contractor shall notify providers and beneficiaries or legal guardians/representatives of review determinations.

    a. The Contractor shall issue a written notification of approved certification results to the provider and the requesting provider.

    b. The Contractor shall issue a written notification of denials, modifications, or reductions to the provider, the requesting provider, and beneficiary or, if a child, the legal guardian/representative.

    c. Time frames for notification to DOM of review outcomes for authorizations, prior authorizations and retrospective reviews shall not exceed one (1) business day from the review determination.

S. Continuous Glucose Monitoring and Remote Patient MonitoringServices

1. DOM covers continuous glucose monitoring and remote patient monitoring services for eligible beneficiaries. For additional information on coverage, see Administrative Code Title 23 Medicaid. As a condition for reimbursement, DOM requires certain continuous glucose monitoring and remote patient monitoring services receive authorization. Specific information concerning prior authorization requirements can be found on DOM's fee schedule, accessed at https://medicaid.ms.gov/providers/fee-schedules-and-rates/#. Failure to obtain the authorization will result in denial of payment to all providers billing for services. Currently, DOM's contract UM/QIO conducts authorization of continuous glucose monitoring and remote patient monitoring services. Historic information on the volume of authorizations is provided on DOM's website.

2. The Contractor shall develop, implement, and maintain a UM/QIO program, which includes authorization, prior authorization and prepayment review of continuous glucose monitoring and remote patient monitoring services.

3. The Contractor shall have the capability and established procedures to receive authorizations, prior authorizations and prepayment review requests and supporting information via Web based submissions, facsimile and mail from DOM, providers and attending physicians.

4. Regardless of the mode of receipt, the Contractor shall have established procedures and sufficient capacity to receive review requests and other forms or documentation, including itemized invoices for manually-priced procedures or items required for authorization, prior authorization and prepayment review.

a. Prior Authorization: The Contractor shall have the capability and established procedures to ensure determinations for authorization, prior authorization and prepayment reviews of molecular testing are completed 98 percent of the time within three (3) business days of receipt.

b. Retrospective Reviews: The Contractor shall have the capability and established procedures to ensure determinations for retrospective reviews for molecular testing are completed 98 percent of the time within ten (10) business days of receipt. (DOM provides retroactive Medicaid eligibility for a beneficiary that was not eligible for Medicaid benefits at the time of service.)

5. The Contractor may develop and maintain a web-based, electronic review request system for authorization, prior authorization and prepayment review that allows for data input by the submitting providers. The Contractor's system may have the capability for automated criteria/rules-based authorization system. The contractor shall manually review each authorization, prior authorization and pre-payment review request that is not authorized by the Contractor's rules-based system, along with any required supporting documentation to support the need for services.

6. The Contractor shall provide a first level review conducted by a complement of qualified staff, which must include registered nurses licensed in the state of Mississippi, to apply Federal and State laws and regulations, DOM policies and/or formal memorandums and DOM approved medical necessity criteria in order to approve the request based on certification policy and criteria or refer requests that cannot be approved to a second level review.

7. If request is not approved at the first level, the Contractor shall provide a second level review conducted by physicians licensed in the state of Mississippi to make review determinations based on: 1) documentation that supports the medical necessity and appropriateness of setting; 2) consideration of unique factors associated with each patient care episode; 3) local healthcare delivery system infrastructure; and 4) clinical experience, judgment, and generally accepted standards of healthcare.

   a. The Contractor shall have the capability and established procedures for verbal consultation by the physician reviewer with the requesting provider to obtain additional information when the documentation submitted does not clearly support medical necessity.

   b. The Contractor shall ensure that authorization requests not meeting medical necessity criteria for services are reviewed by a physician licensed in the state of Mississippi and of the same specialty as the case under review.

8. The Contractor shall have the capability and established procedures for verbal and written notification to the requesting provider of a pended review and informing the provider of the information needed along with a time frame for submission that shall not exceed three (3) business days for precertification and ten (10) business days for retrospective reviews.

9. The Contractor shall have the capability and established procedures for verbal and written notification to the requesting provider of a suspended review. Notification to providers of suspended reviews shall occur within one (1) business day of the past due date for information requested.

10. The Contractor shall establish and maintain a procedure for the provider, the requesting provider, and the attending physician to contact the Contractor's Medical Director to discuss cases that have been denied, reduced or modified.

11. The Contractor shall notify providers and beneficiaries or legal guardians/representatives of review determinations.

    a. The Contractor shall issue a written notification of approved certification results to the provider and the requesting provider.

    b. The Contractor shall issue a written notification of denials, modifications, or reductions to the provider, the requesting provider, and beneficiary or, if a child, the legal guardian/representative.

    c. Time frames for notification to DOM of review outcomes for authorizations, prior authorizations and retrospective reviews shall not exceed one (1) business day from the review determination.

T. Diabetes Self-Management Training Services

1. DOM covers diabetes self-management training (DSMT) services for eligible beneficiaries. Comprehensive information about DSMT Services covered, limitations, and exclusions can be found on DOM's website, see Administrative Code Title 23 Medicaid. As a condition for reimbursement, DOM requires certain DSMT services receive authorization for services. Specific information concerning DSMT prior authorization requirements can be found on DOM's fee schedule, accessed at https://medicaid.ms.gov/providers/fee-schedules-and-rates/#. Failure to obtain the authorization will result in denial of payment to all providers billing for services. Currently, DOM's contract UM/QIO conducts authorization of diabetes self-management training services. Historic information on the volume of authorizations is provided on DOM's website.

2. The Contractor shall develop, implement, and maintain a UM/QIO program, which includes authorization, prior authorization and prepayment review of DSMT services.

3. The Contractor shall have the capability and established procedures to receive authorizations, prior authorizations and prepayment review requests and supporting information via Web based submissions, facsimile and mail from DOM, providers and attending physicians.

4. Regardless of the mode of receipt, the Contractor shall have established procedures and sufficient capacity to receive review requests and other forms or documentation, including itemized invoices for manually-priced procedures or items required for authorization, prior authorization and prepayment review.

    a. Prior Authorization: The Contractor shall have the capability and established procedures to ensure determinations for authorization, prior authorization and prepayment reviews of molecular testing are completed 98 percent of the time within three (3) business days of receipt.

    b. Retrospective Reviews: The Contractor shall have the capability and established procedures to ensure determinations for retrospective reviews for molecular testing are completed 98 percent of the time within ten (10) business days of receipt. (DOM provides retroactive Medicaid eligibility for a beneficiary that was not eligible for Medicaid benefits at the time of service.)

5. The Contractor may develop and maintain a web-based, electronic review request system for authorization, prior authorization and prepayment review that allows for data input by the submitting providers. The Contractor's system may have the capability for automated criteria/rules-based authorization system. The contractor shall manually review each authorization, prior authorization and pre-payment review request that is not authorized by the Contractor's rules-based system, along with any required supporting documentation to support the need for services.

6. The Contractor shall provide a first level review conducted by a complement of qualified staff, which must include registered nurses licensed in the state of Mississippi, to apply Federal and State laws and regulations, DOM policies and/or formal memorandums and DOM approved medical necessity criteria in order to approve the request based on certification policy and criteria or refer requests that cannot be approved to a second level review.

7. If request is not approved at the first level, the Contractor shall provide a second level review conducted by physicians licensed in the state of Mississippi to make review determinations based on: 1) documentation that supports the medical necessity and appropriateness of setting; 2) consideration of unique factors associated with each patient care episode; 3) local healthcare delivery system infrastructure; and 4) clinical experience, judgment, and generally accepted standards of healthcare.

    a. The Contractor shall have the capability and established procedures for verbal consultation by the physician reviewer with the requesting provider to obtain additional information when the documentation submitted does not clearly support medical necessity.

    b. The Contractor shall ensure that authorization requests not meeting medical necessity criteria for services are reviewed by a physician licensed in the state of Mississippi and of the same specialty as the case under review.

8. The Contractor shall have the capability and established procedures for verbal and written notification to the requesting provider of a pended review and informing the provider of the information needed along with a time frame for submission that shall not exceed three (3) business days for precertification and ten (10) business days for retrospective reviews.

9. The Contractor shall have the capability and established procedures for verbal and written notification to the requesting provider of a suspended review. Notification to providers of suspended reviews shall occur within one (1) business day of the past due date for information requested.

10. The Contractor shall establish and maintain a procedure for the provider, the requesting provider, and the attending physician to contact the Contractor's Medical Director to discuss cases that have been denied, reduced or modified.

11. The Contractor shall notify providers and beneficiaries or legal guardians/representatives of review determinations.

    a. The Contractor shall issue a written notification of approved certification results to the provider and the requesting provider.

    b. The Contractor shall issue a written notification of denials, modifications, or reductions to the provider, the requesting provider, and beneficiary or, if a child, the legal guardian/representative.

c. Time frames for notification to DOM of review outcomes for authorizations, prior authorizations and retrospective reviews shall not exceed one (1) business day from the review determination.

U. Cardiac Rehabilitation Services

1. DOM covers cardiac rehabilitation services for eligible beneficiaries. For additional information on coverage, see Administrative Code Title 23 Medicaid. As a condition for reimbursement, DOM requires certain cardiac rehabilitation services receive authorization. Specific information concerning prior authorization requirements can be found on DOM's fee schedule, accessed at https://medicaid.ms.gov/providers/fee-schedules-and-rates/#. Failure to obtain the authorization will result in denial of payment to all providers billing for services. Currently, DOM's contract UM/QIO conducts authorization of cardiac rehabilitation services. Historic information on the volume of authorizations is provided on DOM's website.

2. The Contractor shall develop, implement, and maintain a UM/QIO program, which includes authorization, prior authorization and prepayment review of cardiac rehabilitation services.

3. The Contractor shall have the capability and established procedures to receive authorizations, prior authorizations and prepayment review requests and supporting information via Web based submissions, facsimile and mail from DOM, providers and attending physicians.

4. Regardless of the mode of receipt, the Contractor shall have established procedures and sufficient capacity to receive review requests and other forms or documentation, including itemized invoices for manually-priced procedures or items required for authorization, prior authorization and prepayment review.

   a. Prior Authorization: The Contractor shall have the capability and established procedures to ensure determinations for authorization, prior authorization and prepayment reviews of molecular testing are completed 98 percent of the time within three (3) business days of receipt.

   b. Retrospective Reviews: The Contractor shall have the capability and established procedures to ensure determinations for retrospective reviews for molecular testing are completed 98 percent of the time within ten (10) business days of receipt. (DOM provides retroactive Medicaid eligibility for a beneficiary that was not eligible for Medicaid benefits at the time of service.)

5. The Contractor may develop and maintain a web-based, electronic review request system for authorization, prior authorization and prepayment review that allows for data input by the submitting providers. The Contractor's system may have the capability for automated criteria/rules-based authorization system. The contractor shall manually review each authorization, prior authorization and pre-payment review request that is not authorized by the Contractor's rules-based system, along with any required supporting documentation to support the need for services.

6. The Contractor shall provide a first level review conducted by a complement of qualified staff, which must include registered nurses licensed in the state of Mississippi, to apply Federal and State laws and regulations, DOM policies and/or formal memorandums and DOM approved medical necessity criteria in order to approve the request based on certification policy and criteria or refer requests that cannot be approved to a second level review.

7. If request is not approved at the first level, the Contractor shall provide a second level review conducted by physicians licensed in the state of Mississippi to make review determinations based on: 1) documentation that

supports the medical necessity and appropriateness of setting; 2) consideration of unique factors associated with each patient care episode; 3) local healthcare delivery system infrastructure; and 4) clinical experience, judgment, and generally accepted standards of healthcare.

a. The Contractor shall have the capability and established procedures for verbal consultation by the physician reviewer with the requesting provider to obtain additional information when the documentation submitted does not clearly support medical necessity.

b. The Contractor shall ensure that authorization requests not meeting medical necessity criteria for services are reviewed by a physician licensed in the state of Mississippi and of the same specialty as the case under review.

8. The Contractor shall have the capability and established procedures for verbal and written notification to the requesting provider of a pended review and informing the provider of the information needed along with a time frame for submission that shall not exceed three (3) business days for precertification and ten (10) business days for retrospective reviews.

9. The Contractor shall have the capability and established procedures for verbal and written notification to the requesting provider of a suspended review. Notification to providers of suspended reviews shall occur within one (1) business day of the past due date for information requested.

10. The Contractor shall establish and maintain a procedure for the provider, the requesting provider, and the attending physician to contact the Contractor's Medical Director to discuss cases that have been denied, reduced or modified.

11. The Contractor shall notify providers and beneficiaries or legal guardians/representatives of review determinations.

a. The Contractor shall issue a written notification of approved certification results to the provider and the requesting provider.

b. The Contractor shall issue a written notification of denials, modifications, or reductions to the provider, the requesting provider, and beneficiary or, if a child, the legal guardian/representative.

c. Time frames for notification to DOM of review outcomes for authorizations, prior authorizations and retrospective reviews shall not exceed one (1) business day from the review determination.

V. Authorization of Innovative Programs, Services or Items

1. DOM may require utilization management of programs, services or items not specifically outlined in this RFP, resulting from:

a. CMS approved State Plan Amendments (SPAs);

b. Federal and State laws and regulations;

c. DOM Administrative Code and policy revisions;

d. Program exceptions for services or items that are not listed on the DOM Fee Schedule, if the service or item is FDA approved and generally accepted by the medical community.

2. The Contractor shall be notified of modifications when innovative programs, services or items are implemented

3. The Contractor shall develop, implement, and maintain a UM/QIO program, including but not limited to program manuals, criteria, forms, educational material, provider outreach, authorization, prior authorization and prepayment review of innovative program, services, or item requests.

4. The Contractor shall have the capability and established procedures to receive authorizations, prior authorizations and prepayment review requests and supporting information via Web based submissions, facsimile and mail from DOM, providers and attending physicians.

5. Regardless of the mode of receipt, the Contractor shall have established procedures and sufficient capacity to receive review requests and other forms or documentation, including itemized invoices for manually-priced procedures or items required for authorization, prior authorization and prepayment review.

   a. Prior Authorization: The Contractor shall have the capability and established procedures to ensure determinations for authorization, prior authorization and prepayment reviews for innovative programs, services or items are completed 98 percent of the time within three (3) business days of receipt.

   b. Retrospective Reviews: The Contractor shall have the capability and established procedures to ensure determinations for retrospective reviews for innovative programs, services or items are completed 98 percent of the time within ten (10) business days of receipt. (DOM provides retroactive Medicaid eligibility for a beneficiary that was not eligible for Medicaid benefits at the time of service.)

6. The Contractor may develop and maintain a web-based, electronic review request system for authorization, prior authorization and prepayment review that allows for data input by the submitting providers. The Contractor's system may have the capability for automated criteria/rules-based authorization system. The contractor shall manually review each authorization, prior authorization and pre-payment review request that is not authorized by the Contractor's rules-based system, along with any required supporting documentation to support the need for services.

7. The Contractor shall provide a first level review conducted by a complement of qualified staff, which must include registered nurses and/or behavioral health professionals licensed in the state of Mississippi, to apply Federal and State laws and regulations, DOM policies and/or formal memorandums and DOM approved medical necessity criteria in order to approve the request based on certification policy and criteria or refer requests that cannot be approved to a second level review.

8. If request is not approved at the first level, the Contractor shall provide a second level review conducted by physicians licensed in the state of Mississippi to make review determinations based on: 1) documentation that supports the medical necessity and appropriateness of setting; 2) consideration of unique factors associated with each patient care episode; 3) local healthcare delivery system infrastructure; and 4) clinical experience, judgment, and generally accepted standards of healthcare.

   a. The Contractor shall have the capability and established procedures for verbal consultation by the physician reviewer with the requesting provider to obtain additional information when the documentation submitted does not clearly support medical necessity.

b. The Contractor shall ensure that authorization requests not meeting medical necessity criteria for services are reviewed by a physician licensed in the state of Mississippi and of the same specialty as the case under review.

9. The Contractor shall have the capability and established procedures for verbal and written notification to the requesting provider of a pended review and informing the provider of the information needed along with a time frame for submission that shall not exceed three (3) business days for precertification and ten (10) business days for retrospective reviews.

10. The Contractor shall have the capability and established procedures for verbal and written notification to the requesting provider of a suspended review. Notification to providers of suspended reviews shall occur within one (1) business day of the past due date for information requested.

11. The Contractor shall establish and maintain a procedure for the provider, the requesting provider, and the attending physician to contact the Contractor's Medical Director to discuss cases that have been denied or modified.

12. The Contractor shall notify providers and beneficiaries or legal guardians/representatives of review determinations.

    a. The Contractor shall issue a written notification of approved certification results to the provider and the requesting provider.

    b. The Contractor shall issue a written notification of denials, modifications, or reductions to the provider, the requesting provider, and beneficiary or, if a child, the legal guardian/representative.

    c. Time frames for notification to providers and beneficiaries of review outcomes for prior authorization and prepayment review shall not exceed the following standards:

Table 12: Notification of Review Outcomes of Innovative programs, Services or Items Authorization

Review Type	Contractor Action	Time Standard
Prior Authorization Review	Written Approval to Provider	Within one (1) business day from review determination
	Written Denial to Provider	Within one (1) business day from review determination
	Written Denial to Beneficiary/ Parent/Representative	Within one (1) business day from review determination
Retrospective Review	Written Approval to Provider	Within three (3) business days from review determination
	Written Denial to Provider	Within three (3) business days from review determination
	Written Denial to Beneficiary/ Parent/Representative	Within three (3) business days from review determination

W. Medical Services Criteria Development

1. In performing medical necessity determinations, the Contractor shall use InterQual® criteria (IQ). When InterQual® criteria is not available for medical necessity determination, then the Contractor shall use a nationally recognized standard for the clinical criteria in reviewing each authorization, prior authorization and prepayment review request, as approved by DOM. DOM shall have prior approval of the criteria used for automated and manual reviews. The criteria shall provide a clinically sound basis for professional determinations of the medical necessity for all services reviewed under the resulting Contract.

    a. The Contractor shall maintain the capability to update the review criteria for services reviewed under the resulting Contract. The Contractor shall make recommendations to DOM annually, regarding what, if any, changes should be made to the criteria that will be used for the following calendar year. The recommendations shall be included in the Contractor's annual report required in Section 1.8 of this RFP.

    b. The Contractor shall provide DOM with access to a complete set of materials associated with the criteria annually.

    c. Any modifications to the criteria or guidelines must be prior approved by DOM. Based on the best interest of the State and the review outcome, DOM reserves the right to specify the use of different criteria/guideline products during the resulting Contract.

    d. The Contractor is responsible for any cost associated with the purchase of any review criteria.

2. The Methodology section of the Technical Proposal must provide detailed information on the Offeror's process for determining medical necessity, including: 1) a description of the recommended review criteria for each service; 2) a description of the review instrument(s) for each service; and 3) a description of the Offeror's capability to develop an automated rules-driven certification system.

3. The Contractor shall work with DOM to develop clinically sound, evidence-based, medical necessary criteria for all services. The Contractor shall have the capability to develop an automated criteria/rules-based authorization system. DOM shall approve all criteria prior to utilization by the Contractor. The automated criteria/rules-based authorization system is expected to perform a significant number of reviews.

4. The Methodology section of the Technical Proposal must provide a detailed description of the Offeror's approach to designing, developing, and implementing medical necessity criteria for all services through a web-based prior authorization system.

5. The Contractor shall develop and implement utilization reviews validating the APR-DRG assignment to counterbalance the incentive to arrange diagnosis codes to cause a claim to be assigned to a higher-paying APR-DRG. The Contractor shall review a representative sample of APR-DRGs FFS and CCO encounter claims at intervals determined by DOM during contract implementation for potential coding errors (upcoding/downcoding), other billing errors, or higher than expected utilization to ensure the APR-DRG billed for payment is consistent and accurate with the APR-DRG payment based on the correct diagnostic and procedural information in the medical record of inpatient admissions.

6. The Contractor shall perform retrospective post-payment reviews as directed by DOM, including coding validation audits for FFS and CCO encounter claims comparing the primary and all diagnoses and procedure

codes billed to DOM with documentation in the patient's medical record, including patient's age and gender, to determine the appropriateness and accuracy of the billed APR-DRGs.

1.4.2.2 Behavioral Health Services Utilization Management Technical Requirement

This section describes the requirements for the development, implementation, and operation of a UM/QIO program for behavioral health services to include:

- Inpatient Psychiatric Services;
- Hospital Outpatient Mental Health Services;
- Community/Private Mental Health Centers Services;
- Psychiatric Residential Treatment Facility Services;
- Mississippi Youth Programs Around the Clock (MYPAC) Services;
- Therapeutic and Evaluative Services for Children;
- Autism Spectrum Disorder Services;
- Substance Use Disorder Services; and
- ICF/IID Utilization Review.

The Methodology section of the Technical Proposal must provide information on the Offeror's experience that clearly demonstrates how the Offeror will meet stated requirements and describe in detail the Offeror's experience administering similar UM/QIO programs for behavioral health services for commercial and/or government health care programs.

A. Inpatient Psychiatric Services Authorization

1. DOM covers inpatient psychiatric services for eligible beneficiaries. For additional information on coverage, see Administrative Code Title 23 Medicaid. As a condition for reimbursement, DOM requires certain inpatient hospital admissions receive authorization. Failure to obtain authorization will result in denial of payment to all providers billing for services, including the hospital and the attending physician. Currently, DOM's contracted UM/QIO conducts authorization of hospital admissions. Historic information on the volume of authorizations is provided on DOM's Website.

2. The Contractor shall develop, implement, and maintain a UM/QIO program, which includes authorization, prior authorization and prepayment review of inpatient psychiatric services requests by psychiatric units of general hospitals and acute freestanding psychiatric hospitals.

3. The Contractor shall have the capability and established procedures to receive authorizations, prior authorizations and prepayment review requests and supporting information via web-based submissions, , facsimile, and mail from hospital providers and treating clinicians.

    a. The Contractor shall establish and maintain a dedicated telephone number, toll-free in Mississippi, for the receipt of prior authorization requests for inpatient psychiatric services submitted by telephone.

b. The Contractor shall establish and maintain a dedicated facsimile number, toll-free in Mississippi, for the receipt of prior authorization and prepayment review requests for inpatient psychiatric services submitted by facsimile.

c. The Contractor shall establish and maintain a physical mailing address in Hinds, Rankin or Madison County, Mississippi for the receipt of prior authorization and prepayment review requests for inpatient psychiatric services submitted by mail.

d. The Contractor shall establish and maintain a web-based system for receipt of prior authorization and prepayment review requests for inpatient psychiatric services submitted electronically. This web-based system must comply with the requirements in Section 1.6 of this RFP.

4. Regardless of the mode of receipt, the Contractor shall have established procedures and sufficient capacity to receive review forms and additional medical documentation required for authorization, prior authorization and prepayment review of inpatient psychiatric services.

5. The Contractor shall determine the medical necessity for urgent and non-emergency inpatient admission authorizations, continued stays, and retrospective reviews for inpatient psychiatric services to eligible Mississippi Medicaid beneficiaries utilizing DOM approved criteria and policies.

   a. Urgent Admission Reviews: Urgent psychiatric admissions are defined as admissions to an inpatient hospital setting resulting from mental illness when the beneficiary's condition is such that he/she requires twenty-four (24) hour per day supervision in a secure setting and with presenting symptoms of such severity that the absence of immediate intervention could reasonably result in:

      1) Permanently placing the beneficiary's mental health in jeopardy;

      2) A serious threat to the physical welfare of the beneficiary and/or others; or

      3) Serious and permanent mental dysfunction or other serious medical or psychiatric consequence.

      The Contractor shall have the capability and established procedures to receive retrospective urgent admission reviews that are not planned or elective and conduct authorizations when the beneficiary has not been discharged. The Contractor shall have the capability and established procedures to ensure determinations for urgent admission reviews are completed 98 percent of the time within one (1) business day of receipt.

   b. Non-Emergency Admission Reviews: Non-emergency admissions are for planned or elective admissions and the beneficiary has not been hospitalized. The Contractor shall have the capability and established procedures to receive non-emergency admission review requests and conduct authorizations prior to the planned date of admission. The Contractor shall have the capability and established procedures to ensure determinations for non-emergency admission reviews are completed 98 percent of the time within one (1) business day of receipt.

   c. Weekend and Holiday Admission Reviews: Weekend admissions are when the beneficiary was admitted on a weekend. Holiday admissions are defined as those admissions where a beneficiary is admitted on a holiday defined in Section 1.5 of this RFP. The Contractor shall have the capability and established procedures to receive weekend and holiday admission review requests and conduct authorizations post-

admission when the beneficiary has not been discharged. The Contractor shall have the capability and established procedures to ensure determinations for urgent admission reviews are completed 98 percent of the time within one (1) business day of receipt.

d. Continued Stay Reviews: Continued stay reviews are subsequent reviews performed to determine if continuation of services is medically necessary and appropriate. The Contractor shall have the capability and established procedures to receive continued stay review requests for additional inpatient days of care for admissions previously authorized and conduct prior authorizations on or before the next review point (i.e. the last authorized day). The Contractor shall have the capability and established procedures to provide all hospital providers with a daily listing of beneficiaries whose authorization expires within 48 hours. The Contractor shall have the capability and established procedures to ensure determinations for continued stay reviews are completed 98 percent of the time within one (1) business day of receipt when beneficiaries remain hospitalized and within one (1) business day when beneficiaries have been discharged.

e. Retrospective Reviews: DOM provides retroactive Medicaid eligibility for a beneficiary that was not eligible for Medicaid benefits at the time of hospitalization. Retrospective reviews cover those admissions where the beneficiary was admitted and discharged, authorization was not obtained while the beneficiary was hospitalized, and the length of stay is greater than eight (8) days. The Contractor shall have the capability and established procedures to receive retrospective review requests and conduct prepayment reviews. The Contractor shall have the capability and established procedures to ensure determinations for retrospective reviews are completed 98 percent of the time within ten (10) business days of receipt. (DOM provides retroactive Medicaid eligibility for a beneficiary that was not eligible for Medicaid benefits at the time of service.)

6. The Contractor shall develop and maintain a web-based, electronic review request system for authorization, prior authorization and prepayment review of inpatient psychiatric services that allows for data input by the submitting providers. The Contractor's system shall have the capability for automated criteria/rules-based authorization system. The Contractor shall manually review each authorization, prior authorization and prepayment review request received that is not authorized by the Contractor's rules-based system, along with any required supporting documentation to support the need for inpatient psychiatric services.

7. The Contractor shall provide a first level review conducted by a complement of qualified staff, which must include registered nurses and/or behavioral health professionals licensed in the state of Mississippi, to apply Federal and State laws and regulations, DOM policies and/or formal memorandums and DOM approved medical necessity criteria in order to approve inpatient psychiatric services based on authorization policy and criteria or refer requests that cannot be approved to a second level review.

8. If request is not approved at the first level, the Contractor shall provide a second level review conducted by psychiatrists to make review determinations for inpatient psychiatric services based on: 1) documentation that supports the medical necessity and appropriateness of setting; 2) consideration of unique factors associated with each patient care episode; 3) local healthcare delivery system infrastructure; and 4) clinical experience, judgment, and generally accepted standards of healthcare.

   a. The Contractor shall have the capability and established procedures for verbal consultation by the physician reviewer with the attending physician to obtain additional information when the documentation submitted does not clearly support medical necessity.

b. The Contractor shall ensure that authorization requests not meeting medical necessity criteria for inpatient psychiatric services are reviewed by a physician licensed in the state of Mississippi and of the same specialty as the case under review.

9. The Contractor shall have the capability and established procedures for verbal and written notification to the requesting provider of a pended review and informing the provider of the information needed along with a time frame for submission

10. The Contractor shall have the capability and established procedures for verbal and written notification to the requesting provider of a suspended review. Notification to providers of suspended reviews shall not exceed the following standards:

Table 13: Notification of Suspended Review for Inpatient Psychiatric Services

Review Type	Contractor Action	Time Standard
Urgent Admission Reviews	Verbal Notification to Provider	Within 4 hours past due date for requested information
Non-Emergency Admission Reviews Weekend and Holiday Admission Reviews Continued Stay Reviews	Written Notification to Provider	Within one (1) business day past due date for requested information
Retrospective Reviews	Written Notification to Provider	Within one (1) business day past due date for requested information

11. The Contractor shall establish and maintain a procedure for the treating clinician to contact the Contractor's Medical Director to discuss inpatient psychiatric services cases that have been denied, modified, reduced or considered for denial.

12. The Contractor shall notify providers and beneficiaries or legal guardians/representatives of review determinations for inpatient psychiatric services requests.

a. The Contractor shall issue verbal and written notification of approved authorization results to the hospital provider and treating clinician.

b. The Contractor shall issue a written notification of denials, modifications, or reductions to the hospital provider, treating clinician, and beneficiary or, if a child, the legal guardian/representative.

c. Time frames for notification to providers and beneficiaries of review outcomes for authorization, prior authorization and prepayment review of inpatient psychiatric services shall not exceed the following standards:

Table 14: Notification of Review Outcomes for Inpatient Psychiatric Services

Review Type	Contractor Action	Time Standard
Urgent Admission Reviews	Verbal Approval to Provider	Within one (1) business day from review determination.
Non-Emergency Admission Reviews	Written Approval to Provider	Within one (1) business day from review determination.
Weekend and Holiday Admission Reviews	Verbal Denial to Provider	Within one (1) business day from review determination.
Continued Stay Reviews	Written Denial to Provider	Within one (1) business day from review determination.
	Written Denial to Beneficiary/ Parent/Representative	Within one (1) business day from review determination.
Retrospective Reviews	Written Approval to Provider	Within one (1) business day from review determination.
	Written Denial to Provider	Within 24 hours from receipt of completed request
	Written Denial to Beneficiary/ Parent/Representative	Within three (3) business days from review determination.

B. Hospital Outpatient Mental Health Services Authorization

1. DOM covers mental health services when provided in an outpatient department of a general hospital for eligible beneficiaries. For additional information on coverage, see Administrative Code Title 23 . As a condition for reimbursement, DOM requires certain hospital outpatient mental health services receive authorization. Specific procedures requiring authorization are identified in the Outpatient Mental Health CPT® Codes Listing on DOM's Website. Failure to obtain the authorization will result in denial of payment to providers billing for services. Currently, DOM's contract UM/QIO conducts authorization of hospital outpatient mental health services. Historic information on the volume of authorizations for hospital outpatient mental health services is provided on DOM's Website.

2. The Contractor shall develop, implement, and maintain a UM/QIO program, which includes authorization, prior authorization and prepayment review of outpatient mental health services requests.

3. The Contractor shall have the capability and established procedures to receive authorizations, prior authorizations and prepayment review requests and supporting information via web-based submissions, facsimile, and mail from hospital providers and attending physicians.

    a. The Contractor shall establish and maintain a dedicated facsimile number, toll-free in Mississippi, for the receipt of review requests for outpatient mental health services submitted by facsimile.

    b. The Contractor shall establish and maintain a physical mailing address in Hinds, Rankin or Madison County, Mississippi for the receipt of review requests for outpatient mental health services submitted by mail.

c. The Contractor shall establish and maintain a web-based system for receipt of prior authorization and prepayment review requests for outpatient mental health services submitted electronically. This web-based system must comply with the requirements in Section 1.6 of this RFP.

4. Regardless of the mode of receipt, the Contractor shall have established procedures and sufficient capacity to receive review requests, clinical documentation, plans of care, and other forms or documentation required for authorization, prior authorization and prepayment review of outpatient mental health services.

5. The Contractor shall determine the medical necessity of admission authorizations, concurrent stay, crisis session, and retrospective reviews for outpatient mental health services to eligible Mississippi Medicaid beneficiaries utilizing DOM approved criteria and policies.

   a. Admission Prior Authorization Reviews: The Contractor shall have the capability and established procedures to ensure determinations for admission authorization reviews are completed 98 percent of the time within two (2) business days of receipt.

   b. Continued Stay Reviews: The Contractor shall have the capability and established procedures to ensure determinations for continued stay reviews are completed 98 percent of the time within two (2) business days of receipt.

   c. Crisis Session Reviews: The Contractor shall have the capability and established procedures to ensure determinations for crisis session reviews are completed 98 percent of the time within two (2) business days of receipt.

   d. Retrospective Reviews: The Contractor shall have the capability and established procedures to ensure determinations for retrospective reviews are completed 98 percent of the time within ten (10) business days of receipt. (DOM provides retroactive Medicaid eligibility for a beneficiary that was not eligible for Medicaid benefits at the time of service.)

6. The Contractor shall develop and maintain a web-based, electronic review request system for authorization, prior authorization and prepayment review of outpatient mental health services that allows for data input by the submitting providers. The Contractor's system shall have the capability for automated criteria/rules-based authorization system. The Contractor shall manually review each authorization, prior authorization and prepayment review request received that is not authorized by the Contractor's rules-based system, along with any required supporting documentation to support the need for outpatient mental health services.

7. The Contractor shall provide a first level review conducted by a complement of qualified staff, which must include registered nurses and/or behavioral health professionals licensed in the state of Mississippi or other qualified mental health professionals, to apply Federal and State laws and regulations, DOM policies and/or formal memorandums and DOM approved medical necessity criteria in order to approve outpatient mental health services based on authorization policy and criteria or refer requests that cannot be approved to a second level review.

8. If request is not approved at the first level, the Contractor shall provide a second level review conducted by psychiatrists to make review determinations for outpatient mental health services based on: 1) documentation that supports the medical necessity and appropriateness of setting; 2) consideration of unique factors associated

with each patient care episode; 3) local healthcare delivery system infrastructure; and 4) clinical experience, judgment, and generally accepted standards of healthcare.

a. The Contractor shall have the capability and established procedures for verbal consultation by the physician reviewer with the treating clinician to obtain additional information when the documentation submitted does not clearly support medical necessity.

b. The Contractor shall ensure that authorization requests not meeting medical necessity criteria for outpatient mental health services are reviewed by a physician licensed in the state of Mississippi and of the same specialty as the case under review.

9. The Contractor shall have the capability and established procedures for verbal and written notification to the requesting provider of a pended review and informing the provider of the information needed along with a time frame for submission shall not exceed three (3) business days for admission/prior authorization and ten (10) business days for retrospective reviews.

10. The Contractor shall have the capability and established procedures for verbal and written notification to the requesting provider of a suspended review. Notification to providers of suspended reviews shall occur within one (1) business day of the past due date for information requested.

11. The Contractor shall establish and maintain a procedure for the hospital outpatient provider and treating clinician to contact the Contractor's Medical Director to discuss outpatient mental health services cases that have been denied or modified.

12. The Contractor shall notify providers and beneficiaries or legal guardians/representatives of review determinations for outpatient mental health services requests.

a. The Contractor shall issue verbal and written notification of approved authorization results to the hospital outpatient provider, treating clinician, and attending physician.

b. The Contractor shall issue verbal and written notification of denials, modifications, or reductions to the hospital outpatient provider, treating clinician, attending physician, and beneficiary or, if a child, the legal guardian/representative.

c. Time frames for notification to providers and beneficiaries of review outcomes for authorization, prior authorization and prepayment review of outpatient mental health services shall not exceed the following standards:

Table 15: Notification of Review Outcomes for Hospital Outpatient Mental Health Services

Review Type	Contractor Action	Time Standard
Admission Prior Authorization Reviews	Verbal Approval to Provider	Within one (1) business day from review determination
Concurrent Stay Review	Written Approval to Provider	Within one (1) business day from review determination
Crisis Session Review	Verbal Denial to Provider	Within one (1) business day from review determination

	Written Denial to Provider	Within one (1) business day from review determination
	Written Denial to Beneficiary/ Parent/Representative	Within one (1) business day from review determination
Retrospective Review	Written Approval to Provider	Within three (3) business days from review determination
	Written Denial to Provider	Within three (3) business days from review determination
	Written Denial to Beneficiary/ Parent/Representative	Within three (3) business days from review determination

C. Community/Private Mental Health Centers Services Authorization

1. DOM covers mental health services for eligible beneficiaries when provided by a certified community/private mental health center or by the community services division of a State hospital. For additional information on coverage, see Administrative Code Title 23 Medicaid. As a condition for reimbursement, DOM requires that certain mental health services receive authorization. Failure to obtain authorization will result in denial of payment to providers billing for services. Specific services requiring authorization are identified in the Community/Private Mental Health Codes Listing on DOM's Website.

2. The Contractor shall develop, implement, and maintain a UM/QIO program, which includes authorization, prior authorization and prepayment review of community mental health centers services requests.

3. The Contractor shall have the capability and established procedures that allow for receipt of authorization, prior authorizations and prepayment review requests and supporting information via web-based submissions, facsimile, and mail from mental health providers.

    a. The Contractor shall establish and maintain a dedicated facsimile number, toll-free in Mississippi, for the receipt of review requests for community mental health services submitted by facsimile.

    b. The Contractor shall establish and maintain a physical mailing address in Hinds, Rankin or Madison County, Mississippi for the receipt of review requests for community mental health services submitted by mail.

    c. The Contractor shall establish and maintain a web-based system for receipt of prior authorization and prepayment review requests for community mental health services submitted electronically. This web-based system must comply with the requirements in Section 1.6 of this RFP.

4. Regardless of the mode of receipt, the Contractor shall have established procedures and sufficient capacity to receive review requests, clinical documentation, plans of care, and other forms or documentation required for authorization, prior authorization and prepayment review of community/private mental health center services.

5. The Contractor shall have the capability and established procedures for determining the medical necessity of community/private mental health center services to eligible Mississippi Medicaid beneficiaries utilizing DOM approved criteria and policies.

    a. Prior Authorization Reviews: The Contractor shall have the capability and established procedures to ensure the number of mental health services reasonably required to treat the beneficiary's condition. Procedures

must include information regarding specific discharge plans and a plan to monitor progress. The Contractor shall ensure prior authorization of services provided by community/private mental health centers are completed 98 percent of the time within seven (7) business days of receipt.

b. Continued Stay Reviews: The Contractor shall have the capability and established procedures to ensure determinations for continued stay reviews are completed 98 percent of the time within two (2) business days of receipt.

c. Crisis Residential Reviews: The Contractor shall have the capability and established procedures to ensure determinations for crisis residential reviews are completed 98 percent of the time within two (2) business days of receipt.

d. Retrospective Reviews: The Contractor shall have the capability and established procedures to ensure determinations for retrospective reviews are completed 98 percent of the time within ten (10) business days of receipt. . (DOM provides retroactive Medicaid eligibility for a beneficiary that was not eligible for Medicaid benefits at the time of service.)

6. The Contractor shall develop and maintain a web-based, electronic review request system for authorization, prior authorization and prepayment review of community/private mental health services that allows for data input by the submitting providers. The Contractor's system shall have the capability for automated criteria/rules-based authorization system. The Contractor shall manually review each authorization, prior authorization and prepayment review request received that is not authorized by the Contractor's rules-based system, along with any required supporting documentation to support the need for community/private mental health services.

7. The Contractor shall have the capability and established procedures that allow for a first level review conducted by a complement of qualified staff, which must include registered nurses and/or behavioral health professionals licensed in the state of Mississippi, to apply Federal and State laws and regulations, DOM policies and/or formal memorandums and DOM approved medical necessity criteria in order to approve community/private mental health services based on authorization policy and criteria or refer requests that cannot be approved to a second level review.

8. The Contractor shall have the capability and established procedures that allow for a second level review conducted by psychiatrists to make review determinations for community/private mental health services based on: 1) documentation that supports the medical necessity and appropriateness of setting; 2) consideration of unique factors associated with each patient care episode; 3) local healthcare delivery system infrastructure; and 4) clinical experience, judgment, and generally accepted standards of healthcare.

   a. The Contractor shall have the capability and established procedures for verbal consultation by the physician reviewer with the treating clinician to obtain additional information when the documentation submitted does not clearly support medical necessity.

   b. The Contractor shall ensure that authorization requests not meeting medical necessity criteria for community/private mental health services are reviewed by a physician licensed in the state of Mississippi and of the same specialty as the case under review.

9. The Contractor shall have the capability and established procedures for verbal and written notification to the requesting provider of a pended review and informing the provider of the information needed along with a time frame for submission shall not exceed three (3) business days for prior authorization and ten (10) business days for retrospective reviews.

10. The Contractor shall have the capability and established procedures for verbal and written notification to the requesting provider of a suspended review. Notification to providers of suspended reviews shall occur within one (1) business day of the past due date for information requested.

11. The Contractor shall establish and maintain a procedure for the community/private provider and treating clinician to contact the Contractor's Medical Director to discuss community/private mental health services cases that have been denied or modified.

12. The Contractor shall have the capability and established procedures for notification to providers and beneficiaries or legal guardians/representatives of review determinations for community/private mental health services requests.

    a. The Contractor shall have the capability and established procedures for issuing verbal and written notification of approved authorization results to the community/private provider, treating clinician, and attending physician.

    b. The Contractor shall have the capability and established procedures for issuing verbal and written notification of denials, modifications, or reductions to the community/private provider, treating clinician, attending physician, and beneficiary or, if a child, the legal guardian/representative.

    c. Time frames for notification to providers and beneficiaries of review outcomes for authorization, prior authorization and prepayment review of community/private mental health services shall not exceed the following standards:

Table 16: Notification of Review Outcomes for Community/Private Mental Health Center Services

Review Type	Contractor Action	Time Standard
Prior Authorization Reviews Concurrent Stay Review	Verbal Approval to Provider	Within one (1) business day from review determination
	Written Approval to Provider	Within one (1) business day from review determination
	Verbal Denial to Provider	Within one (1) business day from review determination
	Written Denial to Provider	Within one (1) business day from review determination
	Written Denial to Beneficiary/ Parent/Representative	Within one (1) business day from review determination
Retrospective Review	Written Approval to Provider	Within three (3) business days from review determination
	Written Denial to Provider	Within three (3) business days from review determination

	Written Denial to Beneficiary/ Parent/Representative	Within three (3) business days from review determination

D. Psychiatric Residential Treatment Facility Services Authorization

1. DOM covers PRTF services for beneficiaries under age twenty-one (21) when the child does not require emergency or acute psychiatric care but does require supervision and treatment on a twenty-four (24) hour basis. For additional information on coverage, see Administrative Code Title 23 Medicaid. As a condition for reimbursement, DOM requires that PRTF services receive authorization. Failure to obtain authorization will result in denial of payment to providers billing for services. Currently, DOM's contract UM/QIO conducts authorization of PRTF services. Historic information on the volume of prior authorizations for PRTF services is provided on DOM's Website.

2. The Contractor shall develop, implement, and maintain a UM/QIO program, which includes authorization, prior authorization and prepayment review of PRTF services requests.

3. The Contractor shall have the capability and established procedures to receive authorizations, prior authorizations and prepayment review requests and supporting information via web-based submissions, facsimile, and mail from PRTFs.

    a. The Contractor shall establish and maintain a dedicated facsimile number, toll-free in Mississippi, for the receipt of review requests for PRTF services submitted by facsimile.

    b. The Contractor shall establish and maintain a physical mailing address in Hinds, Rankin or Madison County, Mississippi for the receipt of review requests for PRTF services submitted by mail.

    c. The Contractor shall establish and maintain a web-based system for receipt of review requests for PRTF services submitted electronically. This web-based system must comply with the requirements in Section 1.6 of this RFP.

4. Regardless of the mode of receipt, the Contractor shall have established procedures and sufficient capacity to receive review requests, independent evaluations/pre-discharge recommendation, and other forms or documentation required for authorization, prior authorization and prepayment review of PRTF services.

5. The Contractor shall determine the medical necessity of authorization, continued stay, and retrospective reviews for PRTF services to eligible Mississippi Medicaid beneficiaries utilizing DOM approved criteria and policies.

    a. Admission Prior Authorization Reviews: The Contractor shall have the capability and established procedures to ensure determinations for admission prior authorization reviews are completed 98 percent of the time within three (3) business days of receipt.

    b. Continued Stay Reviews: The Contractor shall have the capability and established procedures to ensure determinations for continued stay reviews are completed 98 percent of the time within three (3) business days of receipt.

    c. Retrospective Reviews: The Contractor shall have the capability and established procedures to ensure determinations for retrospective reviews are completed 98 percent of the time within ten (10) business days

of receipt. (DOM provides retroactive Medicaid eligibility for a beneficiary that was not eligible for Medicaid benefits at the time of service.)

6. The Contractor may develop and maintain a web-based, electronic review request system for authorization, prior authorization and prepayment review of PRTF services that allows for data input by the submitting providers. The Contractor's system may have the capability for automated criteria/rules-based authorization system. The Contractor shall manually review each authorization, prior authorization and prepayment review requests not authorized by the Contractor's rules-based system for PRTF services.

7. The Contractor shall provide a first level review conducted by a complement of qualified staff, which must include registered nurses and/or behavioral health professionals licensed in the state of Mississippi, to apply Federal and State laws and regulations, DOM policies and/or formal memorandums and DOM approved medical necessity criteria in order to approve PRTF services based on authorization policy and criteria or refer requests that cannot be approved to a second level review.

8. If request is not approved at the first level, the Contractor shall provide a second level review conducted by psychiatrists to make review determinations for PRTF services based on: 1) documentation that supports the medical necessity and appropriateness of setting; 2) consideration of unique factors associated with each patient care episode; 3) local healthcare delivery system infrastructure; and 4) clinical experience, judgment, and generally accepted standards of healthcare.

    a. The Contractor shall have the capability and established procedures for verbal consultation by the physician reviewer with the treating clinician to obtain additional information when the documentation submitted does not clearly support medical necessity.

    b. The Contractor shall ensure that authorization requests not meeting medical necessity criteria for PRTF services are reviewed by a physician licensed in the state of Mississippi and of the same specialty as the case under review.

9. The Contractor shall have the capability and established procedures for verbal and written notification to the requesting provider of a pended review and informing the provider of the information needed along with a time frame for submission shall not exceed one (1) business day for admission prior authorization and ten (10) business days for retrospective reviews.

10. The Contractor shall have the capability and established procedures for verbal and written notification to the requesting provider of a suspended review. Notification to providers of suspended reviews shall occur within one (1) business day of the past due date for information requested.

11. The Contractor shall establish and maintain a procedure for the PRTF and treating clinician to contact the Contractor's Medical Director to discuss PRTF services cases that have been denied, modified, reduced or considered for denial.

12. The Contractor shall notify providers and beneficiaries or legal guardians/representatives of review determinations for PRTF services requests.

    a. The Contractor shall issue verbal and written notification of approved authorization results to the PRTF provider and treating clinician.

b. The Contractor shall issue verbal and written notification of denials, modifications, or reductions to the PRTF provider, treating clinician, and beneficiary or, if a child, the legal guardian/representative.

c. Time frames for notification to providers and beneficiaries of review outcomes for authorization, prior authorization and prepayment review of PRTF services shall not exceed the following standards:

Table 17: Notification of Review Outcomes for Psychiatric Residential Treatment Facilities Services

Review Type	Contractor Action	Time Standard
Admission Prior Authorization Reviews	Verbal Approval to Provider	Within one (1) business day from review determination
Concurrent Stay Review	Written Approval to Provider	Within one (1) business day from review determination
	Verbal Denial to Provider	Within one (1) business day from review determination
	Written Denial to Provider	Within one (1) business day from review determination
	Written Denial to Beneficiary/ Parent/Representative	Within one (1) business day from review determination
Retrospective Review	Written Approval to Provider	Within three (3) business days from review determination
	Written Denial to Provider	Within three (3) business days from review determination
	Written Denial to Beneficiary/ Parent/Representative	Within three (3) business days from review determination

E. Mississippi Youth Programs Around the Clock Services Authorization

1. DOM covers Mississippi Youth Programs Around the Clock (MYPAC) services for Medicaid beneficiaries under age twenty-one (21), with serious emotional disturbance at immediate risk of requiring treatment in a PRTF or receiving PRTF treatment and ready to transition back to the community. For additional information on coverage, see Administrative Code Title 23 Medicaid. As a condition for reimbursement, DOM requires certain MYPAC services receive prior authorization. Failure to obtain the prior authorization will result in denial of payment to providers billing for services. Currently, DOM's contract UM/QIO conducts prior authorization of MYPAC services. Historic information on the volume of prior authorizations for MYPAC services is provided on DOM's Website.

2. The Contractor shall develop, implement, and maintain a UM/QIO program, which includes prior authorization for the MYPAC program.

3. The Contractor shall have the capability and established procedures to receive prior authorization requests and supporting information via web-based system, facsimile and mail submissions from MYPAC providers.

   a. The Contractor shall establish and maintain a dedicated facsimile number, toll-free in Mississippi, for the receipt of review requests for MYPAC services submitted by facsimile.

b. The Contractor shall establish and maintain a physical mailing address in Hinds, Rankin or Madison County, Mississippi for the receipt of review requests for MYPAC services submitted by mail.

c. The Contractor shall establish and maintain a web-based system for receipt of review requests for MYPAC services submitted electronically. Any web-based system must comply with the requirements in Section 1.6 of this RFP.

4. Regardless of the mode of receipt, the Contractor shall have established procedures and sufficient capacity to receive review requests, independent evaluations/pre-discharge recommendations, and other forms or documentation required for authorization, prior authorization and prepayment review of MYPAC services.

5. The Contractor shall determine the medical necessity of admission reviews and continued stay reviews for MYPAC services to eligible Mississippi Medicaid beneficiaries utilizing DOM approved criteria and policies.

   a. Prior Authorization Reviews: The Contractor shall have the capability and established procedures to ensure determinations for prior authorization reviews are completed 98 percent of the time within one (1) business day of receipt.

   b. Continued Stay Reviews: The Contractor shall have the capability and established procedures to ensure determinations for continued stay reviews are completed 98 percent of the time within one (1) business day of receipt.

6. The Contractor shall develop and maintain a web-based, electronic review request system for authorization, prior authorization and prepayment review of MYPAC services that allows for data input by the submitting providers. The Contractor's system shall have the capability for automated criteria/rules-based authorization system. The Contractor shall manually review each authorization, prior authorization and prepayment review request received that is not authorized by the Contractor's rules-based system, along with any required supporting documentation to support the need for MYPAC services.

7. The Contractor shall provide a first level review conducted by a complement of qualified staff, which must include registered nurses and/or behavioral health professionals licensed in the state of Mississippi, to apply Federal and State laws and regulations, DOM policies and/or formal memorandums and DOM approved medical necessity criteria in order to approve MYPAC services based on authorization policy and criteria or refer requests that cannot be approved to a second level review.

8. If request is not approved at the first level, the Contractor shall provide a second level review conducted by psychiatrists to make review determinations for MYPAC services based on: 1) documentation that supports the medical necessity and appropriateness of setting; 2) consideration of unique factors associated with each patient care episode; 3) local healthcare delivery system infrastructure; and 4) clinical experience, judgment, and generally accepted standards of healthcare.

   a. The Contractor shall have the capability and established procedures for verbal consultation by the physician reviewer with the treating clinician to obtain additional information when the documentation submitted does not clearly support medical necessity.

   b. The Contractor shall ensure that authorization requests not meeting medical necessity criteria for MYPAC services are reviewed by a physician licensed in the state of Mississippi and of the same specialty as the case under review.

9. The Contractor shall have the capability and established procedures for verbal and written notification to the requesting provider of a pended review and informing the provider of the information needed along with a time frame for submission that shall not exceed one (1) business day.

10. The Contractor shall have the capability and established procedures for verbal and written notification to the requesting provider of a suspended review. Notification to providers of suspended reviews shall occur within one (1) business day of the past due date for information requested.

11. The Contractor shall establish and maintain a procedure for the MYPAC provider, treating clinician, to contact the Contractor's Medical Director to discuss MYPAC services cases that have been denied or modified.

12. The Contractor shall notify providers and beneficiaries or legal guardians/representatives of review determinations for MYPAC services requests.

    a. The Contractor shall issue a written notification of approved authorization results to the MYPAC provider and attending physician.

    b. The Contractor shall issue a written notification of denials, modifications, or reductions to the MYPAC provider, attending physician, and beneficiary or, if a child, the legal guardian/representative.

    c. Time frames for notification to providers and beneficiaries of review outcomes for authorization and prior authorization of MYPAC services shall not exceed the following standards:

Table 18: Notification of Review Outcomes for Mississippi Youth Programs Around the Clock Services

Review Type	Contractor Action	Time Standard
Prior Authorization Review	Written Approval to Provider	Within one (1) business day from the review determination
Continued Stay Review	Written Denial to Provider	Within one (1) business day from the review determination
	Written Denial to Beneficiary/ Parent/Representative	Within one (1) business day from the review determination
Retrospective Review	Written Approval to Provider	Within three (3) business days from review determination
	Written Denial to Provider	Within three (3) business days from review determination
	Written Denial to Beneficiary/ Parent/Representative	Within three (3) business days from review determination

F. Therapeutic and Evaluative Services for Children Authorization

1. DOM covers mental health services through the EPSDT Program including but not limited to therapeutic (psychiatric diagnostic evaluation, individual, family, and group therapy) and evaluative (psychological, developmental, and neuropsychological evaluation) services. For additional information on coverage, see Provider Guidance Therapeutic and Evaluative Mental Health Services (T&E) for Expanded Early and Periodic

Screening, Diagnosis and Treatment (EPSDT). As a condition for reimbursement, DOM requires prior authorization for the following therapeutic and evaluative mental health services for children:

a. All evaluations (psychological, developmental, neuropsychological) for all beneficiaries. Prior authorization is not required for the preparatory (background/information gathering) and follow-up (feedback) sessions.

b. All psychotherapy (psychiatric diagnostic evaluation, individual, family, and group therapy) services for children younger than three (3) years of age; and

c. Psychotherapy services for beneficiaries aged 3-20 that exceed the service standards.

Failure to obtain authorization will result in denial of payment to providers billing for services. Historic information on the volume of authorizations is provided on DOM's Website.

2. The Contractor shall develop, implement, and maintain a UM/QIO program, which includes authorization, prior authorization and retrospective review of therapeutic and evaluative services requests.

3. The Contractor shall have the capability and established procedures to receive prior authorizations and supporting information via web-based submissions, facsimile, and mail from qualified providers.

   a. The Contractor shall establish and maintain a dedicated facsimile number, toll-free in Mississippi, for the receipt of review requests for therapeutic and evaluative services submitted by facsimile.

   b. The Contractor shall establish and maintain a physical mailing address in Hinds, Rankin or Madison County, Mississippi for the receipt of review requests for therapeutic and evaluative services submitted by mail.

   c. The Contractor shall establish and maintain a web-based system for receipt of review requests for therapeutic and evaluative services submitted electronically. This web-based system must comply with the requirements in Section 1.6 of this RFP.

4. Regardless of the mode of receipt, the Contractor shall have established procedures and sufficient capacity to receive review requests, clinical documentation, plans of care, and other forms or documentation required for prior authorization and post-payment review of therapeutic and evaluative services.

5. The Contractor shall determine the medical necessity of precertification of evaluations and therapy services and recertification reviews for therapy services to eligible Mississippi Medicaid beneficiaries utilizing DOM approved criteria and policies.

   a. Evaluation Precertification Reviews: The Contractor shall have the capability and established procedures to ensure determinations for evaluation precertification reviews are completed 98 percent of the time within two (2) business days of receipt.

   b. Therapy Precertification Reviews: The Contractor shall have the capability and established procedures to ensure determinations for therapy precertification reviews are completed 98 percent of the time within three (3) business days of receipt.

   c. Therapy Recertification Reviews: The Contractor shall have the capability and established procedures to ensure determinations for therapy recertification reviews are completed 98 percent of the time within seven (7) business days of receipt.

d. Retrospective Reviews: The Contractor shall have the capability and established procedures to ensure determinations for therapy recertification reviews are completed 98 percent of the time within ten (10) business days of receipt. (DOM provides retroactive Medicaid eligibility for a beneficiary that was not eligible for Medicaid benefits at the time of service.)

6. The Contractor shall develop and maintain a web-based, electronic review request system for prior authorization and prepayment review of therapeutic and evaluative services that allows for data input by the submitting providers. The Contractor's system shall have the capability for automated criteria/rules-based certification system. The Contractor shall manually review each prior authorization and prepayment review request received that is not authorized by the Contractor's rules-based system, along with any required supporting documentation to support the need for therapeutic and evaluative services.

7. The Contractor shall provide a first level review conducted by a complement of qualified staff, which must include registered nurses and/or behavioral health professionals licensed in the state of Mississippi, to apply Federal and State laws and regulations, DOM policies and/or formal memorandums and DOM approved medical necessity criteria in order to approve therapeutic and evaluative services based on certification policy and criteria or refer requests that cannot be approved to a second level review.

8. If request is not approved at the first level, the Contractor shall provide a second level review conducted by psychiatrists to make review determinations for therapeutic and evaluative services based on: 1) documentation that supports the medical necessity and appropriateness of setting; 2) consideration of unique factors associated with each patient care episode; 3) local healthcare delivery system infrastructure; and 4) clinical experience, judgment, and generally accepted standards of healthcare.

    a. The Contractor shall have the capability and established procedures for verbal consultation by the physician reviewer with the treating clinician to obtain additional information when the documentation submitted does not clearly support medical necessity.

    b. The Contractor shall ensure that authorization requests not meeting medical necessity criteria for therapeutic and evaluative services are reviewed by a physician licensed in the state of Mississippi and of the same specialty as the case under review.

9. The Contractor shall have the capability and established procedures for verbal and written notification to the requesting provider of a pended review and informing the provider of the information needed along with a time frame for submission that shall not exceed one (1) business days.

10. The Contractor shall have the capability and established procedures for verbal and written notification to the requesting provider of a suspended review. Notification to providers of suspended reviews shall occur within one (1) business day of the past due date for information requested.

11. The Contractor shall establish and maintain a procedure for the treating clinician to contact the Contractor's Medical Director to discuss therapeutic and evaluative services cases that have been denied or modified.

12. The Contractor shall notify providers and beneficiaries or legal guardians/representatives of review determinations for therapeutic and evaluative services requests.

    a. The Contractor shall issue verbal and written notification of approved certification results to the treatment provider and treating clinician.

b. The Contractor shall issue verbal and written notification of denials, modifications, or reductions to the treatment provider, attending physician, and beneficiary or, if a child, the legal guardian/representative.

c. Time frames for notification to providers and beneficiaries of review outcomes for prior authorization and post-payment review of therapeutic and evaluative services shall not exceed the following standards:

Table 19: Notification of Review Outcomes for Therapeutic and Evaluation Services for Children

Review Type	Contractor Action	Time Standard
Evaluation Precertification Review Therapy Precertification Review Therapy Recertification Review	Verbal Approval to Provider	Within one (1) business day from the review determination
	Written Approval	Within one (1) business day from the review determination
	Verbal Denial to Provider	Within one (1) business day from the review determination
	Written Denial to Provider	Within one (1) business day from the review determination
	Written Denial to Beneficiary/ Parent/Representative	Within three (3) business days from the review determination
Retrospective Review	Verbal Approval to Provider	Within three (3) business days from the review determination
	Written Approval to Provider	Within three (3) business days from the review determination
	Verbal Denial to Provider	Within three (3) business days from the review determination
	Written Denial to Provider	Within three (3) business days from the review determination
	Written Denial to Beneficiary/ Parent/Representative	Within three (3) business days from the review determination

G. Autism Spectrum Disorder Services Authorization

1. DOM covers Autism Spectrum Disorder (ASD) services for EPSDT eligible beneficiaries when medically necessary, prior authorized and provided by certain providers operating within their scope of practice. For additional information on coverage, see Administrative Code Title 23 Medicaid. As a condition for reimbursement, DOM requires that certain autism spectrum disorder services receive prior authorization. Specific services requiring prior authorization are identified in the Autism Spectrum Disorder Codes Listing on DOM's Website. Failure to obtain prior authorization will result in denial of payment to providers billing for services.

2. The Contractor shall develop, implement, and maintain a UM/QIO program, which includes prior authorization and retrospective review of autism spectrum disorder services requests.

3. The Contractor shall have the capability and established procedures to receive prior authorizations and supporting information via web-based submissions, facsimile, and mail from qualified providers and must comply with the requirements in Section 1.4.1. of this RFP.

4. Regardless of the mode of receipt, the Contractor shall have established procedures and sufficient capacity to receive review requests, clinical documentation, plans of care, and other forms or documentation required for prior authorization and post-payment review of autism spectrum disorder services.

5. The Contractor shall determine the medical necessity of precertification of autism spectrum disorder services and recertification reviews for autism spectrum disorder services to eligible Mississippi Medicaid beneficiaries utilizing DOM approved criteria and policies.

    a. Prior Authorization Reviews: The Contractor shall have the capability and established procedures to ensure the number of ASD reasonably required to treat the beneficiary's condition. Procedures must include information regarding specific discharge plans and a plan to monitor progress. The Contractor shall ensure prior authorization of services provided by mental health providers are completed 98 percent of the time within seven (7) business days of receipt.

    b. Continued Stay Reviews: The Contractor shall have the capability and established procedures to ensure determinations for continued stay reviews are completed 98 percent of the time within two (2) business days of receipt.

    c. Retrospective Reviews: The Contractor shall have the capability and established procedures to ensure determinations for retrospective reviews are completed 98 percent of the time within ten (10) business days of receipt. (DOM provides retroactive Medicaid eligibility for a beneficiary that was not eligible for Medicaid benefits at the time of service.)

6. The Contractor shall develop and maintain a web-based, electronic review request system for prior authorization and prepayment review of ASD services that allows for data input by the submitting providers. The Contractor's system shall have the capability for automated criteria/rules-based authorization system. The Contractor shall manually review each prior authorization and prepayment review request received that is not authorized by the Contractor's rules-based system, along with any required supporting documentation to support the need for ASD services.

7. The Contractor shall provide a first level review conducted by a complement of qualified staff, which must include registered nurses and/or behavioral health professionals licensed in the state of

Mississippi, to apply Federal and State laws and regulations, DOM policies and/or formal memorandums and DOM approved medical necessity criteria in order to approve ASD services based on certification policy and criteria or refer requests that cannot be approved to a second level review.

8. If request is not approved at the first level, the Contractor shall provide a second level review conducted by psychiatrists to make review determinations for ASD services based on: 1) documentation that supports the medical necessity and appropriateness of setting; 2) consideration of unique factors associated with each patient care episode; 3) local healthcare delivery system infrastructure; and 4) clinical experience, judgment, and generally accepted standards of healthcare.

    a. The Contractor shall have the capability and established procedures for verbal consultation by the physician reviewer with the treating clinician to obtain additional information when the documentation submitted does not clearly support medical necessity.

    b. The Contractor shall ensure that authorization requests not meeting medical necessity criteria for ASD services are reviewed by a physician licensed in the state of Mississippi and of the same specialty as the case under review.

9. The Contractor shall have the capability and established procedures for verbal and written notification to the requesting provider of a pended review and informing the provider of the information needed along with a time frame for submission that shall not exceed one (1) business days.

10. The Contractor shall have the capability and established procedures for verbal and written notification to the requesting provider of a suspended review. Notification to providers of suspended reviews shall occur within one (1) business day of the past due date for information requested.

11. The Contractor shall establish and maintain a procedure for the treating to contact the Contractor's Medical Director to discuss ASD services cases that have been denied or modified.

12. The Contractor shall notify providers and beneficiaries or legal guardians/representatives of review determinations for ASD services requests.

    a. The Contractor shall issue verbal and written notification of approved certification results to the treatment provider and treating clinician.

    c. The Contractor shall issue verbal and written notification of denials, modifications, or reductions to the treatment provider, attending physician, and beneficiary or, if a child, the legal guardian/representative.

    d. Time frames for notification to providers and beneficiaries of review outcomes for prior authorization and post-payment review of ASD services shall not exceed the following standards:

Table 20*:* Notification of Review Outcomes for Autism Spectrum Disorder Services for Children

Review Type	Contractor Action	Time Standard
Admission Precertification Review	Verbal Approval to Provider	Within one (1) business day from the review determination
Concurrent Stay Review	Written Approval	Within one (1) business day from the review determination
	Verbal Denial to Provider	Within one (1) business day from the review determination

	Written Denial to Provider	Within one (1) business day from the review determination
	Written Denial to Beneficiary/ Parent/Representative	Within three (3) business days from the review determination
Retrospective Review	Verbal Approval to Provider	Within three (3) business days from the review determination
	Written Approval to Provider	Within three (3) business days from the review determination
	Verbal Denial to Provider	Within three (3) business days from the review determination
	Written Denial to Provider	Within three (3) business days from the review determination
	Written Denial to Beneficiary/ Parent/Representative	Within three (3) business days from the review determination

H. Substance Use Disorder Services Authorization

1. DOM covers Substance Use Disorder (SUD) services when provided by one of the fourteen (14) regional community mental health centers located around the state, by the community services division of a State hospital, other certified community/private mental health center, or Primary Substance Use and Rehabilitation Center for eligible beneficiaries. For additional information on coverage, see Administrative Code Title 23 Medicaid. As a condition for reimbursement, DOM requires that certain mental health services receive prior authorization. Specific services requiring prior authorization are identified in the Substance Use Disorder Listing on DOM's Website. Failure to obtain the prior authorization will result in denial of payment to providers billing for services.

2. The Contractor shall develop, implement, and maintain a UM/QIO program, which includes prior authorization and prepayment review of SUD services requests.

3. The Contractor shall have the capability and established procedures that allow for receipt of prior authorizations and prepayment review requests and supporting information via web-based submissions, facsimile, and mail from mental health providers and must comply with the requirements in Section 1.4.1 of this RFP.

4. The Contractor shall establish and maintain a web-based system for receipt of prior authorization and prepayment review requests for SUD services submitted electronically. This web-based system must comply with the requirements in Section 1.6 of this RFP

5. Regardless of the mode of receipt, the Contractor shall have established procedures and sufficient capacity to receive review requests, clinical documentation, plans of care, and other forms or documentation required for prior authorization and post-payment review of SUD services.

6. The Contractor shall determine the medical necessity of prior authorization of services and recertification reviews for SUD services to eligible Mississippi Medicaid beneficiaries utilizing DOM approved criteria and policies.

a. Prior Authorization Reviews: The Contractor shall have the capability and established procedures to ensure the number of mental health services reasonably required to treat the beneficiary's condition. Procedures must include information regarding specific discharge plans and a plan to monitor progress. The Contractor shall ensure prior authorization of services provided by community/private mental health centers are completed 98 percent of the time within seven (7) business days of receipt

b. Continued Stay Reviews: The Contractor shall have the capability and established procedures to ensure determinations for continued stay reviews are completed 98 percent of the time within two (2) business days of receipt.

c. Crisis Residential and Primary Substance Use and Rehabilitation Center Reviews: The Contractor shall have the capability and established procedures to ensure determinations for crisis residential reviews are completed 98 percent of the time within two (2) business days of receipt.

d. Retrospective Reviews: The Contractor shall have the capability and established procedures to ensure determinations for therapy recertification reviews are completed 98 percent of the time within ten (10) business days of receipt. (DOM provides retroactive Medicaid eligibility for a beneficiary that was not eligible for Medicaid benefits at the time of service.)

7. The Contractor shall develop and maintain a web-based, electronic review request system for prior authorization and prepayment review of substance use disorder services that allows for data input by the submitting providers. The Contractor's system shall have the capability for automated criteria/rules-based authorization system. The Contractor shall manually review each prior authorization and prepayment review request received that is not authorized by the Contractor's rules-based system, along with any required supporting documentation to support the need for SUD services.

8. The Contractor shall have the capability and established procedures that allow for a first level review conducted by a complement of qualified staff, which must include registered nurses and/or behavioral health professionals licensed in the state of Mississippi, to apply Federal and State laws and regulations, DOM policies and/or formal memorandums and DOM approved medical necessity criteria in order to approve SUD services based on authorization policy and criteria or refer requests that cannot be approved to a second level review.

9. The Contractor shall have the capability and established procedures that allow for a second level review conducted by psychiatrists to make review determinations for SUD services based on: 1) documentation that supports the medical necessity and appropriateness of setting; 2) consideration of unique factors associated with each patient care episode; 3) local healthcare delivery system infrastructure; and 4) clinical experience, judgment, and generally accepted standards of healthcare.

10. The Contractor shall have the capability and established procedures for verbal consultation by the physician reviewer with the treating clinician to obtain additional information when the documentation submitted does not clearly support medical necessity.

11. The Contractor shall have the capability and established procedures for verbal and written notification to the requesting provider of a pended review and informing the provider of the information needed along with a time frame for submission that shall not exceed three (3) business days for admission/precertification and ten (10) business days for retrospective reviews.

12. The Contractor shall have the capability and established procedures for verbal and written notification to the requesting provider of a suspended review. Notification to providers of suspended reviews shall occur within one (1) business day of the past due date for information requested.

13. The Contractor shall establish and maintain a procedure for the community provider and treating clinician to contact the Contractor's Medical Director to discuss SUD services cases that have been denied or modified.

14. The Contractor shall have the capability and established procedures for notification to providers and beneficiaries or legal guardians/representatives of review determinations for SUD services requests.

    a. The Contractor shall have the capability and established procedures for issuing verbal and written notification of approved authorization results to the community provider, treating clinician, and attending physician.

    b. The Contractor shall have the capability and established procedures for issuing verbal and written notification of denials, modifications, or reductions to the community provider, treating clinician, attending physician, and beneficiary or, if a child, the legal guardian/representative.

15. Time frames for notification to providers and beneficiaries of review outcomes for prior authorization and prepayment review of substance use disorder services shall not exceed the following standards:

Table 21: Notification of Review Outcomes for Substance Use Disorder Services

Review Type	Contractor Action	Time Standard
Admission Precertification Reviews Concurrent Stay Review	Verbal Approval to Provider	Within one (1) business day from the review determination
	Written Approval	Within one (1) business day from the review determination
	Verbal Denial to Provider	Within one (1) business day from the review determination
	Written Denial to Provider	Within one (1) business day from the review determination
	Written Denial to Beneficiary/ Parent/Representative	Within three (3) business days from the review determination
Retrospective Review	Verbal Approval to Provider	Within three (3) business days from the review determination
	Written Approval to Provider	Within three (3) business days from the review determination
	Verbal Denial to Provider	Within three (3) business days from the review determination
	Written Denial to Provider	Within three (3) business days from the review determination
	Written Denial to Beneficiary/ Parent/Representative	Within three (3) business days from the review determination

I. ICF/IID Utilization Review

1. DOM covers Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) services for eligible Mediciad beneficiaries, certified for admission by the Mississippi Department of Mental Health in accordance with Administrative Code Title 23 Medicaid.

2. As a condition for reimbursesment, DOM requires ICF/IID services receive utilization reivew in accordance with C.F.R. § 456 subpart F.

3. The Contractor shall have established a utilization review process for ICF/IIDs which adheres to the following:

   a) The staff performing UR may not include any individual who is directly responsible for the care of the beneficiary whose care is being reviewed; is employed by the ICF, or has a financial interest in any ICF.

   b) For each initial and subsequent continued stay, the staff or its designee shall review and evaluate (at minimum) the following documentation: beneficiary identification, physician's name, Qualified Intellectual Disabilities Professional (QIDP), admission date, Medicaid application and eligibility date, plan of care, initial and subsequent continued stay review dates, reasons and plan for continued stay per the QIDP or physician, and other supporting material appropriate to be included.

   c) The UR staff shall develop written criteria to assess the need for continued stay.

   d) The UR staff shall develop more extensive written criteria for cases which are: associated with high costs, associated with the frequent excessive services, or attended by physicians whose patterns of care are frequently found to be questionable. (C.F.R. 456.432)

   e) The UR staff shall assign a specified date for continued stay review to each admitted beneficiary.

   f) The UR staff shall base assignment of the initial continued stay review date on methods and criteria; the initial continued stay review date is no later than six (6) months after admission or earlier than six (6) months after admission if indicated at the time of admission (C.F.R. 456.433)

   g) The UR staff shall insure that the initial continued stay review date is recorded in the beneficiary's record. (C.F.R. 456.433)

   h) The UR staff shall assign subsequent continued stay review dates each time a continued stay is needed, at least every six (6) months or more frequently if indicated. (C.F.R. 456.434)

   i) The UR staff shall ensure that each continued stay review date assigned is recorded in the beneficiary's record. (C.F.R. 456.434)

   j) The UR staff shall develop methods and criteria for continued stay review dates. (C.F.R. 456.435)

   k) The UR staff shall review a beneficiary's continued stay on or before the expiration of each assigned continued stay review date. (C.F.R. 456.436)

   l) The UR staff shall review and evaluate documentation of each beneficiary's continued stay against the criteria developed and applies close professional scrutiny. (C.F.R. 456.436)

m) If the UR staff identifies a beneficiary's continued stay is needed, a new continued stay review date shall be assigned. (C.F.R. 456.436)

n) If the UR staff identifies a continued stay does not meet the criteria, the staff, including at least one physician, shall review the case to determine the need for continued stay. (C.F.R. 456.436)

o) If the UR staff determines the continued stay is not needed, staff shall notify the beneficiary's attending physician or the QIDP within one (1) business day and give them two (2) business days from the notification date to conduct a peer review prior to issuing a decision on the need for continued stay. (C.F.R. 456.436)

p) Upon additional information or clarification by the attending physician or the QIDP, the need for continued stay shall be reviewed by: the physician(s) member of the UR staff for medical determinations, or the UR staff for cases not involving a medical determination (C.F.R. 456.436)

q) The UR staff shall provide notification of adverse determinations for continued stay, and this notification and to whom it is sent shall be included in the UR plan. (C.F.R. 456.437 and C.F.R. 456.438)

4. The Contractor shall have the capability and established procedures that allow for a first level review conducted by a complement of qualified staff, which must include registered nurses and/or behavioral health professionals licensed in the state of Mississippi, to apply Federal and State laws and regulations, DOM policies and/or formal memorandums and DOM approved medical necessity criteria in order to approve ICF/IID UR services based on authorization policy and criteria or refer requests that cannot be approved to a second level review.

5. The Contractor shall have the capability and established procedures that allow for a second level review conducted by psychiatrists to make review determinations for ICF/IID UR services based on: 1) documentation that supports the medical necessity and appropriateness of setting; 2) consideration of unique factors associated with each patient care episode; 3) local healthcare delivery system infrastructure; and 4) clinical experience, judgment, and generally accepted standards of healthcare.

6. The Contractor shall have the capability and established procedures for verbal consultation by the physician reviewer with the treating clinician to obtain additional information when the documentation submitted does not clearly support medical necessity.

7. The Contractor shall have the capability and established procedures for verbal and written notification to the requesting provider of a pended review and informing the provider of the information needed along with a time frame for submission that shall not exceed one (1) business day for continued stay.

8. The Contractor shall have the capability and established procedures for verbal and written notification to the requesting provider of a suspended review. Notification to providers of suspended reviews shall occur within one (1) business day of the past due date for information requested.

9. The Contractor shall establish and maintain a procedure for the community provider and treating clinician to contact the Contractor's Medical Director to discuss ICF/IID UR services cases that have been denied or modified within two (2) business days.

10. The Contractor shall have the capability and established procedures for notification to providers and beneficiaries or legal guardians/representatives of review determinations for ICF/IID UR services requests.

11. The Contractor shall have the capability and established procedures for issuing verbal and written notification of approved authorization results to the community provider, treating clinician, and attending physician.

12. The Contractor shall have the capability and established procedures for issuing verbal and written notification of denials, modifications, or reductions to the community provider, treating clinician, attending physician, and beneficiary or, if a child, the legal guardian/representative.

J. Behavioral Health Services Criteria Development

1. In performing medical necessity determinations, the Contractor shall use nationally recognized standardized clinical criteria in reviewing each prior authorization and prepayment review request. DOM shall have prior approval of the criteria used for automated and manual review. The criteria shall provide a clinically sound basis for professional determinations of the medical necessity for all behavioral health services reviewed under the resulting Contract.

   a. The Contractor shall maintain the capability to update the review criteria for behavioral health services reviewed under the resulting Contract. The Contractor shall make recommendations to DOM annually, regarding what, if any, changes should be made to the criteria that will be used for the following calendar year. The recommendations shall be included in the Contractor's annual report required in Section 1.8 of the RFP.

   b. The Contractor shall provide DOM with access to a complete set of materials associated with the criteria annually.

   c. Any modifications to the criteria or guidelines must be prior approved by DOM. Based on the best interest of the State of Mississippi and the review outcome, DOM reserves the right to specify the use of different criteria/guideline products during the resulting Contract.

   d. The Contractor is responsible for any cost associated with the purchase of any review criteria.

2. The Methodology section of the Technical Proposal must provide detailed information on the Offeror's process for determining medical necessity, including: 1) a description of the recommended review criteria for each service; 2) a description of the review instrument(s) for each service; and 3) a description of the Offeror's capability to develop an automated rules-driven authorization system.

3. The Methodology section of the Technical Proposal must provide a detailed description of the Offeror's approach to designing, developing, and employing medical necessity criteria through a web-based prior authorization system.

1.4.2.3 Dental Services Utilization Management Technical Requirements

This section describes the requirements for the development, implementation, and operation of a UM/QIO program for dental services to include:

- Dental Services;
- Dental Surgery Services; and
- Orthodontia Services.

The Methodology section of the Technical Proposal must provide information on the Offeror's experience which clearly demonstrates how the Offeror will meet stated requirements and describe in detail the Offeror's experience administering similar UM/QIO programs for dental services for commercial and/or government health care programs.

A. Dental Services Authorization

1. All dental expenditures, excluding orthodontia-related services, covered under DOM are limited to $2,500 per beneficiary per fiscal year. DOM covers palliative dental services for eligible beneficiaries. As required by Title XIX of the Social Security Act, Medicaid will provide medically necessary services through the EPSDT program for EPSDT eligible beneficiaries in accordance with Part 223 of Title 23, without regard to service limitations and with prior authorization. For additional information on coverage, see Administrative Code Title 23 Medicaid.

   As a condition for reimbursement, DOM requires prior authorization for the following benefits: 1) dental services for beneficiaries that have reached a $2,500 limit; 2) other specific dental procedures established by DOM as indicated in the fee schedule; and 3) procedures priced by prior authorization. Specific procedures requiring prior authorization are identified in the Dental Fee Schedules that can be accessed at http://www.medicaid.ms.gov/FeeScheduleLists.aspx.

   Failure to obtain the prior authorization will result in denial of payment to all providers billing for services. Currently, the UM/QIO conducts authorization of dental services.

2. The Contractor shall develop, implement, and maintain a UM/QIO program, which includes authorization, prior authorization and prepayment review of dental services requests.

3. The Contractor shall have the capability and established procedures to receive prior authorizations review requests and supporting information via web-based submissions, facsimile and mail submissions from dental providers.

   a. The Contractor shall establish and maintain a dedicated facsimile number, toll-free in Mississippi, for the receipt of prior authorization requests for dental services submitted by facsimile.

   b. The Contractor shall establish and maintain a physical mailing address in Hinds, Rankin or Madison County, Mississippi for the receipt of prior authorization review requests for dental services submitted by mail.

   c. The Contractor may establish and maintain a web-based system for receipt of prior authorization and prepayment review requests for dental services submitted electronically. Any web-based system must comply with the requirements in Section 1.6 of this RFP.

4. Regardless of the mode of receipt, the Contractor shall have established procedures and sufficient capacity to receive review requests, clinical documentation, and other forms or documentation required for prior authorization review of dental services.

5. The Contractor shall determine the medical necessity of prior authorization and retrospective reviews for dental services to eligible Mississippi Medicaid beneficiaries utilizing DOM approved criteria and policies.

   a. Prior Authorization Reviews: The Contractor shall have the capability and established procedures to ensure determinations for prior authorization reviews are completed 98 percent of the time within seven (7) business days of receipt.

   b. Retrospective Reviews: The Contractor shall have the capability and established procedures to ensure determinations for retrospective reviews are completed 98 percent of the time within ten (10) business days

of receipt. (DOM provides retroactive Medicaid eligibility for a beneficiary that was not eligible for Medicaid benefits at the time of service.)

6. The Contractor shall return original dental radiographs and photographs submitted by providers through the authorization process to the submitting provider.

7. The Contractor may develop and maintain a web-based, electronic review request system for authorization and prior authorization of dental services that allows for data input by the submitting providers. The Contractor's system may have the capability for automated criteria/rules-based authorization system. The Contractor shall manually review each prior authorization request not authorized by the Contractor's rules-based system for dental services.

8. The Contractor shall provide a first level review conducted by a complement of qualified staff, which must include registered nurses licensed in the state of Mississippi, to apply Federal and State laws and regulations, DOM policies and/or formal memorandums and DOM approved medical necessity criteria in order to approve dental services based on certification policy and criteria or refer requests that cannot be approved to a second level review. Manual pricing does not need to be conducted by a licensed health professional.

9. If request is not approved at the first level, the Contractor shall provide a second level review conducted by a Doctor of Dental Medicine (DDM) or Doctor of Dental Surgery (DDS) licensed in the State of Mississippi to make review determinations for dental services based on: 1) documentation that supports the medical necessity and appropriateness of setting; 2) consideration of unique factors associated with each patient care episode; 3) local healthcare delivery system infrastructure; and 4) clinical experience, judgment, and generally accepted standards of healthcare.

    a. The Contractor shall have the capability and established procedures for verbal consultation by the dental reviewer with the dental provider to obtain additional information when the documentation submitted does not clearly support medical necessity.

    b. The Contractor shall ensure that authorization requests not meeting medical necessity criteria for dental services are reviewed by a physician licensed in the state of Mississippi and of the same specialty as the case under review.

10. The Contractor shall have the capability and established procedures for written notification to the requesting provider of a pended review and informing the provider of the information needed along with a time frame for submission.

11. The Contractor shall have the capability and established procedures for written notification to the requesting provider of a suspended review. Notification to providers of suspended reviews shall occur within one (1) business day of the past due date for information requested.

12. The Contractor shall establish and maintain a procedure for the dental provider to contact the Contractor's Dental Director to discuss dental cases that have been denied or modified.

13. The Contractor shall notify providers and beneficiaries or legal guardians/representatives of review determinations for dental services requests.

    a. The Contractor shall issue a written notification of approved certification results to the dental provider.

b. The Contractor shall issue a written notification of denials, modifications, or reductions to the dental provider and beneficiary or, if a child, the legal guardian/representative.

c. Time frames for notification to providers and beneficiaries of review outcomes for prior authorization review of dental services shall not exceed the following standards:

Table 22: Notification of Review Outcomes for Dental Services

Review Type	Contractor Action	Time Standard
Prior Authorization Review	Written Approval to Provider	Within two (2) business days from review determination
	Written Denial to Provider	Within two (2) business days from review determination
	Written Denial to Beneficiary/ Parent/Representative	Within two (2) business days from review determination
Retrospective Review	Written Approval to Provider	Within three (3) business days from the review determination
	Written Denial to Provider	Within three (3) business days from the review determination
	Written Denial to Beneficiary/ Parent/Representative	Within three (3) business days from the review determination

B. Dental Surgery Services Authorization

1. DOM covers dental care that is an adjunct to treatment of an acute medical or surgical condition, services of oral surgeons and dentists in connection with surgery related to the jaw or any structure contiguous to the jaw or the reduction of any fracture of the jaw or any facial bone, and related emergency dental extractions and treatment. For additional information on coverage, see Administrative Code Title 23 Medicaid.

   As a condition for reimbursement, DOM requires authorization for specific procedures identified in the Dental Fee Schedules, which can be accessed at: http://www.medicaid.ms.gov/FeeScheduleLists.aspx.

   Failure to obtain the prior authorization will result in denial of payment to all providers billing for services. Currently, the UM/QIO conducts authorization of dental surgery.

2. The Contractor shall develop, implement, and maintain a UM/QIO program, which includes authorization, prior authorization and prepayment review of dental surgery services requests.

3. The Contractor shall have the capability and established procedures to receive authorizations and prior authorizations review requests and supporting information via facsimile and mail submissions from dental providers.

   a. The Contractor shall establish and maintain a dedicated facsimile number, toll-free in Mississippi, for the receipt of prior authorization requests for dental surgery services submitted by facsimile.

   b. The Contractor shall establish and maintain a physical mailing address in Hinds, Rankin or Madison County, Mississippi for the receipt of prior authorization review requests for dental surgery services submitted by mail.

c. The Contractor may establish and maintain a web-based system for receipt of prior authorization and prepayment review requests for dental surgery services submitted electronically. Any web-based system must comply with the requirements in Section 1.6 of this RFP.

4. Regardless of the mode of receipt, the Contractor shall have established procedures and sufficient capacity to receive review requests, clinical documentation, and other forms or documentation required for authorization and prior authorization review of dental surgery services.

5. The Contractor shall return original dental radiographs and photographs submitted by providers through the authorization process to the submitting provider.

6. The Contractor shall determine the medical necessity of prior authorization and retrospective review for dental surgery services to eligible Mississippi Medicaid beneficiaries utilizing DOM approved criteria and policies.

   a) Prior Authorization Reviews: The Contractor shall have the capability and established procedures to ensure determinations for prior authorization reviews are completed 98 percent of the time within seven (7) business days of receipt.

   b) Retrospective Reviews: The Contractor shall have the capability and established procedures to ensure determinations for retrospective reviews are completed 98 percent of the time within ten (10) business days of receipt. (DOM provides retroactive Medicaid eligibility for a beneficiary that was not eligible for Medicaid benefits at the time of service.)

7. The Contractor may develop and maintain a web-based, electronic review request system for authorization and prior authorization of dental surgery services that allows for data input by the submitting providers. The Contractor's system may have the capability for automated criteria/rules-based authorization system. The Contractor shall manually review each authorization and prior authorization requests not authorized by the Contractor's rules-based system for dental surgery services.

8. The Contractor shall provide a first level review conducted by a complement of qualified staff, which may include registered nurses licensed in the state of Mississippi or other oral health professionals, to apply Federal and State laws and regulations, DOM policies and/or formal memorandums and DOM approved medical necessity criteria in order to approve dental surgery services based on authorization policy and criteria or refer requests that cannot be approved to a second level review.

9. If request is not approved at the first level, the Contractor shall provide a second level review conducted by a DDM or DDS with a specialty license for oral and maxillofacial surgery in the State of Mississippi to make review determinations for dental surgery services based on: 1) documentation that supports the medical necessity and appropriateness of setting; 2) consideration of unique factors associated with each patient care episode; 3) local healthcare delivery system infrastructure; and 4) clinical experience, judgment, and generally accepted standards of healthcare.

   a. The Contractor shall have the capability and established procedures for verbal consultation by the dental reviewer with the dental provider to obtain additional information when the documentation submitted does not clearly support medical necessity.

b. The Contractor shall ensure that authorization requests not meeting medical necessity criteria for dental surgery services are reviewed by a physician licensed in the state of Mississippi and of the same specialty as the case under review.

10. The Contractor shall have the capability and established procedures for written notification to the requesting provider of a pended review and informing the provider of the information needed along with a time frame for submission.

11. The Contractor shall have the capability and established procedures for written notification to the requesting provider of a suspended review. Notification to providers of suspended reviews shall occur within one (1) business day of the past due date for information requested.

12. The Contractor shall establish and maintain a procedure for the dental provider to contact the Contractor's Dental Director to discuss dental cases that have been denied or modified.

13. The Contractor shall notify providers and beneficiaries or legal guardians/representatives of review determinations for dental surgery services requests.

    a. The Contractor shall issue a written notification of approved certification results to the dental provider.

    b. The Contractor shall issue a written notification of denials, modifications, or reductions to the dental provider and beneficiary or, if a child, the legal guardian/representative.

    c. Time frames for notification to providers and beneficiaries of review outcomes for dental surgery services shall not exceed the following standards:

Table 23: Notification of Review Outcomes for Dental Surgery

Review Type	Contractor Action	Time Standard
Prior Authorization Review	Written Approval to Provider	Within two (2) business days from review determination
	Written Denial to Provider	Within two (2) business days from review determination
	Written Denial to Beneficiary/ Parent/Representative	Within two (2) business days from review determination
Retrospective Review	Written Approval to Provider	Within three (3) business days from the review determination
	Written Denial to Provider	Within three (3) business days from the review determination
	Written Denial to Beneficiary/ Parent/Representative	Within three (3) business days from the review determination

C. Orthodontia Services Authorization

1. DOM covers orthodontia-related services that are limited to $4,200 per beneficiary per lifetime. Orthodontia-related services are only covered for EPSDT eligible beneficiaries who meet pre-qualifying criteria. For additional information on coverage, see Administrative Code Title 23 Medicaid.

As a condition for reimbursement, DOM requires authorization for specific procedures identified in the Dental Fee Schedules, which can be accessed at: http://www.medicaid.ms.gov/FeeScheduleLists.aspx. Failure to obtain the authorization will result in denial of payment to all providers billing for services. Currently, the UM/QIO conducts authorization of orthodontia services.

2. The Contractor shall develop, implement, and maintain a UM/QIO program, which includes authorization, prior authorization and prepayment review of orthodontia services requests.

3. The Contractor shall have the capability and established procedures to receive authorizations and prior authorizations review requests and supporting information via web-based submissions, facsimile and mail submissions from dental providers.

   a. The Contractor shall establish and maintain a dedicated facsimile number, toll-free in Mississippi, for the receipt of prior authorization requests for orthodontia services submitted by facsimile.

   b. The Contractor shall establish and maintain a physical mailing address in Hinds, Rankin or Madison County, Mississippi for the receipt of prior authorization review requests for orthodontia services submitted by mail.

   c. The Contractor may establish and maintain a web-based system for receipt of prior authorization and prepayment review requests for orthodontia services submitted electronically. Any web-based system must comply with the requirements in Section 1.6 of this RFP.

4. Regardless of the mode of receipt, the Contractor shall have established procedures and sufficient capacity to receive review requests, clinical documentation, and other forms or documentation required for authorization review of orthodontia services.

5. The Contractor shall return original dental radiographs and photographs submitted by providers through the authorization process to the submitting provider.

6. The Contractor shall determine the medical necessity of prior authorization and retrospective reviews for orthodontia services to eligible Mississippi Medicaid beneficiaries utilizing DOM approved criteria and policies.

   a) Prior Authorization Reviews: The Contractor shall have the capability and established procedures to ensure determinations for prior authorization reviews are completed 98 percent of the time within seven (7) business days of receipt.

   b) Retrospective Reviews: The Contractor shall have the capability and established procedures to ensure determinations for retrospective reviews are completed 98 percent of the time within ten (10) business days of receipt. (DOM provides retroactive Medicaid eligibility for a beneficiary that was not eligible for Medicaid benefits at the time of service.)

7. The Contractor may develop and maintain a web-based, electronic review request system for authorization and prior authorization of orthodontia services that allows for data input by the submitting providers. The Contractor's system may have the capability for automated criteria/rules-based authorization system. The Contractor shall manually review each authorization and prior authorization requests not authorized by the Contractor's rules-based system for orthodontia services.

8. The Contractor shall provide a first level review conducted by a complement of qualified staff, which must include registered nurses licensed in the state of Mississippi, to apply Federal and State laws and regulations, DOM policies and/or formal memorandums and DOM approved medical necessity criteria in order to approve orthodontia services based on certification policy and criteria or refer requests that cannot be approved to a second level review.

9. If request is not approved at the first level, the Contractor shall provide a second level review conducted by a board-certified orthodontist licensed in the State of Mississippi to make review determinations for orthodontia services based on: 1) documentation that supports the medical necessity and appropriateness of setting; 2) consideration of unique factors associated with each patient care episode; 3) local healthcare delivery system infrastructure; and 4) clinical experience, judgment, and generally accepted standards of healthcare.

    a. The Contractor shall have the capability and established procedures for verbal consultation by the dental reviewer with the dental provider to obtain additional information when the documentation submitted does not clearly support medical necessity.

    b. The Contractor shall ensure that authorization requests not meeting medical necessity criteria for orthodontia services are reviewed by a physician licensed in the state of Mississippi and of the same specialty as the case under review.

10. The Contractor shall have the capability and established procedures for written notification to the requesting provider of a pended review and informing the provider of the information needed along with a time frame for submission.

11. The Contractor shall have the capability and established procedures for written notification to the requesting provider of a suspended review. Notification to providers of suspended reviews shall occur within one (1) business day of the past due date for information requested.

12. The Contractor shall establish and maintain a procedure for the dental provider to contact the Contractor's Dental Director to discuss dental cases that have been denied or modified.

13. The Contractor shall notify providers and beneficiaries or legal guardians/representatives of review determinations for orthodontia services requests.

    a. The Contractor shall issue written notification of approved certification results to the dental provider.

    b. The Contractor shall issue written notification of denials, modifications, or reductions to the dental provider and beneficiary or, if a child, the legal guardian/representative.

    c. Time frames for notification to providers and beneficiaries of review outcomes for orthodontia services shall not exceed the following standards:

Table 24: Notification of Review Outcomes for Orthodontia Services

Review Type	Contractor Action	Time Standard
Prior Authorization Review	Written Approval to Provider	Within two (2) business days from review determination
	Written Denial to Provider	Within two (2) business days from review determination
	Written Denial to Beneficiary/ Parent/Representative	Within two (2) business days from review determination
Retrospective Review	Written Approval to Provider	Within three (3) business days from the review determination
	Written Denial to Provider	Within three (3) business days from the review determination
	Written Denial to Beneficiary/ Parent/Representative	Within three (3) business days from the review determination

D. Dental Services Criteria Development

1. In performing medical necessity determinations, the Contractor shall use a nationally recognized standard for the clinical criteria in reviewing each authorization, prior authorization and prepayment review request approved by DOM. DOM shall have prior approval of the criteria used for automated and manual review. The criteria shall provide a clinically sound basis for professional determinations of the medical necessity for all services reviewed under the resulting Contract.

    a. The Contractor shall maintain the capability to update the review criteria for services reviewed under the resulting Contract. The Contractor shall make recommendations to DOM annually, regarding what, if any, changes should be made to the criteria that will be used for the following calendar year. The recommendations shall be included in the Contractor's annual report required in Section 1.8 of this RFP.

    b. The Contractor shall provide DOM with access to a complete set of materials associated with the criteria annually.

    c. Any modifications to the criteria or guidelines must be prior approved by DOM. Based on the best interest of the State and the review outcome, DOM reserves the right to specify the use of different criteria/guideline products during the resulting Contract.

    d. The Contractor is responsible for any cost associated with the purchase of any review criteria.

2. The Methodology section of the Technical Proposal must provide detailed information on the Offeror's process for determining medical necessity, including: 1) a description of the recommended review criteria for each service; 2) a description of the review instrument(s) for each service; and 3) a description of the Offeror's capability to develop an automated rules-driven certification system.

3. The Contractor shall work with DOM to develop clinically sound, evidence-based, medical necessary criteria for all services. The Contractor shall have the capability to develop an automated criteria/rules-based authorization system. DOM shall approve all criteria prior to utilization by the Contractor. The automated criteria/rules-based authorization system is expected to perform a significant number of reviews.

4. The Methodology section of the Technical Proposal must provide a detailed description of the Offeror's approach to designing, developing, and implementing medical necessity criteria for all services through a web-based prior authorization system.

1.4.3. Peer Review Services

Healthcare practitioners and any other persons, including institutions, who furnish health care services or items for which payment may be made, in whole or in part, by DOM have certain obligations as set forth in Title XI of the Social Security Act (U.S.C. Section 1320c *et seq.*) and Mississippi State Law (Miss. Code Ann. Section 43-13-121) that must be met. These obligations are to ensure that services or items are provided economically only when and to the extent they are medically necessary, of a quality that meets professionally recognized standards of health care, and supported by the appropriate documentation of medical necessity and quality.

1. The Contractor shall have the capacity and established procedures to carry out a proper peer review investigation and review of Medicaid providers and providers performing services contracted with the Coordinated Care Organizations operating within the Mississippi Coordinated Access Network (MSCAN). The Contractor shall carry out the peer investigation and review when DOM has identified, by data analysis or other means, a possible violation by a health care practitioner. Following DOM's submission of a written request to the Contractor for a peer investigation, the Contractor shall conduct a peer review in accordance with DOM's Administrative Code, specifically Title 23 Medicaid and DOM directives. Peer review actions shall adhere to the following timelines:

    a. Upon receipt of a referral from DOM, the Contractor's Medical, Dental, Pharmacy, or Quality Director, or his/her designee, as determined by DOM, shall conduct consultant record review and submit initial findings with recommendations to DOM that either no violation of obligation(s) occurred or further review by a Peer Review Panel (PRP) is necessary. The consultant record review shall be completed within sixty (60) calendar days of the receipt of the records by the Contractor.

    b. DOM will respond in writing to the Contractor's recommendations.

    c. For DOM approved recommendations for a PRP, the Contractor shall have fifteen (15) calendar days to select a panel and distribute medical records to panel members. The PRP shall be established in accordance with DOM's Administrative Code and shall consist of at least three (3) health care practitioners, at least one (1) of whom practices in the same class group as the subject health care practitioner. Selection of the PRP members shall be done in such a way as to ensure that their objectivity and judgment will not be affected by personal bias for or against the subject health care practitioner or by direct economic competition or cooperation with the subject health care practitioner. DOM shall make records relevant to the possible violation available to the PRP.

    d. Following the PRP's review of the relevant records, the PRP will meet, either in person or by conference call, to deliberate on the matter. Minutes of the meeting will be taken and documented in the case record. The PRP shall complete this process within thirty (30) to sixty (60) calendar days of the Contractor's receipt of the records.

        i. If the PRP determines that there has been no violation of obligations, it will notify DOM, in writing, of that finding and recommend that no action be taken. The records relied upon to make the recommendation, as well as the minutes of the PRP meeting, shall accompany the written

recommendation. DOM shall make a final decision, within fourteen (14) working days of its receipt of the recommendation, and so inform the Contractor. DOM may accept the recommendation, take other action on the case, or return the case to the Contractor for further action, as specified by DOM.

ii. If the PRP finds a potential violation of obligations, the Contractor shall issue a preliminary findings letter, within ten (10) calendar days, to the health care practitioner by certified mail, restricted delivery, return receipt requested. The letter must contain all requirements of DOM's Administrative Code, Part 300, Rule 1.4 (E)(4)(a)(1) including, but not limited to, giving notice of potential violation(s) will set forth the specific preliminary finding of potential violation(s) and instructing the health care practitioner to attend a Peer Review Panel conference, which will be set no later than thirty (30) days after the letter date, in order to present his or her position on the matters at issue. The health care practitioner shall be instructed by the Contractor in the letter to provide the PRP with any information in support of the health care practitioner's position no later than ten (10) days prior to the conference in order to allow time for its proper study.

iii. If the PRP determines that the health care practitioner has violated one or more DOM obligations, it will formulate a corrective action plan (CAP). The Contractor shall submit the findings with recommendations to DOM within ten (10) calendar days from date of conference with the health care practitioner.

iv. The Contractor shall ensure the CAP lists the specific obligations violated; the specific elements of the CAP which shall address correction of the behavior which led to the violation(s); the duration of the CAP which is a minimum of ninety (90) days; and the means by which compliance with the CAP will be monitored and assessed. The health care practitioner will be required to sign the CAP and return it within ten (10) calendar days to the PRP. If the health care practitioner fails to submit the signed CAP, the PRP will immediately recommend to the Executive Director of DOM that a sanction be imposed on the health care practitioner.

v. The Contractor and the PRP will monitor the signed CAP. After the CAP has been completed, all information subject to being monitored, including, but not limited to FFS and CCO encounter claims history, copies of patient records, files, and charts will be obtained by DOM and submitted to the PRP for review. Within thirty (30) days of the receipt of such information from DOM, the PRP will meet to determine whether or not the health care practitioner complied with the CAP and whether the CAP was effective. Minutes will be kept of the meeting. If the CAP was effective and the health care practitioner is now meeting all obligations, the PRP will provide a written recommendation to DOM that the peer review process has been completed and the identified violation(s) corrected and resolved.

vi. DOM will make a final decision within fourteen (14) working days of its receipt of the recommendation and so inform the Contractor. DOM may accept the recommendation, take other action on the case, or return the case to the Contractor for further action, as specified by DOM. The Contractor shall inform the health care practitioner, as directed by DOM, if it is determined to close the case, by certified mail, restricted delivery, return receipt requested within ten (10) working from date of DOM acceptance of recommendations.

vii. If the CAP was not effective and the health care practitioner, as noted in the minutes of the meeting, is still deemed to be violating obligations, the PRP shall, by a motion approved by a majority of its members, recommend to the Executive Director of DOM that a sanction be imposed. The full and complete record relied upon to make the recommendation and the minutes of the PRP will be submitted to the Executive Director of DOM within fifteen (15) days of the PRP's recommendation for sanction.

e. If the PRP finds violations that arise to the level of gross and flagrant, such that the life and welfare of the health care practitioner's patients are in jeopardy, it will immediately relay its finding to the Contractor's Medical Director, or his/her designee who will recommend to the Executive Director of DOM that the health care practitioner be immediately suspended from the Medicaid program. Violations at this level may also result in a referral, by the Contractor, to the Mississippi State Board of Medical Licensure (MSBML) for further investigation.

f. Contractor shall communicate with DOM in writing if timelines in this section cannot be met. Contractor shall request an extension in writing for extenuating circumstances. Contractor shall provide weekly updates in writing to DOM for any peer review services in an extension status.

2. The Contractor shall ensure the utilization review policies and procedures include procedures to proactively identify potential cases of fraud, waste, and abuse, including notification to DOM about potential cases. The Contractor shall also include the identification of fraud, waste, and abuse in staff training.

3. The Contractor shall provide notification of fraud, waste, and abuse when the health, safety, or welfare of an individual is at risk directly to DOM within twenty four (24) hours of identification of potential cases.

1.4.4. Focused Studies

1. The Contractor must be able to demonstrate the capability to assist DOM in focusing on promoting efficient use of quality health care services at the least cost through intensive studies of data and practice patterns, and reporting the results of such studies with recommendations for improving the health care delivery system.

2. The Contractor must have the capacity and established procedures to conduct intensive studies of data and practice patterns through all of the following:

   a. Collect and analyze Medicaid service utilization data from various sources as approved by DOM including review results data.

   b. Evaluate the efficiency of health care delivery, appropriate use of services, and opportunities to improve quality of care for Mississippi Medicaid beneficiaries.

   c. Propose, design, and implement focused studies related to programs, beneficiaries, providers, services, and other topics related to Medicaid.

   d. Identify opportunities for improving efficiencies in various programs and provide to DOM recommendations and strategies for improving the delivery of health care.

e. Provide education to providers with demonstrated aberrant utilization practice patterns or that have quality of care issues.

3. The Contractor shall propose and implement focused studies related to medical services, providers, and programs on an annual basis to identify opportunities for improving efficiencies in various programs and provide DOM with recommendations and strategies for improving the delivery of health care.

4. The Contractor shall develop and maintain procedures and processes for providing education to providers who demonstrate aberrant practice patterns or have quality of care issues.

1.4.5. Clinical/Medical Consulting Services

1. The Contractor shall have the capacity and established procedures to provide clinical/medical consultation through the Contractor's Medical, Dental, or Pharmacy Director and independent evaluators as appropriate, in order to assist DOM in addressing medical necessity issues, researching new technology, developing medical policies, addressing quality issues, etc.

2. At the request of DOM, the Contractor may also provide clinical/medical consultation for various types of healthcare practitioner participating in the Mississippi Medicaid program. Healthcare practitioner types may include, but are not limited to, medical doctors, doctors of osteopathy, podiatrists, chiropractors, nurse practitioners, certified registered nurse anesthetists, nurse midwives, dentists, therapists, optometrists, and mental health practitioners. All consults conducted by the Contractor shall be performed by a consultant of the same provider type and/or specialty.

3. At the request of DOM, the Contractor shall conduct reviews of adverse benefit determinations (denials, suspensions, terminations) by a Coordinated Care Organization participating in the MississippiCAN.

    a. In accordance with Section 43-13-116 of the Mississippi Code of 1972, as amended, and 42 CFR 431.200 et. seq., Medicaid recipients have an opportunity to request an administrative hearing in order to appeal decisions of denial, termination, suspension or reduction of Medicaid covered services.

    b. If a decision is made by the Coordinated Care Organization participating in the MississippiCAN to reduce, deny, suspend or terminate covered services provided to a member, and the member disagrees with the decision, the member and/or his/her legal representative must request a hearing in writing within thirty (30) days of the notice of adverse benefit.

    c. The Contractor shall conduct an independent evaluation of the case and submit to DOM a determination. The independent evaluation shall be conducted by a professional in the same or a similar specialty as the professional, who originally denied, terminated, suspended or reduced the Medicaid covered service(s). In no case shall the review professional have been involved in the initial adverse benefit determination.

    d. The independent evaluator shall not participate in policy reviews, coverage recommendations, or policy development for DOM.

    e. At the request of DOM the Contractor shall be present and participate in an administrative hearing.

4. The Contractor shall have a written program which outlines the program structure and accountability and includes, at a minimum, procedures and process for clinical/medical consultations through the Medical Director or Dental Director, as appropriate, and consultant advisors of the same provider type and/or specialty or as directed by DOM and mechanisms providing DOM with consultant review summaries within twenty (20) business days of receipt of the case.

1.4.6. Care Management Services

1. The Contractor shall have the capacity and established procedures to provide care management services for FFS beneficiaries with the following diagnoses:

    a. Hepatitis

    b. Hemophilia

    c. Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS):

2. The Contractor shall have the capacity and established procedures to provide care management services for the following FFS beneficiaries:

    a. Beneficiaries enrolled in FFS at date of delivery and for sixty (60) calendar days postpartum.

    b. FFS beneficiaries enrolled in the Disabled Child Living at Home (DCLH) category of eligibility.

3. The Contractor shall develop and maintain policies and procedures to ensure beneficiary access to Care Management service and at a minimum:

    c. Assign the beneficiary to a single point of contact;

    d. Assign the beneficiary to a Care Management team;

    e. Provide access to beneficiary services via dedicated toll-free phone number;

    f. Maintain beneficiary information and ensure the information is accessible twenty-four (24) hours per day seven (7) days per week to the Care Management Team staff.

    g. Make contact with the beneficiary once during a thirty (30) calendar day period, and following inpatient discharge or major health status change (contact may be provided face-to- face or via telephone);

        1) Document a minimum of two (2) contact attempts per thirty (30) calendar day period, and following inpatient discharge or major health status change (contact may be provided face-to- face or via telephone) for any beneficiary which the Care Management Team is unable to reach;

    h. Assist with care coordination and access to primary care, inpatient services, Behavioral Health/Substance Use Disorder Services, preventive and specialty care, as needed;

    i. Coordinate discharge planning and follow-up to care post inpatient discharge;

j. Coordinate with other health and social programs and provide beneficiaries with information about community-based, free care initiatives and support groups;

k. Assist the beneficiary when the beneficiary requests assistance to identify providers;

l. Assist with appointment scheduling when necessary;

m. Provide information about the availability of services and access to those services;

n. Work with beneficiaries, providers, and other Contractors to ensure continuity of care;

o. Monitor and follow up with beneficiaries and providers, which may include regular mailings, newsletters, or face-to-face meetings, as appropriate.

4. The Contractor shall provide care management services conducted by a complement of qualified staff, which must include registered nurses and/or behavioral health professionals licensed in the state of Mississippi, to apply Federal and State laws and regulations, DOM policies and/or formal memorandums and DOM.

1.5. Staffing Requirements

1. The Contractor must have sufficient physical, technological, and financial resources to conduct UM/QIO services that meet the requirements of this RFP. The Contractor shall provide sufficient clinical, administrative and organizational staff to implement the provisions and requirements of the Contract and for fulfillment of the Contractual obligations.

2. The Contractor shall maintain key personnel to perform the required tasks within performance standards, as listed below. At a minimum, the Contractor must employ the following key personnel by sixty (60) days prior to operation start date: a) Project Manager wholly dedicated to this Contract; b) Assistant Project Manager wholly dedicated to this Contract; c) Medical Director d) Dental Director e) Pharmacy Director f) Quality Director wholly dedicated to this Contract located at DOM g) Education Manager wholly dedicated to this Contract; and h) Information Systems Manager.

   a. The Contractor shall employ a full-time wholly dedicated Project Manager who shall have day-to-day authority to manage the UM/QIO Program and is responsible for overseeing the implementation of the Contract requirements. The Project Manager must possess knowledge of Medicaid programs with relevant experience navigating similar complex projects with minimum experience of seven (7) years managing and/or working with Medicaid, government health plans, or authorization programs is required. The Project Manager shall be available to DOM during regular business hours of DOM operation. The Contractor shall not hire a new Project Manager without prior approval from DOM.

   b. The Contractor shall employ a full-time wholly dedicated Assistant Project Manager to assist in overseeing all functions related to the UM/QIO Program, with minimum experience of five (5) years managing and/or working with Medicaid, government health plans, or authorization programs is required. The Contractor shall not hire a new Assistant Project Manager without prior approval from DOM.

   c. The Contractor shall employ a full-time physician with a traditional medical license, licensed in the state of Mississippi to serve as the Medical Director, responsible for all clinical oversite of the UM/QIO program.

An administrative medical license is not sufficient for the Medical Director position. The Medical Director shall be available for consultation on referrals, denials, Complaints, Grievances, and Appeals; review potential quality of care problems, and participate in the development and implementation of corrective action plans. The full-time physician shall not be an active Medicaid provider.

d. The Contractor shall employ a dentist, licensed in the state of Mississippi, to serve as the Dental Director, responsible for applicable clinical oversite of the UM/QIO program. The Dental Director shall be available for consultation on referrals, denials, Complaints, Grievances, and Appeals; review potential quality of care problems, and participate in the development and implementation of corrective action plans.

e. The Contractor shall employ a Pharmacist, licensed in the state of Mississippi, to serve as the Pharmacy Director, responsible for applicable clinical oversite of the UM/QIO program. The Pharmacy Director shall be available for consultation on referrals, denials, Complaints, Grievances, and Appeals; review potential quality of care problems, and participate in the development and implementation of corrective action plans.

f. The Contractor shall employ a full-time wholly dedicated Quality Director, a Physician licensed in the state of Mississippi, to serve as a clinical liaison for quality management and improvement activities for the FFS and MississippiCAN programs, located at the DOM Central office and shall work during normal business hours of DOM. The Onsite Quality Director shall have minimum experience of three (3) years managing and/or working with Medicaid, government health plans, or authorization programs is required.

g. The Contractor shall employ an a full-time wholly dedicated Education Manager, with minimum experience of three (3) years managing and/or working with Medicaid, government health plans, or authorization programs is required.

h. The Contractor shall employ an Information Systems Manager, with minimum experience of five (5) years overseeing information technology and systems operations, including submission of accurate and timely data is required. The Contractor shall notify DOM in writing of any key staff resignations, dismissals, or personnel changes within two (2) business days of the occurrence. Should any key position become vacant, the Contractor must notify DOM immediately and provide information on the replacement within ten (10) business days. DOM shall have the right to participate in the selection process and approve or disapprove the hiring of any key staff positions.

3. DOM reserves the right to approve or disapprove Contractor's key personnel or to require the removal or reassignment of any personnel found by Medicaid to be unwilling or unable to perform the terms of the Contract.

4. The Contractor must demonstrate the ability to secure and retain qualified professional, administrative, and clerical staff. The Contractor shall submit a staffing plan to DOM for approval. The Contractor is solely responsible for ensuring that the staffing plan includes sufficient minimum level qualifications to ensure employment of qualified staff.

5. The Contractor shall ensure that all staff has the training, education, experience, and orientation to conduct activities under the Contract resulting from the RFP. At a minimum, the Contractor shall:

a. Ensure that all physician reviewers meet qualifications required in State and federal regulations and are licensed in the state of Mississippi.

b. Provide all key personnel and other supervisory staff with project management training.

c. Provide staff with intensive training on procedures, medical necessity criteria, and DOM policies.

d. Ensure that staff is knowledgeable of Mississippi Medicaid and other State health care programs, and related federal and State laws and regulations.

6. The Contractor must notify DOM in writing within five (5) business days of any temporary or permanent changes to personnel commitments made in the Contractor's proposal or DOM approved staffing plan.

7. The Contractor shall provide DOM with its staff "turn-over" rates at the request of DOM. In the event DOM determines the Contractor's staff or staffing levels are not sufficient to properly complete the services specified in the RFP and the resulting Contract, it shall advise the Contractor in writing. The Contractor shall have thirty (30) calendar days to remedy the identified staffing deficiencies.

8. The Contractor shall have staff available at their office location at a minimum Monday through Friday, 8:00 a.m. to 5:00 p.m. Central Standard Time. The Contractor's designated office location shall be within Hinds, Madison or Rankin County. The Office shall include at least one statewide toll-free telephone number for receipt of Medical and behavior health authorization requests, a separate statewide toll-free telephone number for inpatient hospital medical/surgical services. The numbers shall be answered by live operators located at the office location within Hinds, Madison or Rankin County at minimum Monday through Friday, 8:00 a.m. to 5:00 p.m. Central Standard Time including State holidays except for New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day and Christmas Day. Calls placed during hours the office is not open shall receive a voice message, in English, stating the hours of operation and advising the caller to dial "911", or the appropriate emergency number, if there is an emergency. The Contractor may also route calls placed during hours that the office is not required by DOM to be open to any office operated by Contractor staff in any location in the United States of America. The Contractor may never route calls outside of the United States of America. The Contractor shall train staff on using services offered by Mississippi Relay for callers who are deaf, hard-of-hearing, deaf-blind or speech disabled. The Contractor shall propose an alternate protocol for non-English speaking or non-verbal beneficiaries. The Project Manager, Assistant Project Manager, Medical Director, Education Manager; shall conduct UM/QIO business and be physically located within the office location. UM/QIO staff shall be capable of conducting business as needed thirty (30) business days prior to the Operational Start Date to ensure adequate pre-operation implementation activities.

9. The Contractor shall maintain a sufficient percentage of clinical review staff in the designated office location. The Contractor must receive DOM approval to allow staff to work from a remote location. DOM reserves the right to approve or disapprove the number of clinical review staff allowed to work from a remote location. In the event DOM identifies deficiencies in service or timeliness standards, DOM has the authority to request additional staffing at no cost to DOM to perform the functions detailed in this RFP.

10. DOM must prior approve any changes to the Contractor office location or when any of the Contractor Contractual obligations will be performed at a different site other than the designated office location.

11. The Contractor shall make its staff available to meet with DOM staff on a schedule, as agreed to by DOM and the Contractor, to review reports and all other obligations under the resulting Contract as requested by DOM. The Contractor shall meet in person with DOM staff, at least monthly, and as required by DOM, to discuss the status of the resulting Contract, Contractor performance, benefits to DOM, necessary revisions, reviews, reports, and planning. The Contract shall submit to DOM meeting minutes within three (3) business days following the meeting with DOM staff.

1.6. Systems Requirements

1.6.1. Management Information System Objectives

1. The Contractor shall use available industry technologies to reduce inefficiencies and errors in UM processes and activities. Such technologies shall include automated review of some prior authorization requests, "smart" electronic and web-based request submission technologies to reduce technical denials due to incomplete submissions, and other such technology that allows for easier communication with providers.

2. The Contractor shall make all data collected in accordance with 42 C.F.R. § 438.242 available to DOM and upon requests from CMS. The Contractor shall provide to DOM all clinical data that is captured by providers and transmitted to the Contractor. Clinical data includes but is not limited to diagnoses, procedures, medications, immunizations, allergies, smoking status, BMI, vitals, visit notes, radiology orders, tests ordered and results received for general labs and pathology labs. Clinical data shall be provided to DOM using the clinical data exchange standards of C-CDA and/or HL7 2.5. Transmission of clinical data shall occur through either direct transmission to DOM Interoperability platform or through the statewide Health Information Exchange (HIE) known as Mississippi Health Information Network (MS-HIN).

   The Contractor's participation shall include sharing clinical data with the HIE to support the goal of sharing clinical data with providers throughout the state as necessary to improve the quality, timeliness and cost of care.

3. DOM seeks to manage costs and minimize the administrative burden on providers by requiring the Contractor to develop and maintain:

   a. A Management Information System (MIS) that can successfully integrate with the Medicaid Management Information System (MMIS) and other Medicaid contractors; and

   b. A web-based data system that will allow for efficiencies and increases in administrative ease, and supports a seamless transition for Medicaid providers that will have to use the system.

4. Many authorization requests are now submitted either through the current contracted UM/QIO's Web portal or the DOM Provider Web Portal. Electronic submission has helped to make the UM process somewhat more efficient, and DOM would like to take full advantage of industry technologies to institute sound, consistent, electronic, and automated UM policies and processes.

1.6.2. Data Exchange

1. DOM maintains the Medicaid MMIS that contains recipient and provider information, including benefit plans and claims data. The Contractor shall be able to receive data and other information necessary to maintain all necessary prior authorization systems, from DOM or its designee, on a daily basis.

2. The Contractor shall have the capability to receive recipient eligibility data that includes Medicaid eligibility and Medicare Part A and Part B eligibility segment data.

3. The Contractor shall have the capability to identify review requests for Medicaid recipients that have reached Medicaid service limits and beneficiaries that have Medicare and ensure that the Medicare benefit has been exhausted for the service requested.

4. The Contractor shall be responsible for verifying the beneficiary's eligibility for Medicaid, including requests for prior authorization that are processed through the Contractor's automated rules system.

5. The Contractor shall have the capability to receive and store eligibility, provider, and MMIS claims data including FFS and CCO encounter data from DOM's fiscal agent. The Contractor shall work with the fiscal agent on any necessary interface changes at no additional cost to DOM.

6. The Contractor shall become knowledgeable of the field definitions related to the data being sent from DOM and/or its agents. The Contractor shall develop systems to allow simple additions or modifications of the data received.

7. The Contractor shall interface with DOM's fiscal agent in order to generate a TAN. The Contractor shall transmit TANs to DOM's MMIS with the result of the authorization request using a mutually agreed upon transfer method via a proprietary format.

8. The Contractor shall have the ability to report the review status of an authorization request, the result of the authorization request, and the reason for the denial if the authorization request was denied.

9. The Contractor shall have the capability to transmit all data from their systems or database to DOM or to a third party designated by DOM to receive the data.

1.6.3. Web-Based Prior Authorization System

1. The Contractor shall establish, during the Implementation Period, a web-based, electronic review request system accessible to providers and DOM staff no less than thirty (30) calendar days prior to Operations Start Date, through which providers may submit requests and view determinations. The Contractor shall also have the capability to accept supporting documentation for prior authorization requests via facsimile transmission, via electronic upload through the web-based system or via a secure email solution that meets DOM's security requirements.

2. The Contractor shall participate in MS-HIN Health Information Exchange and become a member of the organization at no additional cost to DOM.

3. The Contractor's web-based, electronic review request system shall include the ability for authorized users to access the web-based, electronic review request system via a secured logon.

4. The Contractor shall establish a protocol to assign user logons and passwords upon receipt of necessary documentation, to verify that the user is authorized to view beneficiary information.

5. The Contractor shall include in the web-based, electronic review request system the ability for users to view and securely download all data, analytics, or reports that are specific to the user defined by the user's profile and security access.

6. The Contractor's web-based, electronic review request system shall have the ability to receive authorization requests from providers in accordance with requirements of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (Public Law 104-191) Transaction Standards, for all services where electronic submission is required. The Contractor shall have the capability to assign a unique tracking number to each review record.

7. The Contractor's web-based, electronic review request system shall have the ability to send and receive HIPAA-compliant PII and PHI transactions for authorization requests requiring attachments.

8. The Contractor's web-based system shall support provider submission of proof that the Medicare benefits for the given service have been exhausted for the benefit period. The Contractor's systems will allow entry of the Medicaid utilization request, if the provider supplies the information that the Medicare benefits are exhausted.

9. The Contractor shall create a "smart" electronic authorization request form, customized for each service that requires authorization. The Contractor shall design this form so that it reduces the chances of technical denials due to incorrect or missing information.

10. The Contractor shall provide training in the use of the web-based system and the equipment required for DOM online access to the web-based system. DOM staff shall be given access to the Contractor's electronic system for the purpose of monitoring the utilization management program (at no additional cost to DOM.)

1.6.4. Database Creation and Maintenance

1. The Contractor shall develop and maintain databases necessary to support the UM processes and activities in any resulting Contract. The database and data developed as a result of this RFP and the resulting Contract are the property of DOM.

2. The Contractor is responsible for maintaining a comprehensive database that provides the current status of all review activity. The database should include historical data from an existing peer review database, which will be provided by DOM.

3. The database shall be updated with all activity, at a minimum, on a daily basis. The database must include all review elements and provider and recipient service information. The data elements shall be approved by DOM. The Contractor shall maintain a process by which the dates, history, and steps of each submitted authorization request are kept.

4. The Contractor shall provide DOM with direct read-only access to its database. The Contractor shall provide training in the use of the database for DOM online access to the database. DOM staff shall be given access to the Contractor's database for the purpose of monitoring the UM/QIO programs (at no additional cost to DOM.)

5. Upon DOM's request, the Contractor shall make data samples, in a format prescribed by DOM, available to DOM or its designee for ad hoc reporting, program monitoring, and quality assurance activities by DOM. Criteria for inclusion in any data sample requested will be provided by DOM. The data sample may include elements previously sent from DOM or its designee and data collected by the Contractor.

1.6.5. Other Systems Requirements

1. The Contractor shall have facsimile and scanning capability, secure internet mail capability, and provide DOM online access to the Contractor databases, reports, and other information related to the program at no cost to DOM.

2. The Contractor shall have the capability to provide electronic imaging and storage of all supporting review documentation.

3. The Contractor shall also have the technical capability to provide accessibility through an enhanced Internet security communications system and an adequate number of phone and fax lines to interface with the Medicaid fiscal agent, MMIS, DOM, and providers. Accessibility shall be centralized, with no change in Internet address, telephone, or facsimile numbers for the duration of the resulting Contract period.

4. The Contractor shall fully comply with all HIPAA requirements and shall maintain compliance with federal HIPAA requirements throughout the term of the contract at no additional cost to DOM.

5. The Contractor shall have protocols and internal procedures for ensuring system security and the confidentiality of recipient identifiable data.

6. The Contractor shall ensure that only authorized personnel can process transactions or access recipient information. The Contractor shall provide administrative support through a browser based administrative terminal that conforms to DOM security protocols.

7. The Contractor shall have the capacity (hardware, software, and personnel) sufficient to access and generate all data and reports needed for this program. The Contractor shall maintain a sufficient number of qualified MIS and technical staff to continue operation of the Contractor's system, provide prompt, on-going system support and accurate data access to DOM and its authorized agents and service providers.

1.6.6. System Modifications

1. The Contractor shall have the capability to maintain, upgrade, and modify the web-based prior authorization system as specified by DOM on an ongoing basis, at no additional charge direct or indirect to DOM.

2. When the Contractor needs to upgrade or make changes to any part of the web-based system that will affect a provider's ability to submit authorization requests or review status reports, the changes must be scheduled to occur after 10:00 p.m., Central Time, and before 6:00 a.m., Central Time, unless a different time is agreed upon by DOM. DOM and providers must be notified by e-mail twelve (12) hours prior to any scheduled maintenance. Scheduled downtime must be approved in writing by DOM.

3. DOM may request system changes or modifications not otherwise specified or required in this RFP on an as needed basis. In the event that changes or modification requested by DOM would require additional staff commitment beyond that which is proposed by the Contractor in response to this RFP, DOM would allow the Contractor thirty (30) calendar days to provide a cost analysis of the changes and a timeline for completing the changes. If the Contractor's response is accepted by DOM, the change or modification shall be reduced to writing in an amendment to the resulting Contract.

4. DOM will designate a single point of contact to prioritize systems changes.

1.7. Reporting Requirements

The Contractor shall provide DOM with the reports specified in this RFP in a format that will be provided by DOM prior to the Implementation or Operation Date, as appropriate. Report formats may include paper reports or data files. The Contractor shall provide additional reports or make revisions in the data elements or format upon the request of DOM, without additional charge to DOM and without a contract amendment. Upon request of DOM, the Contractor shall supply the underlying data to support any report submitted. The data shall be in a mutually agreed upon electronic file format. DOM may add or delete reports to be submitted without requiring a Contract amendment. Failure to meet the timeliness standard set forth for each report may, at the sole discretion of DOM, result in the assessment of liquidated damages as specified in this RFP.

1. Deliverable reports shall be submitted to DOM by the fifth (5th) business day of the month following the report month/quarter in which they are due unless otherwise agreed to in writing by DOM

2. Reports defined and approved by DOM to be generated by the Contractor shall meet all applicable State and federal reporting requirements. The needs of DOM and other appropriate agencies for planning, monitoring, and evaluation shall be taken into account when developing report formats and compiling data. Reports to be generated shall be agreed upon during the Contract Implementation Phase and shall include but not be limited to those listed below.

    a. Monthly Administrative Project Summary to include operational priorities, outstanding issues, staffing, volume, review volume, phone activity, and Contractor calendar of events;

    b. Monthly Authorization, Continued Stay Workload, and Timeliness Detailed and Summary per Review Type;

    c. Monthly Retrospective Workload and Timeliness Detailed and Summary per Review Type;

    d. Monthly Reconsideration, Outcome, and Timeliness Summary per Review Type;

    e. Monthly Approval, Approved Less Than Requested, Denial, and Technical Denial Rates per Review Type and Provider Type;

    f. Monthly Physician Referral Rates by Reason per Review Type and Provider Type;

    g. Monthly Average Days Certified by Principal Diagnosis by Age and Provider Type;

    h. Quarterly Report of All Activity Relating to Provider non-compliance;

    i. Monthly Care Management Report of Activity and Contact;

    j. Monthly Deliveries Report; and

    k. Monthly Cost Incurred Associated with each MSCAN Review Activity.

3. The Contractor shall provide an in-depth analysis of each review responsibility in one aggregate state fiscal year (July- June) annual report. Each annual report must be accompanied by the raw data on a CD ROM, in a format agreed to by DOM. At a minimum, each report must include:

    a. Executive Summary;

b. Accomplishments;

c. Significant organizational changes/staffing issues;

d. Provider Seminars;

e. Provider Concerns;

f. Patterns and trends, quarterly and cumulative;

g. Estimated savings, if applicable;

h. Assessment of the impact of the UM/QIO program by each individual provider type including summary of authorization requests and outcomes;

i. Policy recommendations that improve the utilization of Medicaid services, improve provider performance, improve the quality of services, and/or reduce the cost of Medicaid services; and

j. Cumulative summary of all reports/Contract deliverables including a description of how the Contractor met required time frames.

4. The Contractor shall provide ad hoc reports on an as needed basis. The Contractor should be prepared to process up to a minimum of 100 ad hoc reports annually. This is an estimate and subject to change based on management and legislative priorities. All ad hoc reports are to be provided at no additional charge to DOM.

1.8. Quality Improvement and Quality Control

1.8.1. Quality Improvement Program

1. DOM is dedicated to ensuring that Medicaid beneficiaries receive the highest quality health care. The goals of the Quality Improvement Program include but are not limited to:

   a. Establish a process to provide DOM with comparison results of quality reviews and coordinate improvement activities across delivery systems (fee-for-service and managed care);

   b. Develop, implement and maintain systems and programs that monitor, measure and improve health care outcomes;

   c. Provides structure and processes to continuously improve the quality and safety of care and service provided to beneficiaries;

   d. Establish standards and performance goals for the delivery of care and service;

   e. Ensure the coordination of and transition of care needs are identified and provided to beneficiaries;

   f. Ensure compliance with standards as required by contract, regulatory statutes and accreditation agencies;

   g. Establish a process to retrieve medical records for analysis, or survey beneficiaries about their outcomes;

   h. Measure performance against the standards with a post utilization review program; and

i. Take actions to improve performance.

2. The Offeror shall provide a written program which outlines the program structure and accountability and includes, at a minimum:

   a. Quality of care review process that is in accordance with local and national healthcare standards and approved in writing by DOM;

   b. Procedures to provide a surveillance system to identify quality of care issues during the first level reviews for each type review performed by the Contractor, unless otherwise approved in writing by DOM;

   c. Procedures to perform a minimum representative sample of all authorizations and reviews performed by the Contractor, unless otherwise instructed in writing by DOM;

   d. Procedures for quality of care problems to be reviewed and confirmed by a physician licensed in the state of Mississippi and of the same specialty as the treating physician;

   e. Procedures for identifying and documenting aberrant practices and applying and monitoring interventions for those practices; and

   f. Procedures for communicating the problems and intervention methods to proper parties.

3. The Contractor must provide a monthly report of quality improvement activities to include interventions and results due the fifth (5th) business day of the month following the report period.

1.8.2. Internal Quality Control

1. The Contractor shall be responsible for establishing and maintaining internal quality controls for the responsibilities specified in this contract. The Contractor shall be responsible for implementation of an approved plan that shall become effective not later than thirty (30) calendar days following execution of this contract. The plan must describe the orientation of new employees, ongoing training of employees, and monitoring of all activities. The Contractor must establish a method for assuring inter-rater reliability to ensure consistent findings between reviewers.

2. The Contractor must develop and maintain an internal quality control program that will, at a minimum:

   a. Provide specific orientation, training and monitoring of:

      - knowledge and appropriate application of review criteria,
      - knowledge and application of Medicaid policy as defined in the MS Administrative Code, Title 23,
      - understanding and adherence to the entire review process with required time frames, and
      - data collection requirements;

   b. Monitor one (1) percent or ten (10) medical records (whichever is greater) per employee per month (including work performed by physician advisors and temporary staff); and

   c. Monitor the development of Corrective Action Plans (CAPs) with appropriate follow through and completion.

3. The Contractor must provide, at a minimum, a report of the findings of internal quality control reviews including a status report for all CAP's initiated during the month as well as those still outstanding from previous months. The deliverables are due the fifth (5th) workday of the month following the report period.

1.8.3. Records Retention and Access to Records

1. The Contractor must preserve and make available its records (all documentation regardless of review determination) for a period of five (5) years from the date of final payment under this contract, and for such period, if any, as it is required by applicable statute or by any other paragraph of this contract.

2. If the contract is completely or partially terminated, the records relating to the work terminated shall be preserved and made available for a period of five (5) years from the date of any resulting final settlement.

3. Records which relate to appeals, litigation or the settlement of claims arising out of the performance of this agreement as to which exception has been taken by the Mississippi State Auditor, General Accounting Office (GAO), Department of Health and Human Services (DHHS), or any of their duly authorized representatives, shall be retained by the Contractor until such appeals, litigations, claims or exceptions have been disposed of.

4. The Contractor shall agree to the following terms for access to records relating to the contract:

    a. All medical records must be retained for a minimum of one (1) year at the Contractor's location. All other medical records must be made available and retrievable within three (3) business days for review at the request of DOM, unless a shorter time period is specified in writing.

    b. Unless DOM specifies in writing a shorter period of time, the Contractor must preserve and make available all pertinent books, documents, papers, and records of the Contractor involving transactions related to the contract for a period of five (5) years from the date of final payment under this contract.

    c. The Contractor must keep and make available records involving matters in litigation for five (5) years following the termination of litigation, including all appeals.

    d. The Contractor must agree that authorized federal, State, and DOM representatives shall have access to and the right to examine the items listed above during the contract period and during the five (5) year post contract period or until resolution. During the contract period, the access to these items will be provided at the Contractor's facility at all reasonable times at no cost to DOM or other authorized state and federal officials.

    e. The Contractor must document and maintain policies and procedures to ensure privacy in accordance with all HIPAA regulations as specified in Attachment B – Business Associate Agreement.

    f. The Contractor must accept full responsibility for record retention in accordance with state and federal regulations.

    g. The Contractor will provide DOM with a detailed plan for record retention upon implementation of the operations. Any changes or updates must be approved through DOM.

1.9. Implementation, Operations, and Turnover Plans

1.9.1. Implementation Phase

The implementation phase encompasses those activities required to ensure a smooth transition from the incumbent to the successful Offeror. This will entail development of a series of DOM-approved plans and performance of activities preparatory to actually beginning the Contract operations in the next phase. The Implementation Phase will begin January 1, 2018.

1. The Contractor shall create comprehensive work plans with DOM approval, prior to undertaking all facets of the development and implementation of the Contract. These plans may include Project Work Plan, Communications Strategy Plan, Staffing Plan, Risk Management Plan, Testing Plan, Implementation Plan, Transition Plan, and Corrective Action Plan. The work plans must be logical in sequence of events, including appropriate review time by DOM and sufficient detail for review. The plans must include a narrative that provides an overview of the approach that will result in fulfillment of Contractor responsibilities. It must encompass all activities necessary to assume operational responsibilities including identification of all key personnel listed in Section 1.5, full staffing plan, and back-up and disaster recovery plans.

2. The Contractor shall submit a written report of program progress to DOM weekly. The progress report must specify accomplishments during the report period in a task-by-task format, including personnel hours expended, whether the planning tasks are being performed on schedule, and any administrative problems encountered. Any problem or issue that arises should be reported immediately to the DOM contract manager.

3. The Contractor will be required to adhere to the performance requirements of the Contract, as well as the requirements of any revisions in federal and State legislation or regulations that may be enacted or implemented during the period of performance of this Contract, that are directly applicable to the performance requirements of this Contract. Such requirements will become a part of this Contract effort through execution of a written Contract amendment.

4. No less than forty-five (45) calendar days prior to the Operations Start Date, DOM will initiate a Readiness Review of the Contractor. The Contractors shall demonstrate abilities to receive authorizations review requests and supporting information via telephone facsimile, mail and web-based submissions from providers. After which, DOM may approve the Contractor for implementation. The Contractor must receive written DOM approval for all submission and demonstration requirements prior to the implementation date. Implementation payment is contingent upon readiness review approval by DOM.

5. The Contractor must be fully capable and prepared to receive and process authorization review requests and supporting information via telephone facsimile, mail and web-based submissions from providers no less than thirty (30) calendar days prior to Operations Start Date.

1.9.2. Operations Phase

1. Upon commencing the operations phase, the Contractor must be fully capable and prepared to perform the responsibilities described in this RFP. The operations phase is scheduled to begin August 1, 2018.

2. The Contractor is subject to monitoring and evaluation by DOM as set forth in 42 C.F.R. Part 456 – Utilization Control. The Contractor will be required to adhere to the performance requirements of the Contract, as well as

the requirements of any revisions in federal and State legislation or regulations that may be enacted or implemented during the period of performance of this Contract, that are directly applicable to the performance requirements of this Contract. Such requirements will become a part of this Contract effort through execution of a written Contract amendment.

1.9.3. Turnover Phase

1. The Contractor must provide assistance in turning over the responsibilities under this RFP to DOM or its designated agent. Upon receipt of notification of DOM's intent to transfer the Contract functions to DOM or another Contractor, the Contractor must provide a Turnover Plan within thirty (30) calendar days from notification of intent to transfer. Time lines for turnover activities will be specified by DOM.

2. During this phase the Contractor shall prepare DOM or other applicable parties to take over the operations of those initiatives implemented under this Contract. The Contractor shall put procedures in place and provide training so that DOM sustains the ability to continue each initiative even after the project is completed and after expiration of the Contract. The Contractor shall provide detailed written documentation of all new procedures implemented and any system changes made during the Operations Phase. Failure to properly prepare the State and provide written documentation will be cause for continued withholding of payment(s).

3. The Turnover Plan shall include, but is not limited to, the following:

    a. Proposed approach to turnover;

    b. Tasks and subtasks for turnover;

    c. Schedule for turnover;

    d. Detailed chart depicting the Contractor's total operation; and

    e. Transfer of Medicaid documents and case files to DOM or its designated agent.

4. Deliverables shall be produced in an organized manner according to reasonable and customary business standards as determined by DOM. Deliverables shall be turned over to DOM in a form and condition that is satisfactory to DOM and in the time frames specified by DOM. Deliverables include but not limited to the following:

    a. Turnover Plan;

    b. Detailed organizational chard;

    c. All Medicaid documents and case files; and

    d. Turnover results report.

1.10. Contractor Payment

1.10.1. Implementation Price

The Contractor shall be paid an implementation price of no more than the actual implementation costs up to the amount specified in the Contractor's proposal set forth in the Budget Summary (Appendix A). The implementation

payment is contingent upon meeting milestones and deliverables; final payment is contingent on readiness review approval by DOM. The total bid price for implementation must be entered in the appropriate block of Appendix A.

1.10.2. Operations Price

The Contractor shall be paid monthly in accordance with the Contractor's bid price proposal set forth in Budget Summary (Appendix A), which shall be a firm and fixed price , unless otherwise specified, for the period of the Contract. The Contract award will be based on the submitted price per year and the total amount payable under the Contract will not exceed the submitted price per year.

Payments will be based on submitted invoices and progress reports. Progress reports must provide a description to sufficiently support payment by DOM. The deliverable-based payments for this project will be made only upon DOM acceptance of the prescribed deliverables.

1.10.3. Turnover Price

No specific or lump-sum payment shall be made by DOM for Turnover Phase services. Payment for such services shall be encompassed in the Operations Phase.

1.10.4. Travel

All travel performed in conjunction with performing the responsibilities of this Contract shall not include any profit for the Contractor. Travel costs should be included in the implementation and operations costs as necessary.

1.10.5. Erroneous Issuance of Compensation

In the event compensation to the Contractor of any kind is issued in error, the Contractor shall reimburse DOM the full amount of erroneous payment within thirty (30) days of written notice of such error. Interest shall accrue at the statutory rate upon any amounts determined to be due and not repaid within thirty (30) days following the notice. If payment is not made within thirty (30) days following notice, DOM may deduct the amount from the Contractor's monthly administrative invoice.

1.10.6. Release

Upon final payment of the amounts due under this Contract, the Contractor shall release DOM, its officers and employees, and the State of Mississippi from all liabilities and obligations whatsoever under or arising from this Contract.

Payment to the Contractor by DOM shall not constitute final release of the Contractor. Should audit or inspection of the Contractor's records or client complaints subsequently reveal outstanding Contractor liabilities or obligations, the Contractor shall remain liable to DOM for such liabilities and obligations. Any overpayments by DOM shall be subject to any appropriate recoupment to which DOM is lawfully entitled. Any payment under this Contract shall not foreclose the right of DOM to recover excessive or illegal payments as well as interest, attorney fees, and costs incurred in such recovery.

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2 AUTHORITY

This RFP is issued under the authority of Title XIX of the Social Security Act, as amended, implementing regulations issued under the authority thereof and under the provisions of the Mississippi Code of 1972, as amended. All Offerors are charged with presumptive knowledge of all requirements of the cited authorities. The submission of a valid executed proposal by an Offeror shall constitute admission of such knowledge on the part of each Offeror. Any proposal submitted by an Offeror that fails to meet any published requirement of the cited authorities may, at the option of DOM, be rejected without further consideration.

Medicaid is a program of medical assistance for the needy administered by each state using state appropriated funds and matching federal funds within the provisions of Title XIX and Title XXI of the Social Security Act, as amended.

In addition, Section 1902(a)(30)(A) of the Social Security Act requires that state Medicaid agencies provide methods and procedures to safeguard against unnecessary utilization of care and services and to assure "efficiency, economy and quality of care."

The IT solution proposed in response to this RFP must be in compliance with the State of Mississippi's Enterprise Security Policy. The Enterprise Security Policy is based on industry-standard best practices, policy, and guidelines and covers the following topics: web servers, email, virus prevention, firewalls, data encryption, remote access, passwords, servers, physical access, traffic restrictions, wireless, laptop and mobile devices, disposal of hardware/media, and application assessment/certification. Given that information security is an evolving technology practice, the State reserves the right to introduce new policy during the term of the contract resulting from this RFP and require the Contractor to comply with same in the event the industry introduces more secure, robust solutions or practices that facilitate a more secure posture for the State of Mississippi.

The Enterprise Security Policy is available to third parties on a need-to-know basis and requires the execution of a non-disclosure agreement with the Department of Information Technology Services (ITS) prior to accessing the policy. The Offeror or Contractor may request individual sections of the Enterprise Security Policy or request the entire document by contacting the procurement officer.

Instructions to acquire a copy of the Enterprise Security Policy can be found at the following link: http://www.its.ms.gov/Services/Documents/Security/Instructions%20for%203Party%20Acquiring%20ITS%20ESP.pdf

2.1 ORGANIZATIONS ELIGIBLE TO SUBMIT PROPOSALS

To be eligible to submit a proposal, an Offeror must provide documentation for each requirement as specified below:

1. The Offeror has not been sanctioned by a State or Federal government within the last ten (10) years.
2. The Offeror must have a minimum of five (5) years of experience in contractual services providing the type of services described in this RFP.
3. The Offeror must have a minimum of five (5) years of designation as a QIO or QIO-like entity.

4. The Offeror must be able to provide all required components detailed in the Scope of Work.
5. The Offeror must be able to provide all required components of the RFP no less than thirty (30) days prior to the Operational Date.

2.2 PROCUREMENT APPROACH

The major steps of the procurement approach are described in detail in Section 3 of this RFP. Proposals must be submitted in two (2) parts: Technical Proposal and Business Proposal. The format and content are each specified in Sections 5 and 6 of this RFP.

2.3 ACCURACY OF STATISTICAL DATA

All statistical information provided by DOM in relation to this RFP represents the best and most accurate information available to DOM from DOM records at the time of the RFP preparation. DOM, however, disclaims any responsibility for the inaccuracy of such data. Should any element of such data later be discovered to be inaccurate, such inaccuracy shall not constitute a basis for contract rejection by any Offeror. Neither shall such inaccuracy constitute a basis for renegotiation of any payment rate after contract award. Statistical information is available on DOM's website.

2.4 ELECTRONIC AVAILABILITY

The materials listed below are on the Internet for informational purposes only. This electronic access is a supplement to the procurement process and is not an alternative to official requirements outlined in this RFP.

This RFP, any amendments thereto, and RFP Questions and Answers (following official written release) will be posted on the Procurement page of the DOM website at http://www.medicaid.ms.gov/resources/procurement/.

Information concerning services covered by Mississippi Medicaid and a description of the DOM organization and functions can also be found on the Procurement page of the DOM website.

DOM's website is http://www.medicaid.ms.gov and contains Annual Reports, Provider Manuals, Bulletins and other information. The DOM Annual Report Summary provides information on beneficiary enrollment, program funding, and expenditures broken down by types of services covered in the Mississippi Medicaid program for the respective fiscal years.

State financial information is available at http://www.dfa.state.ms.us.

The State of Mississippi portal is http://www.mississippi.gov.

MAGIC system information can be found at http://www.dfa.ms.gov/dfa-offices/mmrs/mmrs-applications/magic/.

Information regarding Mississippi Department of Information Technology Services Enterprise Security Policy can be found at http://www.its.ms.gov/Services/Pages/ENTERPRISE-SECURITY-POLICY.aspx.

Rules and Regulations of the Mississippi State Personnel Board/Personal Services Contract Review Board can be found at http://www.mspb.ms.gov.

The Mississippi Code of 1972 covers all sections of and amendments to the Constitution of the United States and the Constitution of the State of Mississippi. Access to the Mississippi Code can be found at http://www.sos.ms.gov/Education-Publications/Pages/Mississippi-Code.aspx.

3 PROCUREMENT PROCESS

3.1 APPROACH

This RFP is designed to provide the Offeror with the information necessary to prepare a competitive proposal. Similarly, the RFP process is intended to also provide DOM with the necessary information to adequately assist DOM in the selection of a Contractor to provide the desired services. It is not intended to be comprehensive, and each Offeror is responsible for determining all factors necessary for submission of a comprehensive and accurate proposal. DOM reserves the right to interpret the language of this RFP or its requirements in a manner that is in the best interest of the State.

DOM will ensure the fair and equitable treatment of all persons and Offerors in regards to the procurement process. The procurement process provides for the evaluation of proposals and selection of the best proposal in accordance with Federal and State laws and regulations. Specifically, the procurement process is guided by appropriate provisions of the Personal Service Contract Review Board Regulations which are available for inspection at 210 East Capitol Street, Suite 800, Jackson, Mississippi or downloadable at www.mspb.ms.gov.

Separate technical and business proposals shall be submitted simultaneously but will be opened at different stages of the evaluation process. Technical Proposals will be thoroughly evaluated in order to determine point scores for each evaluation factor and a final technical score determined before evaluation of the Business Proposal. The evaluation and selection process is described in more detail in Section 7 of this RFP.

Submission of a proposal in response to this RFP constitutes acceptance of the conditions governing the procurement process, including the evaluation factors contained in Section 7 of this RFP, and constitutes acknowledgment of the detailed descriptions of the Mississippi Medicaid Program.

No public disclosure or news release pertaining to this procurement shall be made without prior written approval of DOM. Failure to comply with this provision may result in the Offeror being disqualified.

3.2 QUALIFICATION OF OFFEROR

Each corporation shall report its corporate charter number in its transmittal letter or, if appropriate, have attached to its transmittal letter a signed statement to the effect that said corporation is exempt from the above described, and set forth the particular reason(s) for exemption. All corporations shall be in full compliance with all Mississippi laws regarding incorporation or formation and doing business in the State of Mississippi and shall be in compliance with the laws of the state in which they are incorporated, formed, or organized.

DOM may make such investigations as necessary to determine the ability and commitment of the Offeror to adhere to the requirements specified within this RFP and its proposal, and the Offeror shall furnish to DOM all such information and data for this purpose as may be requested. DOM reserves the right to inspect Offeror's physical facilities prior to award to satisfy questions regarding the Offeror's capability to fulfill the requirements of the contract. DOM reserves the absolute right to reject any proposal if the evidence submitted by, or investigations of, such Offeror fail to satisfy DOM that such Offeror is properly qualified to carry out the obligations of the contract and to complete the work or furnish the items contemplated.

DOM reserves the right to reject any and all proposals, to request and evaluate "best and final offers" from some or all of the respondents, to negotiate with the best proposed Offeror to address issues other than those described in the proposal, to award a contract other than the lowest cost Offeror, or not to make any award if it is determined to be in the best interest of DOM and the State.

Discussions may be conducted by the procurement officer with any Offeror that submits a proposal determined to be reasonably susceptible of being selected for award. Proposals may also be accepted without such discussions. DOM reserves the right to request additional information or clarification of an Offeror's proposal. The Offeror's cooperation during the evaluation process in providing DOM staff with adequate responses to requests for clarification will be considered a factor in the evaluation of the Offeror's overall responsiveness. Lack of such cooperation or failure to provide the information in the manner required may, at DOM's discretion, result in the disqualification of the Offeror's proposal.

3.3 RULES OF PROCUREMENT

To facilitate the DOM procurement, various rules have been established and are described in the following paragraphs.

3.3.1 Restrictions on Communications with DOM Staff

From the issue date of this RFP until a Contractor is selected and the contract is signed, Offerors and/or their representatives are not allowed to communicate with any DOM staff regarding this procurement except the RFP Issuing Officer Matt Nassar.

For violation of this provision, DOM shall reserve the right to reject any proposal.

3.3.2 Amendments to this Request for Proposals

DOM reserves the right to amend the RFP at any time. All amendments will be posted to the DOM website at http://www.medicaid.ms.gov/resources/procurement/. After August 31, 2017, Offerors submitting Letters of Intent will be notified when amendments are released.

Offerors shall acknowledge receipt of any amendment to the RFP by signing and returning the form provided with the amendment, and identifying the amendment number and date in the Offeror's Transmittal Letter. The acknowledgment must be received by DOM by the time and at the place specified for receipt of proposals.

3.3.3 Cost of Preparing Proposal

Costs of developing the proposals are solely the responsibility of the Offerors. DOM will provide no reimbursement for such costs. Any costs associated with any oral presentations to DOM shall be the responsibility of the Offeror and shall in no way be billable to DOM. If site visits are made, DOM's cost for such visits shall be the responsibility of DOM and the Offeror's cost shall be the responsibility of the Offeror and shall in no way be billable to DOM.

3.3.4 Certification of Independent Price Determination

The Offeror certifies that the prices submitted in response to the RFP have been arrived at independently and without, for the purpose of restricting competition, any consultation, communication, or agreement with any other Offeror or competitor relating to those prices, the intention to submit a proposal, or the methods or factors used to calculate the proposed prices.

3.3.5 Acceptance of Proposals

After receipt of the proposals, DOM reserves the right to award the contract based on the terms, conditions, and premises of the RFP and the proposal of the selected Contractor without negotiation.

All proposals properly submitted will be accepted by DOM. After review DOM may request necessary modifications or clarifications from all Offerors, reject any or all proposals received, or cancel this RFP, according to the best interest of DOM and the State of Mississippi.

DOM also reserves the right to waive minor irregularities in proposals, provided such action is in the best interest of DOM and the State of Mississippi. A minor irregularity is defined as a variation of the RFP which does not affect the price of the proposal, or give one party an advantage or benefit not enjoyed by other parties, or adversely impact the interest of DOM.

Where DOM may waive minor irregularities as determined by DOM, such waiver shall in no way modify the RFP requirements or excuse the Offeror from full compliance with the RFP specifications and other contract requirements if the Offeror is awarded the contract.

DOM reserves the right to exclude any and all non-responsive proposals from any consideration for contract award. DOM will award a contract to the Offeror whose proposal is responsive to the RFP and is most advantageous to DOM and the State of Mississippi in quality, price, and other factors considered.

3.3.6 Rejection of Proposals

A proposal may be rejected for failure to conform to the rules or the requirements contained in this RFP. Proposals must be responsive to all requirements of the RFP in order to be considered for contract award. DOM reserves the right at any time to cancel the RFP, or after the proposals are received to reject any of the submitted proposals determined to be non-responsive. DOM further reserves the right to reject any and all proposals received by reason of this request. Reasons for rejecting a proposal include, but are not limited to, the following:

1. The proposal contains unauthorized amendments to the requirements of the RFP.
2. The proposal is conditional.
3. The proposal is incomplete or contains irregularities that make the proposal indefinite or ambiguous.
4. The proposal is not signed by an authorized representative of the party.
5. The proposal contains false or misleading statements or references.
6. The Offeror is determined to be non-responsible as specified in Section 3-401 of the Personal Service Contract Review Board Rules and Regulations.
7. The proposal ultimately fails to meet the announced requirements of the State in some material aspect.
8. The proposal price is clearly unreasonable.
9. The proposal is not responsive, i.e., does not conform in all material respects to the RFP.
10. The supply or service item offered in the proposal is unacceptable by reason of its failure to meet the requirements of the specifications or permissible alternates or other acceptability criteria set forth in the RFP.
11. The Offeror does not comply with the Proposal Submission Requirements as set forth in the RFP.
12. The Offeror currently owes the State money.

3.3.7 Alternate Proposals

Each Offeror, its subsidiaries, affiliates, or related entities shall be limited to one Technical Proposal and one Business Proposal which is responsive to the requirements of this RFP. Failure to submit a responsive proposal will result in the rejection of the Offeror's proposal. Submission of more than one proposal by an Offeror may, at

the discretion of DOM, result in the summary rejection of all proposals submitted. An Offeror's proposal shall not include variable, contingent, or multiple pricing options.

3.3.8 Proposal Modification and Withdrawal

Prior to the proposal due date, a submitted proposal may be withdrawn by submitting a written request for its withdrawal to DOM Procurement Officer, signed by the Offeror.

An Offeror may submit a modification to its proposal before the due date for receipt of proposals. Such modified proposal must be a complete replacement for a previously submitted proposal and must be clearly identified as such in the Transmittal Letter. DOM will not merge, collate, or assemble proposal materials.

Unless requested by DOM, no other modifications, revisions, or alterations to proposals will be accepted after the proposal due date.

Any submitted proposal shall remain a valid proposal for one hundred eighty (180) days from the proposal due date.

3.3.9 Disposition of Proposals

The proposal submitted by the successful Offeror shall be incorporated into and become part of the resulting contract. All proposals received by DOM shall upon receipt become and remain the property of DOM.

3.3.10 Responsible Contractor

DOM shall contract only with a responsible Contractor who possesses the ability to perform successfully under the terms and conditions of the RFP and implementation of the proposal. In letting the contract, consideration shall be given to such matters as Contractor's integrity, performance history, financial and technical resources, and accessibility to other necessary resources.

3.3.11 Best and Final Offers

The Executive Director of DOM may make a written determination that it is in the State's best interest to conduct additional discussions or change the State's requirements and require submission of best and final offers. The Procurement Officer shall establish a date and time for the submission of best and final offers. Otherwise, no discussion of or changes in the Business Proposals shall be allowed prior to award. Offerors shall also be informed that if they do not submit a notice of withdrawal or another best and final offer, their immediate previous offer will be construed as their best and final offer.

3.4 ORAL PRESENTATION

Oral presentations may be held as part of the Technical Evaluation; however, they are not required. The purpose of the oral presentation is to provide an opportunity for the Offeror to present its proposal and credentials of proposed staff, and to respond to any questions from DOM. The original proposal cannot be supplemented, changed, or corrected either in writing or orally.

The presentation will be via toll-free conference call and WebEx to be hosted and recorded by the Offeror. The WebEx shall include a maximum fifteen (15) minute presentation, a maximum fifteen (15) minute technology demonstration, followed by a one (1) hour question and answer session. Offerors will receive a ten (10) day prior notification, when possible, requesting their participation in Oral Presentations. The determination of participants, time, order, and schedule for the presentations is at the sole discretion of DOM and will be provided during the Evaluation process.

The presentations are tentatively scheduled for September 28 – September 29, 2017. The Offeror's presentation team shall include, at a minimum, the proposed Project Manager and other key management staff necessary to implement the contract requirements. Offeror's presentation and team shall not be at the DOM location. However, DOM reserves the right to limit the number of participants in the Offeror's presentation and will notify Offeror of any limitations at the time they are notified of the request to participate. DOM reserves the right to limit the time period for the presentation.

3.5 REQUIRED STATE APPROVAL

Approval from the Personal Service Contract Review Board must be received before contract execution. Every effort will be made by DOM to facilitate rapid approval and a start date consistent with the proposed schedule.

3.6 NOTICE OF INTENT TO AWARD

Award shall be made in writing to the responsible Offeror whose proposal is determined to be the most advantageous to the State taking into consideration evaluation factors and price as set forth in the RFP. The notice of intended contract award shall be sent by e-mail with reply confirmation to the winning Offeror. Unsuccessful Offerors will be notified in the same manner after the award has been accepted or declined.

Consistent with existing State law, no Offeror shall infer or be construed to have any rights or interest to a contract with DOM until final approval is received from all necessary entities and until both the Offeror and DOM have executed a valid contract.

3.7 POST-AWARD DEBRIEFING

3.7.1 Debriefing Request

Offerors may request a post-award debriefing, by email to the Procurement Officer, to be received by DOM within three (3) business days of notification of the contract award. The Offeror shall submit a list of written questions simultaneously with its debriefing request. A debriefing is a meeting and not a hearing; therefore, legal representation is not required. If a vendor prefers to have legal representation present, the Offeror shall notify DOM and identify the Offeror's attorney prior to the debriefing. DOM may include its own legal representation in the debriefing.

3.7.2 Scheduling the Debriefing

The debriefing may occur any time within five (5) business days of award, unless good cause exists for a delay. The debriefing may be conducted during a face-to-face meeting, by telephone, or by any other method acceptable to both DOM and the Offeror. The Procurement Officer or designee shall chair the meeting, and where practicable, may include other staff with direct knowledge of the procurement.

3.7.3 Information to Be Provided

The debriefing information may include the following:

1. Evaluation of significant weaknesses or deficiencies in the Offeror's proposal, if applicable;
2. The overall evaluated technical rating of the debriefed Offeror;
3. The overall ranking of all Offerors developed during the selection process;
4. A summary of the rationale for award; and,

5. Reasonable responses to relevant questions as submitted by the debriefed Offeror with its request for debrief. Questions may pertain to selection procedures contained in the RFP, applicable regulations, and other applicable authorities that were followed.

3.7.4 Information Which Will Not Be Provided

The debriefing shall not include point-by-point comparisons of the debriefed Offeror's proposal with those of other Offerors. Moreover, DOM shall not reveal any information prohibited by law and/or the following:

1. Trade secrets as identified by the Offeror;
2. Privileged or confidential processes and techniques as identified by the Offeror;
3. Commercial and financial information that is privileged or confidential, to include Offeror's cost, breakdowns, profit, indirect cost rates, and similar information as identified by the Offeror and/or;
4. The names of individuals providing reference information about any Offeror's past performance.

DOM will not release copies of proposals or price information in the debriefing. These items may be requested through a Request for Public Information to DOM's Public Information Officer at RFI@medicaid.ms.gov.

3.8 PROTEST POLICY AND PROCEDURES

3.8.1 Form of the Protest

Offerors who submit technical and business proposals in response to this RFP may protest the award of the contract resulting from this RFP. Protests must be made in writing and must be received no later than ten (10) business days from the Notice of Non-Award; however, all protesting parties may revise their protests in accordance with Miss. Code Ann. § 25-61-5(1)(b). Protests should be addressed to DOM's Executive Director and must contain specific grounds for the protest. Supporting documentation may be included with the protest.

A protest must state all grounds upon which the protesting party asserts that the solicitation or award was improper. Issues not raised by the protesting party in the protest are deemed waived. Protests submitted within the ten (10) business days may be supplemented and/or modified in accordance with state law.

Only the following are acceptable grounds for protest:

- Failure to follow any of the following: 1) DOM procedures established in the RFP, 2) DOM rules of procurement, or 3) PSCRB Rules and Regulations;
- Errors in computing scores which contributed to the selection of an Offeror other than the best and lowest proposal; or,
- Bias, discrimination, or conflict of interest on the part of an evaluator.

Disallowed grounds include:

- Evaluators' qualifications to serve on the Evaluation Committee;
- The professional judgment of the Evaluation Committee; and,
- DOM's assessment of its own needs regarding the solicitation.

A protest that is incomplete or not submitted within the prescribed time limits will be summarily dismissed.

3.8.2 Protest Bond

Protests must be accompanied by a bond for two hundred fifty thousand dollars and zero cents ($250,000.00) or the price of the contract whichever is lower. The protest bond shall be maintained through final resolution, whether at the agency level or through a court of competent jurisdiction.

DOM will return a protest bond if (1) the protesting Offeror withdraws its protest or (2) the bond is ordered to be returned by a court of competent jurisdiction. In the event DOM finds that an Offeror's protest has no merit, DOM shall at its own discretion retain all or a percentage of the submitted bond. Please refer to Section 4.9 for further details regarding proposal protests.

3.8.3 DOM's Responsibilities Regarding Protests

The Notice of Non-Award shall be accompanied by redacted copies of the evaluation score sheets.

The Procurement Officer shall provide a copy of the protest documents to the successful Offeror within three (3) business days of receipt of the protest. The successful Offeror shall have the right to provide documentation supporting the decision to award.

The Executive Director shall review all documentation concerning the procurement and may request additional documentation. The Executive Director shall then determine whether or not the award of the contract shall be delayed or cancelled; or, if the protest is clearly without merit or that award of the contract without delay is necessary to protect the interests of the State. The Executive Director will provide written notice of the decision to the protesting Offeror. This written notice will be the final agency decision.

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4 TERMS AND CONDITIONS

4.1 GENERAL

The contract between the State of Mississippi and the Contractor shall consist of 1) the contract and any amendments thereto; 2) this RFP and any amendments thereto; 3) the Contractor's proposal submitted in response to the RFP by reference and as an integral part of this contract; 4) written questions and answers. In the event of a conflict in language among the four documents referenced above, the provisions and requirements set forth and/or referenced in the contract and its amendments shall govern. The RFP in its entirety is a part of the Contract. In the event of a dispute or conflict among any of the components of the contract, the contract shall govern. After the Contract, the order of priority is: Att. D, Bidder Questions and Answers; Att. C or E, the Business Proposal or BAFO, if applicable; Att. A, the RFP; and Att. B, the Technical Proposal. All the documents shall be read and construed as far as possible to be one harmonious whole; however, in the event of a conflict or dispute, the above list is the list of priority.

The contract shall be governed by the applicable provisions of the *Personal Service Contract Review Board Rules and Regulations*, a copy of which is available at 210 East Capitol Street, Suite 800, Jackson, Mississippi, 39201 for inspection, or downloadable at http://www.mspb.ms.gov.

No modification or change of any provision in the contract shall be made, or construed to have been made, unless such modification or change is mutually agreed upon in writing by the Contractor and DOM. The agreed upon modification or change will be incorporated as a written contract amendment and processed through DOM for approval prior to the effective date of such modification or change. In some instances, the contract amendment must be approved by CMS before the change becomes effective.

The only representatives authorized to modify this contract on behalf of DOM and the Contractor are shown below:

Contractor: Person(s) designated by the Contractor

DOM: Executive Director

4.2 PERFORMANCE STANDARDS, ACTUAL DAMAGES, LIQUIDATED DAMAGES, AND RETAINAGE

4.2.1 General

DOM may require corrective action in the event that any deliverable, report or the like should indicate that the Contractor is not in compliance with any provision of this Contract. DOM may also require the modification of any policies or procedures of the Contractor relating to the fulfillment of its obligations pursuant to this Contract. DOM may issue a deficiency notice and may require a corrective action plan be filed within fifteen (15) calendar days following the date of the notice. A corrective action plan shall delineate the time and manner in which each deficiency is to be corrected. The corrective action plan shall be subject to approval by DOM, which may accept it as submitted, accept it with specified modifications, or reject it. DOM may extend or reduce the time frame for corrective action depending on the nature of the deficiency, and shall be entitled to exercise any other right or remedy available to it, whether or not it issues a deficiency notice or provides Contractor with the opportunity to take corrective action.

Because performance failures by the Contractor may cause DOM to incur additional administrative costs that are difficult to compute, DOM may assess liquidated damages against the Contractor pursuant to this Contract, and deduct the amount of the damages from any payments due the Contractor. DOM, at its sole discretion, may establish an installment deduction plan for the amount of any damages. The determination of the amount of damages shall be at the sole discretion of DOM, within the ranges set forth in this Contract. Self-reporting by the Contractor will be taken into consideration in determining the amount of damages to be assessed. Unless specified otherwise, DOM shall give written notice to the Contractor of the failure that might result in the assessment of damages and the proposed amount of the damages. The Contractor shall have fifteen (15) calendar days from the date of the notice in which to dispute DOM's determination. DOM may assess damages for specific performance failures set forth below and in this Contract. DOM may assess higher liquidated damages amounts when the Contractor consistently fails to meet specific performance standards and the deficient performance has not been corrected.

Assessment of actual or liquidated damages does not waive any other remedies available to DOM pursuant to this contract or State and Federal law. If liquidated damages are known to be insufficient then DOM has the right to pursue actual damages.

If the Contractor's failure to perform satisfactorily exposes DOM to the likelihood of contracting with another person or entity to perform services required of the Contractor under this contract, upon notice setting forth the services and retainage, DOM may withhold from the Contractor payments in an amount commensurate with the costs anticipated to be incurred. If costs are incurred, DOM shall account to the Contractor and return any excess to the Contractor. If the retainage is not sufficient, the Contractor shall immediately reimburse DOM the difference or DOM may offset from any payments due the Contractor. The Contractor will cooperate fully with the retained Contractor and provide any assistance it needs to implement the terms of its agreement for services for retainage.

1. Failure by Contractor to develop or maintain all required electronic and data systems. ($2,500 per calendar day)

2. Failure by the Contractor to comply with reporting requirements set forth in this RFP, including but not limited to timeliness of submission and accuracy of data. ($250 per instance, per calendar day)

3. Failure by Contractor to maintain staffing levels, including the number and qualifications of staff, and provision of key positions that are outlined in this RFP. ($2,500 per calendar day)

4. Failure to fill key personnel vacancies within sixty (60) days of a vacancy. ($100 per instance, per calendar day)

5. Failure to notify DOM in writing within five (5) business days of any temporary and permanent changes to personnel commitments made in the Contractor's proposal or DOM approved staffing plan. ($100 per instance, per calendar day)

6. Failure by Contractor to meet the timeliness or accuracy standards for deliverables, or the deliverable is unavailable, unacceptable, deficient, or incomplete. ($250 per instance, per calendar day)

7. Failure of Contractor to comply with the close out and turnover requirements of this RFP may result in the assessment of damages of up to $25,000, which, if imposed, shall be deducted from the final payment to be made to Contractor.

8. Failure by the Contractor to obtain approval in writing by the Division of Medicaid for material requiring DOM approval as outlined in the RFP. ($1,000 per instance, per calendar day)

9. Any other failure of Contractor that DOM determines constitutes a substantial non-compliance with any material term of the Contract and/or RFP not specifically enumerated herein. (between $1 and $5,000 for each failure)

4.2.2 Failure to Meet Performance Standards related to Utilization Management

1. DOM may assess liquidated damages in the amount of $100 per workday for each failure to meet the UM performance standard of review determinations completion time frames.

2. DOM may assess liquidated damages in the amount of $100 per workday for each failure to meet the UM performance standard of review determinations notification time frames.

3. DOM may assess liquidated damages equal to the associated claims amount for TANs authorized by the Contractor outside of DOM approved policy.

4.2.3 Failure to Meet Performance Standards related to Quality Improvement

1. Failure to implement and manage a continuous quality improvement program for each type review performed by the Contractor. ($5,000 per month)

4.2.4 Failure to Meet Performance Standards for Corrective Action Plans

1. Failure to timely submit a DOM approved Corrective Action Plan (CAP). ($500 per calendar day until CAP submitted)

2. Failure to successfully carry out a DOM approved CAP within the time frames outlined in the CAP. ($500 per calendar day until CAP completed)

4.2.5 Failure to Implement

1. If the Contractor does not meet the pre-operational implementation date of thirty (30) days prior to Operation or the Operational start date of August 1, 2018, the Contractor shall pay to DOM liquidated damages in the amount of $2,000 per calendar day from August 1, 2018, until the Contractor becomes fully operational.

4.3 TERM OF CONTRACT

DOM will award a contract based on proposals. The contract period begins January 1, 2018 and will terminate December 31, 2020. DOM may have, under the same terms and conditions as the existing contract, an option for two (2) one-year extension periods, provided DOM obtains approval from the Personal Service Contract Review Board to allow an extension period.

4.3.1 Stop Work Order

1. Order to Stop Work: The DOM Contract Administrator may, by written order to the Contractor at any time and without notice to any surety, require the Contractor to stop all or any part of the work called for by this contract. This order shall be for a specified period not exceeding ninety (90) days after the order is

delivered to the Contractor, unless the parties agree to any further period. Any such order shall be identified specifically as a stop work order issued pursuant to this clause. Upon receipt of such an order, the Contractor shall forthwith comply with its terms and take all reasonable steps to minimize the occurrence of costs allocable to the work covered by the order during the period of work stoppage. Before the stop work order expires, or within any further period to which the parties shall have agreed, the DOM Contract Administrator shall either:

a. Cancel the stop work order; or

b. Terminate the work covered by such order as provided in the "Termination for Default by the Contractor" clause or the "Termination for Convenience" clause of this contract.

2. Cancellation or Expiration of the Order: If a stop work order issued under this clause is canceled at any time during the period specified in the order, or if the period of the order or any extension thereof expires, the Contractor shall have the right to resume work. An appropriate adjustment shall be made in the delivery schedule or Contractor price, or both, and the contract shall be modified in writing accordingly, if:

   a. The stop work order results in an increase in the time required for, or in the Contractor's cost properly allocable to, the performance of any part of this contract; and

   b. The Contractor asserts a claim for such an adjustment within thirty (30) days after the end of the period of work stoppage; provided that, if the DOM Contract Administrator decides that the facts justify such action, any such claim asserted may be received and acted upon at any time prior to final payment under this Contract

3. Termination of Stopped Work: If a stop work order or extension is not canceled and the work covered by such order is terminated for default or convenience, the reasonable costs resulting from the stop work order shall be allowed by adjustment or otherwise.

4. Adjustments of Price: Any adjustment in contract price made pursuant to this clause shall be negotiated between DOM and the Contractor.

4.3.2 Termination of Contract

The contract resulting from this RFP may be terminated by DOM as follows:

1. For default by the Contractor;
2. For convenience;
3. For the Contractor's bankruptcy, insolvency, receivership, liquidation; and,
4. For non-availability of funds.

At DOM's option, termination for any reason listed herein may also be considered termination for convenience.

4.3.2.1 Termination for Default by the Contractor

(1) *Default*. If Contractor refuses or fails to perform any of the provisions of this contract with such diligence as will ensure its completion within the time specified in this contract or any extension thereof, or otherwise fails to timely satisfy the contract provisions, or commits any other substantial breach of this contract, the Agency Head or designee may notify Contractor in writing of the delay or nonperformance and if not cured in ten (10) days or any longer time specified in writing by the Agency Head or designee, such officer may terminate Contractor's right to proceed with the contract or such part of the contract as to which there has been delay or a failure to properly

perform. In the event of termination in whole or in part, the Agency Head or designee may procure similar supplies or services in a manner and upon terms deemed appropriate by the Agency Head or designee. Contractor shall continue performance of the contract to the extent it is not terminated and shall be liable for excess costs incurred in procuring similar goods or services.

(2) *Contractor's Duties*. Notwithstanding termination of the contract and subject to any directions from the DOM Contract Administrator, Contractor shall take timely, reasonable, and necessary action to protect and preserve property in the possession of Contractor in which the State has an interest.

(3) *Compensation*. Payment for completed services delivered and accepted by the State shall be at the contract price. The State may withhold from amounts due Contractor such sums as the Agency Head or designee deems to be necessary to protect the State against loss because of outstanding liens or claims of former lien holders and to reimburse the State for the excess costs incurred in procuring similar goods and services.

(4) *Excuse for Nonperformance or Delayed Performance*. Except with respect to defaults of subcontractors, Contractor shall not be in default by reason of any failure in performance of this contract in accordance with its terms (including any failure by Contractor to make progress in the prosecution of the work hereunder which endangers such performance) if Contractor has notified the Agency Head or designee within fifteen (15) days after the cause of the delay and the failure arises out of causes such as: acts of God; acts of the public enemy; acts of the State and any other governmental entity in its sovereign or contractual capacity; fires; floods; epidemics; quarantine restrictions; strikes or other labor disputes; freight embargoes; or unusually severe weather. If the failure to perform is caused by the failure of a subcontractor to perform or to make progress, and if such failure arises out of causes similar to those set forth above, Contractor shall not be deemed to be in default, unless the services to be furnished by the subcontractor were reasonably obtainable from other sources in sufficient time to permit Contractor to meet the contract requirements. Upon request of Contractor, the Agency Head or designee shall ascertain the facts and extent of such failure, and, if such officer determines that any failure to perform was occasioned by any one or more of the excusable causes, and that, but for the excusable cause, Contractor's progress and performance would have met the terms of the contract, the delivery schedule shall be revised accordingly, subject to the rights of the State under the clause entitled (in fixed-price contracts, "Termination for Convenience," in cost-reimbursement contracts, "Termination"). (As used in this Paragraph of this clause, the term "subcontractor" means subcontractor at any tier).

(5) *Erroneous Termination for Default*. If, after notice of termination of Contractor's right to proceed under the provisions of this clause, it is determined for any reason that the contract was not in default under the provisions of this clause, or that the delay was excusable under the provisions of Paragraph (4) (Excuse for Nonperformance or Delayed Performance) of this clause, the rights and obligations of the parties shall, if the contract contains a clause providing for termination for convenience of the State, be the same as if the notice of termination had been issued pursuant to such clause.

(6) *Additional Rights and Remedies*. The rights and remedies of DOM provided in this clause shall not be exclusive and are in addition to any other rights and remedies provided by law or under this contract.

4.3.2.2 Termination for Convenience

(1) *Termination*. The Agency Head or designee may, when the interests of the State so require, terminate this contract in whole or in part, for the convenience of the State. The Agency Head or designee shall give written notice of the termination to Contractor specifying the part of the contract terminated and when termination becomes effective. Termination shall be effective as of the close of business on the date specified in the notice, which shall be at least thirty (30) days from the date of receipt of the notice by the Contractor.

(2) *Contractor's Obligations*. Contractor shall incur no further obligations in connection with the terminated work and on the date set in the notice of termination Contractor will stop work to the extent specified. Contractor shall also terminate outstanding orders and subcontracts as they relate to the terminated work. Contractor shall settle the liabilities and claims arising out of the termination of subcontracts and orders connected with the terminated work. The Agency Head or designee may direct Contractor to assign Contractor's right, title, and interest under terminated orders or subcontracts to the State. Contractor must still complete the work not terminated

4.3.2.3 Termination for the Contractor Bankruptcy

This contract may be terminated in whole or in part by DOM upon written notice to Contractor, if Contractor should become insolvent, become the subject of bankruptcy or receivership proceedings, whether voluntary or involuntary, upon the execution by Contractor of an assignment for the benefit of its creditors, avail itself of, or become subject to, any proceeding under the Bankruptcy Reform Act of 1978 or any other applicable Federal or State statute relating to insolvency or the protection of the rights of creditors.

In the event DOM elects to terminate the contract under this provision, it shall do so by sending Notice of Termination to the Contractor by certified mail, return receipt requested, or delivered in person. The date of termination shall be the close of business on the date specified in such notice to the Contractor. In the event of the filing of a petition in bankruptcy by or against a principal subcontractor, the Contractor shall immediately so advise DOM. The Contractor shall ensure and shall satisfactorily demonstrate to DOM that all tasks related to the subcontract are performed in accordance with the terms of this contract.

In the event of such termination, Contractor shall be entitled to recover just and equitable compensation for satisfactory work performed under this contract, but in no case shall said compensation exceed the total contract price.

4.3.2.4 Availability of Funds

It is expressly understood and agreed that the obligation of DOM to proceed under this contract is conditioned upon the appropriation of funds by the Mississippi State Legislature and the receipt of State and/or Federal funds. If the funds anticipated for the continuing fulfillment of the contract are, at any time, not forthcoming or insufficient, either through the failure of the Federal government to provide funds or of the State of Mississippi to appropriate funds or the discontinuance or material alteration of the program under which the funds were provided or if funds are not otherwise available to DOM, DOM shall have the right upon ten (10) working days written notice to the Contractor, to terminate this contract without damage, penalty, cost, or expenses to DOM of any kind whatsoever. The effective date of termination shall be as specified in the notice of termination.

4.3.3 Procedure on Termination

4.3.3.1 Contractor Responsibilities

Upon delivery by certified mail, return receipt requested, or in person to the Contractor a Notice of Termination specifying the nature of the termination, the extent to which performance of work under the contract is terminated, and the date upon which such termination becomes effective, the Contractor shall:

- Stop work under the contract on the date and to the extent specified in the Notice of Termination;
- Place no further orders or subcontracts for materials, services or facilities, except as may be necessary for completion of such portion of the work in progress under the contract until the effective date of termination;
- Terminate all orders and subcontracts to the extent that they relate to the performance of work

terminated by the Notice of Termination;

- Deliver to DOM within the time frame as specified by DOM in the Notice of Termination, copies of all data and documentation in the appropriate media and make available all records required to assure continued delivery of services to beneficiaries and providers at no cost to DOM;
- Complete the performance of the work not terminated by the Notice of Termination;
- Take such action as may be necessary, or as DOM may direct, for the protection and preservation of the property related to the contract which is in the possession of the Contractor and in which DOM has or may acquire an interest;
- Fully train DOM staff or other individuals at the direction of DOM in the operation and maintenance of the process;
- Promptly transfer all information necessary for the reimbursement of any outstanding claims; and
- Complete each portion of the Turnover Phase after receipt of the Notice of Termination. The Contractor shall proceed immediately with the performance of the above obligations notwithstanding any allowable delay in determining or adjusting the amount of any item of reimbursable price under this clause.
    - The Contractor has an absolute duty to cooperate and help with the orderly transition of the duties to DOM or its designated Contractor following termination of the contract for any reason.

4.3.3.2 DOM Responsibilities

Except for Termination for Contractor Default, DOM will make payment to the Contractor on termination and at contract price for completed deliverables delivered to and accepted by DOM. The Contractor shall be reimbursed for partially completed deliverables, accepted by DOM, at a price commensurate with actual cost of performance.

In the event of the failure of the Contractor and DOM to agree in whole or in part as to the amounts to be paid to the Contractor in connection with any termination described in this RFP, DOM shall determine on the basis of information available the amount, if any, due to the Contractor by reason of termination and shall pay to the Contractor the amount so determined.

The Contractor shall have the right of appeal, as stated under Disputes (Paragraph 4.9.5) from any such determination made by DOM.

4.3.4 Assignment of the Contract

The Contractor shall not sell, transfer, assign, or otherwise dispose of the contract or any portion thereof or of any right, title, or interest therein without the prior written consent of DOM. Any such purported assignment or transfer shall be void. If approved, any assignee shall be subject to all terms and conditions of this contract and other supplemental contractual documents. No approval by DOM of any assignment may be deemed to obligate DOM beyond the provisions of this contract. This provision includes reassignment of the contract due to change in ownership of the Contractor. DOM shall at all times be entitled to assign or transfer its rights, duties, and/or obligations under this contract to another governmental agency in the State of Mississippi upon giving prior written notice to the Contractor.

4.3.5 Excusable Delays/Force Majeure

The Contractor and DOM shall be excused from performance under this contract for any period that they are prevented from performing any services under this contract as a result of an act of God, war, civil disturbance, epidemic, court order, government act or omission, or other cause beyond their reasonable control. When such a cause arises, the Contractor shall notify DOM immediately in writing of the cause of its inability to perform, how it affects its performance, and the anticipated duration of the inability to perform. Delays in delivery or in meeting completion dates due to force majeure events shall automatically extend such dates for a period equal to the duration of the delay caused by such events, unless DOM determines it to be in its best interest to terminate the Contract.

4.3.6 Applicable Law

The contract shall be governed by and construed in accordance with the laws of the State of Mississippi, excluding its conflict of laws, provisions, and any litigation with respect thereto shall be brought in the courts of the State of Mississippi. The Contractor shall comply with applicable Federal, State, and local laws and regulations including, but not limited to, Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; the Americans with Disabilities Act of 1990 as amended; section 1557 of the Patient Protection and Affordable Care Act; and all other state and federal laws and regulations referenced in this RFP.

4.4 NOTICES

Whenever, under this RFP, one party is required to give notice to the other, except for purposes of Notice of Termination under Section 4.3, such notice shall be deemed given upon delivery, if delivered by hand, or upon the date of receipt or refusal, if sent by registered or certified mail, return receipt requested or by other carriers that require signature upon receipt. Notice may be delivered by facsimile transmission, with original to follow by certified mail, return receipt requested, or by other carriers that require signature upon receipt, and shall be deemed given upon transmission and facsimile confirmation that it has been received. Notices shall be addressed as follows:

In case of notice to the Contractor:

Project Manager
Street Address
City, State Zip Code

In case of notice to DOM:

Executive Director
Division of Medicaid
550 High St., Suite 1000
Jackson, Mississippi 39201

Copy to Contract Administrator, DOM

4.5 COST OR PRICING DATA

If DOM determines that any price, including profit or fee, negotiated in connection with this RFP was increased because the Contractor furnished incomplete or inaccurate cost or pricing data not current as certified in the

Contractor's certification of current cost or pricing data, then such price or cost shall be reduced accordingly and this RFP shall be modified in writing and acknowledged by the Contractor to reflect such reduction.

4.6 SUBCONTRACTING

The Contractor is solely responsible for fulfillment of the contract terms with DOM. DOM will make contract payments only to the Contractor.

The Contractor shall not subcontract any portion of the services to be performed under this contract without the prior written approval of DOM. The Contractor shall notify DOM not less than thirty (30) days in advance of its desire to subcontract and include a copy of the proposed subcontract with the proposed subcontractor.

Approval of any subcontract shall neither obligate DOM nor the State of Mississippi as a party to that subcontract nor create any right, claim, or interest for the subcontractor against the State of Mississippi or DOM, their agents, their employees, their representatives, or successors.

Any subcontract shall be in writing and shall contain provisions such that it is consistent with the Contractor's obligations pursuant to this Contract.

The Contractor shall be solely responsible for the performance of any subcontractor under such subcontract approved by DOM.

The Contractor shall give DOM immediate written notice by certified mail, facsimile, or any other carrier that requires signature upon receipt of any action or suit filed and prompt notice of any claim made against the Contractor or subcontractor which in the opinion of the Contractor may result in litigation related in any way to the contract with DOM.

4.7 PROPRIETARY RIGHTS

4.7.1 Ownership of Documents

Where activities supported by this contract produce original writing, sound recordings, pictorial reproductions, drawings, or other graphic representation and works of any similar nature, DOM shall have the right to use, duplicate, and disclose such materials in whole or in part, in any manner, for any purpose whatsoever and to have others do so. If the material is qualified for copyright, the Contractor may copyright such material, with approval of DOM, but DOM shall reserve a royalty-free, non-exclusive, and irrevocable license to reproduce, publish, and use such materials, in whole or in part, and to authorize others to do so.

4.7.2 Ownership of Information and Data

DOM, DHHS, CMS, the State of Mississippi, and/or their agents shall have unlimited rights to use, disclose, or duplicate, for any purpose whatsoever, all information and data developed, derived, documented, or furnished by the Contractor under any contract resulting from this RFP.

The Contractor agrees to grant in its own behalf and on behalf of its agents, employees, representatives, assignees, and subcontractors to DOM, DHHS, CMS and the State of Mississippi and to their officers, agents, and employees acting in their official capacities a royalty-free, non-exclusive, and irrevocable license throughout the world to publish, reproduce, translate, deliver, and dispose of all such information now covered by copyright of the proposed Contractor.

Excluded from the foregoing provisions in this Section 4.7.2, however, are any pre-existing, proprietary tools owned, developed, or otherwise obtained by Contractor independent of this Contract. Contractor is and shall remain the owner of all rights, title and interest in and to the Proprietary Tools, including all copyright, patent, trademark, trade secret and all other proprietary rights thereto arising under Federal and State law, and no license or other right to the Proprietary Tools is granted or otherwise implied. Any right that DOM may have with respect to the Proprietary Tools shall arise only pursuant to a separate written agreement between the parties.

4.7.3 Public Information

Offerors shall provide an electronic, single document version of proposals redacting those provisions of the proposal which contain trade secrets or other proprietary data. However, Offerors should be aware that their un-redacted proposals are considered public record and are subject to release by DOM pursuant to and in accordance with Miss. Code Ann. § 25-61-1 (1972, as amended) absent a court-issued protective order or agreement by the requesting party to receive a redacted version.

4.7.4 Right of Inspection

DOM, the Mississippi Department of Audit, DHHS, CMS, OIG, the General Accounting Office (GAO), or any other auditing agency prior-approved by DOM, or their authorized representative shall, at all reasonable times, have the right to enter onto the Contractor's premises, or such other places where duties under this contract are being performed, to inspect, monitor, or otherwise evaluate (including periodic systems testing) the work being performed. The Contractor shall provide access to all facilities and assistance for DOM and Mississippi Audit Department representatives. All inspections and evaluations shall be performed in such a manner as will not unduly delay work. Refusal by the Contractor to allow access to all documents, papers, letters or other materials, shall constitute a breach of contract. All audits performed by persons other than DOM staff will be coordinated through DOM and its staff.

4.7.5 Licenses, Patents and Royalties

DOM does not tolerate the possession or use of unlicensed copies of proprietary software. The Contractor shall be responsible for any penalties or fines imposed as a result of unlicensed or otherwise defectively titled software.

The Contractor, without exception, shall indemnify, save, and hold harmless DOM and its employees from liability of any nature or kind, including cost and expenses for or on account of any copyrighted, patented, or non-patented invention, process, or article manufactured by the Contractor. DOM will provide prompt written notification of a claim of copyright or patent infringement.

Further, if such a claim is made or is pending, the Contractor may, at its option and expense, procure for DOM the right to continue use of, replace or modify the article to render it non-infringing. If none of the alternatives are reasonably available, the Contractor agrees to take back the article and refund the total amount DOM has paid the Contractor under this contract for use of the article.

If the Contractor uses any design, device, or materials covered by letters, patent or copyright, it is mutually agreed and understood without exception that the proposed prices shall include all royalties or costs arising from the use of such design, device, or materials in any way involved in the work.

4.7.6 Records Retention Requirements

The Contractor shall maintain detailed records evidencing all expenses incurred pursuant to the Contract, the provision of services under the Contract, and complaints, for the purpose of audit and evaluation by DOM and other Federal or State personnel. All records, including training records, pertaining to the contract must be readily

retrievable within three (3) business days for review at the request of DOM and its authorized representatives. All records shall be maintained and available for review by authorized federal and State personnel during the entire term of the Contract and for a period of ten (10) years thereafter, unless an audit is in progress or there is pending litigation. The right to audit shall exist for ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later.

4.8 REPRESENTATION REGARDING CONTINGENT FEES

The Offeror represents that it has not retained a person to solicit or secure a State contract upon an agreement or understanding for a commission, percentage, brokerage, or contingent fee, except as disclosed in the Offeror's bid or proposal.

4.9 INTERPRETATIONS/CHANGES/DISPUTES

The RFP in its entirety is a part of the Contract. In the event of a dispute or conflict among any of the components of the contract, the contract shall govern. After the Contract, the order of priority is: Att. D, Bidder Questions and Answers; Att. C or E, the Business Proposal or BAFO, if applicable; Att. A, the RFP; and Att. B, the Technical Proposal.

All the documents shall be read and construed as far as possible to be one harmonious whole; however, in the event of a conflict or dispute, the above list is the list of priority.

DOM reserves the right to clarify any contractual relationship in writing and such clarification will govern in case of conflict with the requirements of the RFP. Any ambiguity in the RFP shall be construed in favor of DOM.

The contract represents the entire agreement between the Contractor and DOM and it supersedes all prior negotiations, representations, or agreements, either written or oral between the parties hereto relating to the subject matter hereof.

4.9.1 Conformance with Federal and State Regulations

The Contractor shall be required to conform to all Federal and State laws, regulations, and policies as they exist or as amended.

In the event that the Contractor requests that the Executive Director of DOM or his/her designee issue policy determinations or operating guidelines required for proper performance of the contract, DOM shall do so in a timely manner. The Contractor shall be entitled to rely upon and act in accordance with such policy determinations and operating guidelines unless the Contractor acts negligently, maliciously, fraudulently, or in bad faith.

The Contractor expressly agrees to all of the provisions and requirements as set forth in the State Plan for Medical Assistance approved by the State of Mississippi and by the Secretary of the United States Department of Health and Human Services, pursuant to Title XIX of the Social Security Act, and understands those provisions and requirements are also incumbent on the Contractor.

4.9.2 Waiver

No assent, expressed or implied, by the parties hereto to the breach of the provisions or conditions of this contract shall be deemed or taken to be a waiver of any succeeding breach of the same or any other provision or condition and shall not be construed to be a modification of the terms of this Contract.

Moreover, no delay or omission by either party to this contract in exercising any right, power, or remedy hereunder or otherwise afforded by contract, at law, or in equity shall constitute an acquiescence therein, impair any other right, power or remedy hereunder or otherwise afforded by any means, or operate as a waiver of such right, power, or remedy. No waiver by either party to this contract shall be valid unless set forth in writing by the party making said waiver. No waiver of or modification to any term or condition of this contract will void, waive, or change any other term or condition. No waiver by one party to this contract of a default by the other party will imply, be construed as or require waiver of future or other defaults.

4.9.3 Severability

If any part, term or provision of the contract (including items incorporated by reference) is held by the courts or other judicial body to be illegal or in conflict with any law of the State of Mississippi or any Federal law, the validity of the remaining portions or provisions shall not be affected and the obligations of the parties shall be construed in full force as if the contract did not contain that particular part, term or provision held to be invalid.

4.9.4 Change Orders and/or Amendments

The Executive Director of DOM or designated representative may, at any time, by written order delivered to the Contractor at least thirty (30) days prior to the commencement date of such change, make administrative changes within the general scope of the contract. If any such change causes an increase or decrease in the cost of the performance of any part of the work under the contract an adjustment commensurate with the costs of performance under this contract shall be made in the contract price or delivery schedule or both. Any claim by the Contractor for equitable adjustment under this clause must be asserted in writing to DOM within thirty (30) days from the date of receipt by the Contractor of the notification of change. Failure to agree to any adjustment shall be a dispute within the meaning of the Disputes Clause of this Contract. Nothing in this clause, however, shall in any manner excuse the Contractor from proceeding diligently with the contract as changed.

If the parties are unable to reach an agreement within thirty (30) days of DOM receipt of the Contractor's cost estimate, the Executive Director of DOM shall make a determination of the revised price, and the Contractor shall proceed with the work according to a schedule approved by DOM subject to the Contractor's right to appeal the Executive Director's determination of the price pursuant to the Disputes clause.

The rate of payment for changes or amendments completed per contract year shall be at the rates specified by the Contractor's proposal.

At any time during the term of this contract, DOM may increase the quantity of goods or services purchased under this contract by sending the Contractor a written amendment or modification to that effect which references this contract and is signed by the Executive Director of DOM. The purchase price shall be the lower of the unit cost identified in the Contractor's proposal or the Contractor's then-current, published price. The foregoing shall not apply to services provided to DOM at no charge. The delivery schedule for any items added by exercise of this option shall be set by mutual agreement.

4.9.5 Disputes

Any dispute concerning the contract which is not disposed of by agreement shall be decided by the Executive Director of DOM who shall reduce such decision to writing and mail or otherwise furnish a copy thereof to the Contractor. The decision of the Executive Director shall be final and conclusive. Nothing in this paragraph shall be construed to relieve the Contractor of full and diligent performance of the contract.

4.9.6 Cost of Litigation

In the event that DOM deems it necessary to take legal action to enforce any provision of the contract, the Contractor shall bear the cost of such litigation, as assessed by the court, in which DOM prevails. Neither the State of Mississippi nor DOM shall bear any of the Contractor's cost of litigation for any legal actions initiated by the Contractor against DOM regarding the provisions of the contract. Legal action shall include administrative proceedings.

4.9.7 Attorney Fees

The Contractor agrees to pay reasonable attorney fees incurred by the State and DOM in enforcing this contract or otherwise reasonably related thereto.

4.10 INDEMNIFICATION

The Contractor agrees to indemnify, defend, save, and hold harmless DOM, the State of Mississippi, their officers, agents, employees, representatives, assignees, and Contractors from any and all claims and losses accruing or resulting to any and all the Contractor employees, agents, subcontractors, laborers, and any other person, association, partnership, entity, or corporation furnishing or supplying work, services, materials, or supplies in connection with performance of this contract, and from any and all claims and losses accruing or resulting to any such person, association, partnership, entity, or corporation who may be injured, damaged, or suffer any loss by the Contractor in the performance of the contract.

The Contractor agrees to indemnify, defend, save, and hold harmless DOM, the State of Mississippi, their officers, agents, employees, representatives, assignees, and Contractors against any and all liability, loss, damage, costs or expenses which DOM may sustain, incur or be required to pay: 1.) by reason of any person suffering personal injury, death or property loss or damage of any kind either while participating with or receiving services from the Contractor under this contract, or while on premises owned, leased, or operated by the Contractor or while being transported to or from said premises in any vehicle owned, operated, leased, chartered, or otherwise contracted for or in the control of the Contractor or any officer, agent, or employee thereof; or 2.) by reason of the Contractor or its employee, agent, or person within its scope of authority of this contract causing injury to, or damage to the person or property of a person including but not limited to DOM or the Contractor, their employees or agents, during any time when the Contractor or any officer, agent, employee thereof has undertaken or is furnishing the services called for under this contract.

The Contractor agrees to indemnify, defend, save, and hold harmless DOM, the State of Mississippi, their officers, agents, employees, representatives, assignees, and Contractors against any and all liability, loss, damages, costs or expenses which DOM or the State may incur, sustain or be required to pay by reason of the Contractor, its employees, agents or assigns: 1.) failing to honor copyright, patent or licensing rights to software, programs or technology of any kind in providing services to DOM, or 2.) breaching in any manner the confidentiality required pursuant to Federal and State law and regulations.

The Contractor agrees to indemnify, defend, save, and hold harmless DOM, the State of Mississippi, their officers, agents, employees, representatives, assignees, and Contractors from all claims, demands, liabilities, and suits of any nature whatsoever arising out of the contract because of any breach of the contract by the Contractor, its agents or employees, including but not limited to any occurrence of omission or commission or negligence of the Contractor, its agents or employees.

If in the reasonable judgment of DOM a default by the Contractor is not so substantial as to require termination and reasonable efforts to induce the Contractor to cure the default are unsuccessful and the default is capable of being cured by DOM or by another resource without unduly interfering with the continued performance of the Contractor, DOM may provide or procure such services as are reasonably necessary to correct the default. In such event, the

Contractor shall reimburse DOM for the entire cost of those services. DOM may deduct the cost of those services from the Contractor's monthly administrative invoices. The Contractor shall cooperate with DOM or those procured resources in allowing access to facilities, equipment, data or any other Contractor resources to which access is required to correct the default. The Contractor shall remain liable for ensuring that all operational performance standards remain satisfied.

4.10.1 No Limitation of Liability

Nothing in this contract shall be interpreted as excluding or limiting any liability of the Contractor for harm caused by the intentional or reckless conduct of the Contractor, or for damages incurred in the negligent performance of duties by the Contractor, or for the delivery by the Contractor of products that are defective, or for breach of contract or any other duty by the Contractor. Nothing in the contract shall be interpreted as waiving the liability of the Contractor for consequential, special, indirect, incidental, punitive or exemplary loss, damage, or expense related to the Contractor's conduct or performance under this contract.

4.10.2 Third Party Action Notification

Contractor shall give DOM prompt notice in writing of any action or suit filed, and prompt notice of any claim made against Contractor by any entity that may result in litigation related in any way to this Contract.

4.11 STATUS OF THE CONTRACTOR

4.11.1 Independent Contractor

It is expressly agreed that the Contractor is an Independent Contractor performing professional services for DOM and is not an officer or employee of the State of Mississippi or DOM. It is further expressly agreed that the contract shall not be construed as a partnership or joint venture between the Contractor and DOM.

The Contractor shall be solely responsible for all applicable taxes, insurance, licensing and other costs of doing business. Should the Contractor default on these or other responsibilities jeopardizing the Contractor's ability to perform services effectively, DOM, in its sole discretion, may terminate this contract.

The Contractor shall not purport to bind DOM, its officers or employees nor the State of Mississippi to any obligation not expressly authorized herein unless DOM has expressly given the Contractor the authority to do so in writing.

The Contractor shall give DOM immediate notice in writing of any action or suit filed, or of any claim made by any party which might reasonably be expected to result in litigation related in any manner to this contract or which may impact the Contractor's ability to perform.

No other agreements of any kind may be made by the Contractor with any other party for furnishing any information or data accumulated by the Contractor under this contract or used in the operation of this program without the written approval of DOM. Specifically, DOM reserves the right to review any data released from reports, histories, or data files created pursuant to this Contract.

In no way shall the Contractor represent itself directly or by inference as a representative of the State of Mississippi or DOM except within the confines of its role as an Independent Contractor for DOM. DOM's approval must be received in all instances in which the Contractor distributes publications, presents seminars or workshops, or performs any other outreach.

The Contractor shall not use DOM's name or refer to the contract and the services provided therein directly or indirectly in any advertisement, news release, professional trade or business presentation without prior written approval from DOM.

4.11.2 Employment of DOM Employees

The Contractor shall not knowingly engage on a full-time, part-time, or other basis during the period of the contract, any professional or technical personnel who are or have been at any time during the period of the contract in the employ of DOM, without the written consent of DOM. Further, the Contractor shall not knowingly engage in this project, on a full-time, part-time, or other basis during the period of the contract, any former employee of DOM who has not been separated from DOM for at least one year, without the written consent of DOM.

The Contractor shall give priority consideration to hiring interested and qualified adversely affected State employees at such times as requested by DOM to the extent permitted by this contract or State law.

4.11.3 Conflict of Interest

No official or employee of DOM and no other public official of the State of Mississippi or the Federal Government who exercises any functions or responsibilities in the review or approval of the undertaking or carrying out of the project shall, prior to the completion of the project, voluntarily acquire any personal interest, direct or indirect, in the contract or proposed contract. A violation of this provision shall constitute grounds for termination of this contract. In addition, such violation will be reported to the State Ethics Commission, Attorney General, and appropriate Federal law enforcement officers for review.

The Contractor covenants that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services hereunder. The Contractor further covenants that in the performance of the contract no person having any such known interests shall be employed including subsidiaries or entities that could be misconstrued as having a joint relationship, and no immediate family members of Medicaid providers shall be employed by the Contractor.

4.11.4 Personnel Practices

All employees of the Contractor involved in the Medicaid function will be paid as any other employee of the Contractor who works in another area of their organization in a similar position. The Contractor shall develop any and all methods to encourage longevity in Contractor's staff assigned to this contract.

Employees of the Contractor shall receive all benefits afforded to other similarly situated employees of the Contractor.

The Contractor shall sign the Drug Free Workplace Certificate (Exhibit 1).

4.11.5 No Property Rights

No property rights inure to the Contractor except for compensation for work that has already been performed.

4.12 EMPLOYMENT PRACTICES and COMPLIANCE WITH LAWS

The Contractor understands that DOM is an equal opportunity employer and therefore, maintains a policy which prohibits unlawful discrimination based on race, color, creed, religion, sex, age, national origin, physical handicap, disability, genetic information, political affiliation, ancestry, limited English proficiency, or any other consideration made unlawful by Federal, State, or local laws. All such discrimination is unlawful and the Contractor agrees during the term of the contract that the Contractor shall strictly adhere to this policy in its employment practices and

provision of services, including, but not limited to, hiring, termination/discharge, promotion/demotion, or other terms and conditions of employment. The Contractor shall comply with, and all activities under this contract shall be subject to, all applicable Federal, State of Mississippi, and local laws and regulations related to unlawful discrimination, as now existing and as may be amended or modified.

The Contractor agrees to post in conspicuous places, available to employees and applicants for employment notices setting forth the provisions of this clause.

The Contractor shall, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, state that all qualified applicants will receive consideration for employment without regard to race, color, creed, religion, sex, age, national origin, physical handicap, disability, genetic information, political affiliation, ancestry, limited English proficiency, or any other consideration made unlawful by Federal, State, or local laws, except where it relates to a bona fide occupational qualification or requirement.

The Contractor shall comply with the non-discrimination clause contained in Federal Executive Order 11246, as amended by Federal Executive Order 11375, relative to Equal Employment Opportunity for all persons without regard to race, color, religion, sex, or national origin, and the implementing rules and regulations prescribed by the Secretary of Labor and with Title 41, Code of Federal Regulations, Chapter 60. The Contractor shall comply with related State laws and regulations, if any.

The Contractor shall comply with the Civil Rights Act of 1964, and any amendments thereto, and the rules and regulations thereunder, and Section 504 of Title V of the Rehabilitation Act of 1973, as amended, and related State laws and regulations, if any.

If DOM finds that the Contractor is not in compliance with any of these requirements at any time during the term of this contract, DOM reserves the right to terminate this contract or take such other steps as it deems appropriate, in its sole discretion, considering the interests and welfare of the State.

4.13 OWNERSHIP AND FINANCIAL INFORMATION

4.13.1 Information to Be Disclosed

In accordance with 42 C.F.R. § 455.104(b), the Contractor shall disclose the following:

1. The name and address of any individual or corporation with an ownership or control interest in the disclosing entity, DOM's Fiscal Agent, or managed care entity. The address for corporate entities shall include as applicable primary business, every business location, and P.O. Box address;
2. Date of birth and Social Security Number (in the case of an individual);
3. Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity (or DOM's Fiscal Agent or managed care entity) or in any subcontractor in which the disclosing entity (or DOM's Fiscal Agent or managed care entity) has a five percent (5%) or more interest;
4. Whether the individual or corporation with an ownership or control interest in the disclosing entity (or DOM's Fiscal Agent or managed care entity) is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the individual or corporation with an ownership or control interest in any subcontractor in which the disclosing entity (or DOM's Fiscal Agent or managed care entity) has a five percent (5%) or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling;
5. The name of any other disclosing entity (or DOM's Fiscal Agent or managed care entity) in which an owner of the disclosing entity (or DOM's Fiscal Agent or managed care entity) has an ownership or control interest; and,
6. The name, address, date of birth, and Social Security Number of any managing employee of the disclosing

entity (or DOM's Fiscal Agent or managed care entity).

4.13.2 When Information Will Be Disclosed

In accordance with 42 C.F.R. § 455.104(c), disclosures from the Contractor are due at any of the following times:

1. Upon the Contractor submitting a proposal in accordance with the State's procurement process;
2. Annually, including upon the execution, renewal, and extension of the contract with the State; and,
3. Within thirty-five (35) days after any change in ownership of the Contractor.

4.13.3 To Whom Information Will Be Disclosed

In accordance with 42 C.F.R. § 455.104(d), all disclosures shall be provided to DOM, the State's designated Medicaid agency.

4.13.4 Federal Financial Participation

In accordance with 42 C.F.R. § 455.104(e), Federal financial participation (FFP) is not available in payments made to a disclosing entity that fails to disclose ownership or control information as required by said section.

4.13.5 Information Related to Business Transactions

In accordance with 42 C.F.R. § 455.105, the Contractor shall fully disclose all information related to business transactions. The Contractor shall submit, within thirty-five (35) days of the date on a request by the Secretary or DOM, full and complete information about:

1. The ownership of any subcontractor with whom the Contractor has had business transactions totaling more than twenty-five thousand dollars and zero cents ($25,000.00) during the twelve (12)-month period ending on the date of the request; and,

2. Any significant business transactions between the Contractor and any wholly owned supplier, or between the Contractor and any subcontractor, during the five (5)-year period ending on the date of the request.

4.13.6 Disclosure of Identity of Any Person Convicted of a Criminal Offense

In accordance with 42 C.F.R. § 455.106(a), the Contractor shall disclose to DOM the identity of any person who:

1. Has ownership or control interest in the Contractor, or is an agent or managing employee of the Contractor; and,
2. Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.

4.13.7 Disclosure to the Inspector General

In accordance with 42 C.F.R. § 455.106(b), DOM must notify the Inspector General of the Department of any disclosures under § 455.106(a) within twenty (20) working days from the date it receives the information. DOM must also promptly notify the Inspector General of the Department of any action it takes on the Contractor's agreement and participation in the program.

4.13.8 DOM's Right of Refusal

In accordance with 42 C.F.R. § 455.106(c), DOM may refuse to enter into or renew an agreement with a Contractor if any person who has an ownership or control interest in the Contractor, or who is an agent or managing employee of the Contractor, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid, or the Title XX Services Program. Further, DOM may refuse to enter into or may terminate a Contractor agreement if it determines that the Contractor did not fully and accurately make any disclosure required under 42 C.F.R. § 455.106(a).

4.13.9 Additional Requirements of DOM and Contractors

In accordance with 42 C.F.R. § 455.436, the State Medicaid agency and all Medicaid Contractors shall do the following:

1. Confirm the identity and determine the exclusion status of Contractors/subcontractors and any person with an ownership or control interest or who is an agent or managing employee of the Contractor/subcontractor through routine checks of Federal databases; and,

2. Consult appropriate databases to confirm identity of the above-mentioned persons and entities by searching the List of Excluded Individuals/Entities (LEIE) and the System for Award Management (SAM) upon enrollment, re-enrollment, credentialing, or re-credentialing, and no less frequently than monthly thereafter, to ensure that the State does not pay Federal funds to excluded persons or entities.

4.14 RISK MANAGEMENT

The Contractor may insure any portion of the risk under the provision of the contract based upon the Contractor's ability (size and financial reserves included) to survive a series of adverse experiences, including withholding of payment by DOM, or imposition of penalties by DOM.

On or before beginning performance under this Contract, the Contractor shall obtain from an insurance company, duly authorized to do business and doing business in Mississippi, insurance as follows:

4.14.1 Workers' Compensation

The Contractor shall take out and maintain, during the life of this contract, workers' compensation insurance for all employees employed under the contract in Mississippi. Such insurance shall fully comply with the Mississippi Workers' Compensation Law. In case any class of employees engaged in hazardous work under this contract at the site of the project is not protected under the Workers' Compensation Statute, the Contractor shall provide adequate insurance satisfactory for protection of his or her employees not otherwise protected.

4.14.2 Liability

The Contractor shall ensure that professional staff and other decision making staff shall be required to carry professional liability insurance in an amount commensurate with the professional responsibilities and liabilities under the terms of this RFP and other supplemental contractual documents.

The Contractor shall obtain, pay for and keep in force during the contract period general liability insurance against bodily injury or death in an amount commensurate with the responsibilities and liabilities under the terms of this RFP; and insurance against property damage and fire insurance including contents coverage for all records maintained pursuant to this contract in an amount commensurate with the responsibilities and liabilities under the terms of this RFP. On an annual basis, the Contractor shall furnish to DOM certificates evidencing such insurance is in effect on the first working day following contract signing.

4.15 CONFIDENTIALITY OF INFORMATION

4.15.1 Confidentiality of Beneficiary Information

All information as to personal facts and circumstances concerning Medicaid beneficiaries obtained by the Contractor shall be treated as privileged communications, shall be held confidential, and shall not be divulged without the written consent of DOM and the written consent of the enrolled beneficiary, his attorney, or his responsible parent or guardian, except as may be required by DOM.

The use or disclosure of information concerning beneficiaries shall be limited to purposes directly connected with the administration of the contract.

All of the Contractor officers and employees performing any work for or on the contract shall be instructed in writing of this confidentiality requirement and required to sign such a document upon employment and annually thereafter.

The Contractor shall immediately notify DOM of any unauthorized possession, use, knowledge or attempt thereof, of DOM's data files or other confidential information. The Contractor shall immediately furnish DOM full details of the attempted unauthorized possession, use or knowledge, and assist in investigating or preventing the recurrence thereof.

This requirement of confidentiality survives the term of the contract between DOM and Contractor.

4.15.2 Release of Public Information

Offerors must provide an electronic, single document version of proposals redacting those provisions of the proposal which contain trade secrets or other proprietary data which they believe may remain confidential in accordance with Miss. Code Ann. § 25-61-9 (1972, as amended) and other applicable state and federal laws, if any. Offerors should be aware that the un-redacted version of their proposals is considered public record and is subject to release by DOM pursuant to and in accordance with Miss. Code Ann. § 25-61-1, *et seq*. (1972, as amended).

In the event that either party to the executed Contract receives notice that a third party requests divulgence of confidential or otherwise protected information and/or has served upon it a subpoena or other validly issued administrative or judicial process ordering divulgence of confidential or otherwise protected information, that party shall promptly inform the other party and thereafter respond in conformity with such subpoena to the extent mandated by State law. This provision shall survive termination or completion of the executed Contract. The parties agree that this provision is subject to and superseded by Miss. Code Ann. § 25-61-1, *et seq*. (1972, as amended) regarding Public Access to Public Records.

4.15.3 Trade Secrets, Commercial and Financial Information

It is expressly understood that Mississippi law requires that the provisions of this contract which contain the commodities purchased or the personal or professional services provided, the price to be paid, and the term of the contract shall not be deemed to be a trade secret or confidential commercial or financial information and shall be available for examination, copying, or reproduction.

4.15.4 Transparency

This contract, including any accompanying exhibits, attachments, and appendices, is subject to the "Mississippi Public Records Act of 1983," and its exceptions. See Miss. Code Ann. § 25-61-1 *et seq.*, (1972, as amended). In

addition, this contract is subject to the provisions of the Mississippi Accountability and Transparency Act of 2008. Miss. Code Ann. § 27-104-151 *et seq.* (1972, as amended).

Unless exempted from disclosure due to a court-issued protective order, a copy of this executed contract is required to be posted to the Department of Finance and Administration's independent agency contract website for public access at http://www.transparency.mississippi.gov. Information identified by the Contractor as information which is required confidential by State or Federal law or outside the applicable freedom of information statutes shall be redacted by the Offeror.

This contract, including any accompanying exhibits, attachments, and appendices, is subject to the "Mississippi Public Records Act of 1983," and its exceptions. See Miss. Code Ann.§§ 25-61-1 *et seq.*, (1972, as amended) and Miss. Code Ann. § 79-23-1 (1972, as amended). In addition, this contract is subject to the provisions of the Mississippi Accountability and Transparency Act of 2008. Miss. Code Ann. §§ 27-104-151 *et seq*. (1972, as amended). Unless exempted from disclosure due to a court-issued protective order, a copy of this executed contract is required to be posted to the Department of Finance and Administration's independent agency contract website for public access at http://www.transparency.mississippi.gov. Information identified by Contractor as trade secrets, or other proprietary information, including confidential vendor information, or any other information which is required confidential by state or federal law or outside the applicable freedom of information statutes, will be redacted by the contractor.

4.16 THE CONTRACTOR COMPLIANCE ISSUES

The Contractor agrees that all work performed as part of this contract shall comply fully with administrative and other requirements established by Federal and State laws, regulations and guidelines, and assumes responsibility for full compliance with all such laws, regulations and guidelines, and agrees to fully reimburse DOM for any loss of funds, resources, overpayments, duplicate payments or incorrect payments resulting from noncompliance by the Contractor, its staff, or agents, as revealed in any audit. In addition the Contractor agrees that all work performed shall comply with all CMS guidelines necessary to maintain the enhanced funding provided by CMS for eligibility and enrollment systems development.

4.16.1 Federal, State, and Local Taxes

Unless otherwise provided herein, the contract price shall include all applicable Federal, State, and local taxes.

The Contractor shall pay all taxes lawfully imposed upon it with respect to this contract or any product delivered in accordance herewith. DOM makes no representation whatsoever as to exemption from liability to any tax imposed by any governmental entity on the Contractor.

4.16.2 License Requirements

The Contractor shall have, or obtain, any license/permits that are required prior to and during the performance of work under this contract.

4.16.3 Privacy/Security Compliance

The Contractor shall execute DOM's Business Associate Agreement (BAA) and Data Use Agreement (DUA) before contract execution. The BAA and DUA can be found on the Procurement Website at http://www.medicaid.ms.gov/resources/procurement/. Moreover, all activities under this contract shall be performed in accordance with all applicable Federal and/or State laws, rules and/or regulations including the Administrative Simplification provisions of HIPAA, as amended by the Genetic Information Nondiscrimination Act (GINA) of 2008 and the Health Information Technology for Economic and Clinical Health Act (HITECH Act),

Title XIII of Division A, and Title IV of Division B of the American Recovery and Reinvestment Act (ARRA) of 2009, and their implementing regulations at 45 C.F.R. Parts 160, 162, and 164, involving electronic data interchange, code sets, identifiers, and the security and privacy of protected health information (PHI), as may be applicable to the services under this Contract. Each party to this contract shall treat all data and information to which it has access under this contract as confidential information to the extent that confidential treatment of same is required under Federal and State law and shall not disclose same to a third party without specific written consent of the other party. In the event that either party receives notice that a third party requested divulgence of the confidential or otherwise protected information and/or has served upon it a subpoena or other validly issued administrative or judicial process ordering divulgence of the confidential or otherwise protected information, the party shall promptly inform the other party and thereafter respond in conformity with such subpoena as required by applicable State and/or Federal law, rules, and regulations. The provision herein shall survive the termination of the contract for any reason and shall continue in full force and effect and shall be binding upon both parties and their agents, employees, successors, assigns, subcontractors, or any party claiming an interest in the contract on behalf of, or under, the rights of the parties following termination.

4.16.4 Site Rules and Regulations

The Contractor shall use its best efforts to ensure that its employees and agents, while on DOM premises, shall comply with site rules and regulations.

4.16.5 Environmental Protection

The Contractor shall be in compliance with all applicable standards, orders or requirements issued under Section 306 of the Clean Air Act (42 U.S.C. § 7606), Section 508 of the Clean Water Act (33 U.S.C. § 1368), Executive Order 11738, and applicable United States Environmental Protection Agency (EPA) regulations which prohibit the use under non-exempt Federal contracts, grants, or loans of facilities included on the EPA list of Violating Facilities. The Contractor shall report violations to the applicable grantor Federal agency and the United States EPA Assistant Administrator for Enforcement.

4.16.6 Lobbying

The Contractor certifies, to the best of its knowledge and belief, that no Federal appropriated funds have been paid or will be paid, by or on behalf of the Contractor to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, or an employee of a member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, member of Congress, an officer or employee of Congress or an employee of a member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the Contractor shall complete and submit "Disclosure Form to Report Lobbying," in accordance with its instructions.

This certification is a material representation of fact upon which reliance is placed when entering into this contract. Submission of this certification is a prerequisite for making or entering into this contract imposed under 31 U.S.C. § 1352. Failure to file the required certification shall be subject to civil penalties for such failure.

The Contractor shall abide by lobbying laws of the State of Mississippi.

4.16.7 Bribes, Gratuities, and Kickbacks Prohibited

The receipt or solicitation of bribes, gratuities and kickbacks is strictly prohibited.

No elected or appointed officer or other employee of the Federal Government or of the State of Mississippi shall benefit financially or materially from this contract. No individual employed by the State of Mississippi shall be permitted any share or part of this contract or any benefit that might arise there from.

The Offeror or Contractor represents that it has not violated, is not violating, and promises that it will not violate the prohibition against gratuities set forth in Section 6-204 (Gratuities) of the *Mississippi Personal Service Contract Review Board Rules and Regulations*.

4.16.8 Small and Minority Businesses

DOM encourages the employment of small business and minority business enterprises. Therefore, the Contractor shall report, separately, the involvement in this contract of small businesses and businesses owned by minorities and women. Such information shall be reported on an invoice annually on the contract anniversary and shall specify the actual dollars contracted to-date with such businesses, actual dollars expended to date with such businesses, and the total dollars planned to be contracted for with such businesses on this contract.

4.16.9 Suspension and Debarment

The Contractor certifies that it is not suspended or debarred under Federal law and regulations or any other state's laws and regulations.

4.16.10 E-Payment

The Contractor agrees to accept all payments in United States currency via the State of Mississippi's electronic payment and remittance vehicle. DOM agrees to make payment in accordance with Mississippi law on "Timely Payments for Purchases by Public Bodies," which generally provides for payment of undisputed amounts by the agency within forty-five (45) days of receipt of invoice. Miss. Code Ann. § 31-7-305 (1972, as amended).

4.16.11 Paymode

Payments by state agencies using the State's accounting system shall be made and remittance information provided electronically as directed by the State. These payments shall be deposited into the bank account of the Contractor's choice. The State may, at its sole discretion, require the Contractor to electronically submit invoices and supporting documentation at any time during the term of this Contract. Contractor understands and agrees that the State is exempt from the payment of taxes. All payments shall be in United States currency.

4.16.12 E-VERIFICATION

If applicable, Contractor represents and warrants that it will ensure its compliance with the Mississippi Employment Protection Act of 2008, and will register and participate in the status verification system for all newly hired employees. Miss. Code Ann. §§ 71-11-1 *et seq.* (1972, as amended). The term "employee" as used herein means any person that is hired to perform work within the State of Mississippi. As used herein, "status verification system" means the Illegal Immigration Reform and Immigration Responsibility Act of 1996 that is operated by the United States Department of Homeland Security, also known as the E-Verify Program, or any other successor electronic verification system replacing the E-Verify Program. Contractor agrees to maintain records of such compliance. Upon request of the State and after approval of the Social provide a copy of each such verification. Contractor further represents and warrants that any person assigned to perform services hereafter meets the

employment eligibility requirements of all immigration laws. The breach of this agreement may subject Contractor to the following:

(1) termination of this contract for services and ineligibility for any state or public contract in Mississippi for up to three (3) years with notice of such cancellation/termination being made public;

(2) The loss of any license, permit, certification or other document granted to Contractor by an agency, department or governmental entity for the right to do business in Mississippi for up to one (1) year; or, both.

(3) In the event of such cancellations/termination, Contractor would also be liable for any additional costs incurred by the State due to Contract cancellation or loss of license or permit to do business in the State.

4.17 REPRESENTATION REGARDING GRATUITIES

The Offeror, represents that it has not violated, is not violating, and promises that it will not violate the prohibition against gratuities set forth in Section 6-204 (Gratuities) of the *Mississippi Personal Service Contract Review Board Rules and Regulations*.

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5 TECHNICAL PROPOSAL

5.1 INTRODUCTION

All proposals shall be typewritten on standard 8 ½ x 11 paper (larger paper is permissible for charts, spreadsheets, etc.) with tabs delineating each section. One copy of the proposal shall be submitted on CD in a single searchable document in Microsoft Word or Adobe Acrobat (PDF) format.

The Technical Proposal must include the following sections:

1. Transmittal Letter;
2. Executive Summary;
3. Corporate Background and Experience (including audited financials);
4. Ownership and Financial Disclosure Information (Section 4.13 of the RFP);
5. Project Organization and Staffing;
6. Methodology;
7. Project Management and Control; and,
8. Work Plan and Schedule.

Items to be included under each of these headings are identified in the paragraphs below. Each section within the Technical Proposal should include all items listed in the paragraphs below. The evaluation of proposals will be done on a section-by-section basis. A format that easily follows the requirements and order of the RFP should be used.

Any proposal that does not adhere to these requirements may be deemed non-responsive and rejected on that basis.

5.2 TRANSMITTAL LETTER

The Transmittal Letter shall be in the form of a standard business letter on letterhead of the Offeror and shall be signed by an individual authorized to legally bind the Offeror. The transmittal letter should identify all material and enclosures being submitted in response to the RFP. Failure to include the statements or items listed below may result in rejection of the proposal. The transmittal letter shall include the following:

1. A statement indicating the Offeror confirms that DOM is seeking proposals from qualified organizations to enter into contracts with DOM to provide Utilization Management (UM) and Quality Improvement Organization (QIO) services in accordance with 42 C.F.R. § 456.1(b)(1).
2. A statement indicating that the Offeror is a corporation or other legal entity;
3. A statement confirming that the Offeror is registered to do business and in "Good Standing" with the State of Mississippi and providing their corporate charter number to work in Mississippi, if applicable;
4. A statement identifying the Offeror's Federal tax identification number;
5. A statement that, if the Offeror is awarded the contract, the Contractor agrees that any lost or reduced Federal matching money resulting from unacceptable performance of a Contractor task or responsibility, as defined in this RFP, shall be accompanied by reductions in State payments to the Contractor;

6. A statement identifying any prior project where the Offeror was terminated before the final solution was operational;
7. A statement that no attempt has been made or will be made by the Offeror to induce any other person or firm to submit or not to submit a proposal;
8. A statement that the Contractor has or has not (*use applicable word*) retained any person or agency on a percentage, commission, or other contingent arrangement to secure this contract;
9. A statement that the Offeror has not violated, is not violating, and promises that it will not violate the prohibition against gratuities set forth in Section 6-204 of the *Personal Service Contract Review Board Rules and Regulations*;
10. A statement of Affirmative Action, that the Offeror does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, disability or genetic information;
11. A statement that the Offeror agrees to the language of DOM's BAA and DUA;
12. A statement that no cost or pricing information has been included in this letter or any other part of the technical proposal;
13. A statement identifying by number and date all amendments to this RFP issued by DOM which have been received by the Offeror. If no amendments have been received, a statement to that effect should be included;
14. A statement that the Offeror has read, understands and agrees to all provisions of this RFP without reservation;
15. Certification that the Offeror's proposal will be firm and binding for one hundred eighty (180) days from the proposal due date;
16. A statement naming any outside firms responsible for writing the proposal;
17. A statement that the Contractor has included the signed Drug Free Workplace Certificate (Exhibit 1) (Contractor and all subcontractors);
18. A statement that the Offeror has included the signed DHHS Certification Regarding Debarment, Suspension, and Other Responsibility Matters for Primary Covered Transactions (Exhibit 2) with the Transmittal letter;
19. All proposals submitted by corporations must contain certifications by the secretary, or other appropriate corporate official other than the corporate official signing the corporate proposal, that the corporate official signing the corporate proposal has the full authority to obligate and bind the corporation to the terms, conditions, and provisions of the proposal;
20. All proposals submitted must include a statement that the Offeror presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of services under this contract, and it shall not employ, in the performance of this contract, any person having such interest; and,
21. If the proposal deviates from the detailed specifications and requirements of the RFP, the transmittal letter shall identify and explain these deviations. DOM reserves the right to reject any proposal containing such deviations or to require modifications before acceptance.
22. A statement that the Offeror has included audited financial statements or a document similar to industry standard for each of the last five (5) years.
23. A statement from the Offeror affirming a minimum of five (5) years' experience in contractual services

providing the type of services described in this RFP.

24. A Statement from the Offeror affirming a minimum of five (5) years of designation as a QIO or QIO-like entity. (Please provide documentation).

5.3 EXECUTIVE SUMMARY

The Executive Summary shall condense and highlight the contents of the Technical Proposal in such a way as to provide a broad understanding of the entire proposal. The Executive Summary shall include a summary of the proposed technical approach, the staffing structure, and the task schedule, including a brief overview of:

1. Proposed work plan;
2. Staff organizational structure;
3. Key personnel; and,
4. A brief discussion of the Offeror's understanding of the objectives and expectations of this RFP.

The Executive Summary should be no more than five (5) single-spaced typed pages (no less than 11 point standard font) in length. Information contained on pages exceeding the five (5) single-spaced typed page limit will not be considered by the Evaluation Committee.

5.4 CORPORATE BACKGROUND AND EXPERIENCE

The Corporate Background and Experience Section shall include for the Offeror details of the background of the company, its size and resources, details of corporate experience relevant to the proposed contract, audited financial statements to prove Offeror's financial status, and a list of all current or recent Medicaid or related projects. The time frame to be covered should begin, at a minimum, in August 2012 through present date. Audited financial statements or a document similar according to industry standard are only required for each of the last five (5) years.

5.4.1 Corporate Background

The details of the background of the corporation, its size, and resources, shall cover:

1. Date established;
2. Location of the principal place of business;
3. Location of the place of performance of the proposed Contract;
4. Ownership (e.g.: public company, partnership, subsidiary);
5. Total number of employees;
6. Number of personnel currently engaged in project operations;
7. Computer resources;
8. Performance history and reputation;
9. Current products and services; and
10. Professional accreditations pertinent to the services provided by this RFP.

5.4.2 Audited Financial Statements

Audited financial statements for the contracting entity for each of the last five (5) years, should include, at a minimum:

1. Statement of income;
2. Balance sheet;
3. Statement of changes in financial position during the last five (5) years;
4. Statement of cash flow;
5. Auditors' reports;
6. Notes to financial statements; and,
7. Summary of significant accounting policies.

The State reserves the right to request or accept any additional or supplemental information to assure itself of an Offeror's financial status.

5.4.3 Corporate Experience

The Corporate Experience Section must present the details of the Offeror's experience with the type of service to be provided by this RFP and Medicaid experience. A minimum of three (3) corporate references are required for this type of experience. DOM will check references during the evaluation process at its option. Each reference shall include the client's name and address and the current telephone number of the client's responsible project administrator or of a senior official of the client who is familiar with the Offeror's performance and who may be contacted by DOM during the evaluation process. DOM reserves the right to contact officials of the client other than those indicated by the Offeror. Overlapping responsibilities on the same client's contract should be depicted so that they are easily recognized. Please note that references are a part of the scoring process. Responsive and unresponsive references will be scored accordingly.

The Offeror shall provide for each experience:

1. The client's name;
2. Client references (including phone numbers);
3. Description of the work performed;
4. Time period of contract;
5. Total number of staff hours expended during time period of contract;
6. Personnel requirements;
7. Geographic and population coverage requirements;
8. Publicly funded contract cost; and,
9. Any contractual termination within the past five (5) years.
10. Direct Contact for client (see Appendix C)

Offeror may submit as many references as desired by submitting as many additional copies of Appendix C, References, as deemed necessary. References will be contacted in order listed until three (3) references have been interviewed and Reference Score Sheets completed for each of the three (3) references. No further references will be contacted; however, Offerors are encouraged to submit additional references to ensure that at least three

(3) references are available for interview. DOM staff must be able to contact three (3) references within three (3) business days of proposal due date for scoring purposes.

The Corporate Experience should be no more than ten (10) single-spaced typed pages (no less than 11 point standard font) in length, excluding references. Information contained on pages exceeding the ten (10) single-spaced typed page limit will not be considered by the Evaluation Committee.

5.5 PROJECT ORGANIZATION AND STAFFING

The Project Organization and Staffing Section shall include project team organization, charts of proposed personnel and positions, estimates of the staff-hours by major task(s) to be provided by proposed positions, and résumés of all management and key professional personnel as required in this RFP.

The Offeror shall:

1. Provide experience and qualifications of each staff person proposed to work on this project;
2. Describe how the Offeror will train, educate, and supervise staff regarding this project;
3. Describe how the Offeror will ensure inter-rater reliability among its staff for this project; and,
4. Discuss the Offeror's relationship with any proposed subcontractors, including how it will monitor these subcontractors; and its experience working with any proposed subcontractors. The Offeror shall provide references and qualifications of proposed subcontractors, and biographies of any subcontractor staff proposed to work on this project.

5.5.1 Organization

The organization charts shall show:

1. Organization and staffing during each phase as described in the RFP; and
2. Full-time, part-time, and temporary status of all employees.

5.5.2 Résumés

Offerors shall submit résumés of all proposed key staff persons including: a) Project Manager solely dedicated to this Contract; b) Assistant Project Manager solely dedicated to this Contract; c) Medical Director d) Dental Director e) Pharmacy Director f) Quality Director solely dedicated to this Contract located at DOM g) Education Manager solely dedicated to this Contract; and h) Information Systems Manager and other key management staff. Experience narratives shall be attached to the résumés describing specific experience with the type service to be provided by this RFP, a Medicaid program, and professional credentials, including any degrees, licenses, and recent and relevant continuing education.

The résumés of proposed personnel shall include:

1. Duration and experience as an employee with the Offeror;
2. All experience in working with Medicaid programs;
3. Experience in the type of services to be provided by this RFP;
4. Relevant education and training, including college degrees, dates of completion, and institution name and address; and,

5. Names, positions, current addressed, and current phone numbers of a minimum of three (3) persons who can give information on the individual's experience and competence. Current DOM staff shall not be submitted for any reference for the above requirements.

The résumés of proposed managers shall also include:

1. Experience in managing large-scale contractual services projects;
2. Other management experience; and,
3. Supervisory experience including details and number of people supervised.

If project management responsibilities will be assigned to more than one individual during the project (i.e., management may be changed following implementation), résumés shall be provided for all persons concerned.

Each project referenced in a résumé should include the client name, the time period of the project, and the time period the person performed, as well as a brief description of the project and the person's responsibilities.

5.5.3 Responsibilities

This Section should discuss the anticipated roles of personnel during all phases of the contract. All proposed key technical team leaders, including definitions of their responsibilities during each phase of the contract, should be included.

5.5.4 Backup Personnel Plan

If additional staff is required to perform the functions of the contract, the Offeror should outline specifically its plans and resources for adapting to these situations. The Offeror should also address plans to ensure the longevity of staff in order to allow for effective DOM support.

5.6 METHODOLOGY

The Methodology Section should describe the Offeror's approach to providing the services described in the Scope of Work, Section 1, of the RFP. This Section should contain a comprehensive description of the proposed work plan and specify how it will improve clinical quality, promote beneficiary and provider satisfaction, and achieve savings for the State. The narrative descriptions within this Section must include the following:

1. The description shall encompass the requirements of this RFP as outlined in Scope of Work.
2. The section must describe the methodology to be followed in accomplishing each requirement outlined in the Scope of Work in sufficient detail to demonstrate the Offeror's direction and understanding of this RFP.
3. The section must include a high-level project plan for the project. This project plan must be at the level of major tasks and milestones and be submitted in Adobe Acrobat (PDF) or Microsoft Word.
4. The section must summarize how DOM staff will be used as resources in this project. It is DOM's preference that DOM staff be included in all aspects of the engagement.
5. The section should include information about past performance results and a plan for evaluating the proposed project.

5.7 PROJECT MANAGEMENT AND CONTROL

The Project Management and Control Section shall include details of the methodology to be used in management and control of the project, project activities, and progress reports. This Section will also provide processes for identification and correction of problems. Specific explanation must be provided if solutions vary from one phase to another. This Section covers:

1. Project management approach;
2. Project control approach;
3. Manpower and time estimating methods;
4. Sign-off procedures for completion of all deliverables and major activities;
5. Management of performance standards, milestones, and/or deliverables;
6. Assessment of project risks and approach to managing them;
7. Anticipated problem areas and the approach to management of these areas, including loss of key personnel and loss of technical personnel;
8. Internal quality control monitoring;
9. Approach to problem identification and resolution;
10. Project status reporting, including examples of types of reports; and
1. Approach to DOM's interaction with contract management staff.

   The Project Management and Control should be no more than ten (10) single-spaced typed pages (no less than 11 point standard font) in length, excluding attachments. Information contained on pages exceeding the ten (10) single-spaced typed page limit will not be considered by the Evaluation Committee.

5.8 WORK PLAN AND SCHEDULE

The Work Plan and Schedule must include a detailed work plan broken down by tasks and subtasks and a schedule for the performance of each task included in each phase of the contract. The schedule should allow fifteen (15) business days for DOM approval of each submission or re-submission of each individual deliverable or document, unless another time frame has been specified for a particular deliverable in other sections of this RFP. The work plan to be proposed should include all responsibilities, milestones, and deliverables outlined previously in this RFP. This Section shall cover:

1. Any assumptions or constraints identified by the Offeror, both in developing the work plan and in completing the work plan.
2. Person-weeks of effort for each task or subtask, showing the Offeror's personnel and DOM personnel efforts separately.
3. A network diagram, showing the planned start and end dates for all tasks and subtasks, indicating the interrelationships of all tasks and subtasks, and identifying the critical path.
4. A Gantt chart, showing the planned start and end dates of all tasks and subtasks.
5. A discussion of how the work plan provides for handling of potential and actual problems.
6. A schedule for all deliverables or documents. A minimum of fifteen (15) business days review time by DOM.

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6 BUSINESS/COST PROPOSAL

6.1 GENERAL

All Offerors must certify in the transmittal letter that their offer shall be binding upon the Offeror for a period of one hundred eighty (180) calendar days following the proposal due date. Pricing will be considered as separate criteria of the overall proposal package.

Offerors shall propose a firm fixed price for each of the requirements contained on the pricing schedule (Appendix A).

6.2 BID MODIFICATION IN THE EVENT OF A FEDERAL AND/OR STATE LAW, REGULATION OR POLICY

In the event any change occurs in Federal or State law, regulations, policies, or Medicaid plan coverage, and DOM determines that these changes impact materially on proposal pricing, DOM reserves the right to require the Offerors to amend their proposals. The failure of an Offeror to negotiate these required changes will exclude such Offeror from further consideration for contract award. All proposals shall be based upon the provisions of Federal and State laws and regulations and DOM's approved Medicaid State Plan.

6.3 PROPOSAL CONTENT

The Business Proposal shall include only the following:

1. Appendix A – Budget Summary - A detailed worksheet by line item of all costs as it pertains to the Contractor Responsibilities and Deliverables as found in Section 1.0 of the RFP.
2. Additional pricing schedules to adequately explain method of cost determination including all assumptions (i.e. service or enrollment volume assumptions).
3. Each pricing schedule must be signed and dated by an authorized corporate official.
4. All proposals submitted by corporations shall contain certification by the secretary or other appropriate corporate official, other than the signer of the corporate proposal, that the corporate official signing the corporate proposal has the authority to obligate and bind the corporation to the terms, conditions and provisions of the proposal.

Proposals received that do not include the above items may be rejected at the discretion of DOM. Proposals that contain any material other than the above may be rejected at the discretion of DOM.

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7 PROPOSAL EVALUATION

7.1 GENERAL

An Evaluation Committee comprised of DOM staff will be established to evaluate the merits of eligible proposals. The committee will be appointed by the Executive Director of the Division of Medicaid and will include members who have relevant experience in the Medicaid program. The Committee will be responsible for the evaluation of the technical and business proposals.

7.2 EVALUATION OF PROPOSALS

A standard evaluation form will be utilized by the Evaluation Committee to ensure consistency in evaluation criteria. However, DOM retains the right to deviate from the standard form, if necessary to maintain the integrity of the procurement; and to ensure selection of the best qualified Contractor.

A maximum of 100 points will be available for each proposal which shall be comprised of a technical and a business proposal. The points awarded per phase by the evaluation committee will be totaled to determine the points awarded per proposal.

Evaluation of eligible proposals will be conducted in five (5) phases. The Procurement Officer will complete Phase One. The Technical Proposal Evaluation Committee will complete Phase Two. The Business Proposal Evaluation Committee will complete Phase Three. In Phase Four, the Procurement Officer will compile the results of the technical and business evaluations and make a recommendation to the Executive Director of DOM based on the results of the evaluation. In Phase Five the award decision will be made by the Executive Director.

At its option, the State may request an interview from Offerors in a competitive range in the evaluation. Offerors must be prepared to meet with DOM staff within five (5) calendar days of notification. All costs associated with the interview will be the responsibility of the Offeror.

7.2.1 Phase One- Evaluation of Offerors' Response to RFP

In this phase, the Procurement Officer reviews each proposal to determine if it is responsive. Each proposal will be evaluated to determine if it is complete and whether it complies with the instructions to Offerors in the RFP. Each proposal that is incomplete will be declared non-responsive and may be rejected with no further evaluation.

The Procurement Officer will determine if an incomplete proposal is sufficiently responsive to continue to Phase Two. If necessary, the Procurement Officer may request clarifications from the Offeror(s) in order to determine if they may advance to Phase Two.

7.2.2 Phase Two - Evaluation of Technical Proposal

Only those proposals which meet the requirements of the RFP and are determined responsive in Phase One will be considered in Phase Two.

Any Technical Proposal that is incomplete or in which there are significant inconsistencies or inaccuracies may be rejected by DOM. DOM reserves the right to waive minor variances or reject any or all proposals. In addition, DOM reserves the right to request clarifications or enter into discussions with all Offerors.

The Evaluation Committee will review each Offeror's Technical Proposal in order to determine if the Offeror sufficiently addresses all of the RFP requirements and that the Offeror has developed a specific approach to meeting each requirement.

TECHNICAL PROPOSAL SECTION	MAXIMUM SCORE
Executive Summary/Understanding of Project	3
Corporate Background and Experience	7
Project Organization and Staffing	10
Methodology	35
Project Management and Control	5
Work Plan and Schedule	5
TOTAL	**65**

Oral presentations will be held solely if desired by DOM. Oral presentations are not evaluated but Technical Proposal evaluations may be adjusted based on information gathered during the oral presentations.

7.2.2.1 Executive Summary

The Evaluation Committee will review the Executive Summary to determine if it provides all information required in Section 5.3 of this RFP.

7.2.2.2 Corporate Background and Experience

The Corporate Background and Experience Section shall include for the Offeror details of the background of the company, its size and resources, details of corporate experience relevant to the proposed contract, audited financial statements, and a list of all current or recent Medicaid or related projects. The time frame to be covered should begin, at a minimum, in May 2012 through present date. The evaluation criteria will address:

1. Date established;
2. Location of the principal place of business;
3. Location of the place of performance of the proposed Contract;
4. Ownership (e.g. public company, partnership, subsidiary);
5. Total number of employees;
6. Number of personnel currently engaged in project operations;
7. Computer resources;
8. Scope of services provided through partnerships or subcontractors;
9. Performance history and reputation;
10. Current products and services;
11. Professional accreditations pertinent to the services provided by this RFP
12. Number of current UM/QIO State Medicaid projects; and
13. Number of current UM/QIO related project (non-Medicaid projects).

7.2.2.3 Methodology

The Evaluation Committee will evaluate the approach and process offered to provide services as required by this RFP. In addition to the information required in Section 1.0 of this RFP, the evaluation criteria will address at a minimum the following (if applicable):

1. Processes and requirements for completion of the project.
2. Data management plan, including hardware, software, communications links, and data needs and proposed coordination plan.
3. Processes for maintaining confidentiality of PHI.
4. Processes for development and submission of required deliverables.
5. Scope of services provided through partnerships or subcontractors.
6. Quality Assurance processes.

7.2.2.4 Organization and Staffing

The Evaluation Committee will review this Section of the Offeror's proposal to determine if the proposed organizational structure and staffing level are sufficient to accomplish the requirements of the RFP. The committee will review the organizational chart(s), time lines, the job descriptions including job qualifications, the resumes of staff and their qualifications for the positions they will hold, and the relationship of their past experience to their proposed responsibilities under this contract. The committee will evaluate the explanation of the Offeror regarding the relationship between the Offeror and the Project Manager to determine if they will have sufficient autonomy to make management decisions to improve the Offeror's delivery of services to DOM.

7.2.2.5 Project Management and Control

The Evaluation Committee will evaluate the Offeror's proposal to determine if all of the elements required by Section 5.7 of the RFP are addressed. Specifically, the committee will evaluate:

1. Offeror's approach to the management of the project and ability to keep the project on target and to ensure that the requested services are provided;
2. Offeror's control of the project to ensure that all requests are being met and that the Offeror is able to identify and resolve problems which occur;
3. Offeror's methods for estimating and documenting personnel hours spent by staff on project activities to be sure they are sound and fair;
4. Offeror's plans to comply with the reporting requirements of the contract, including the provision of status reports to DOM, and whether the reports are appropriate and sufficient to keep DOM informed of all aspects of the implementation and operation of the project; and
5. Offeror's understanding of the importance of interacting with DOM management staff and presenting a plan to do so appropriately.

7.2.2.6 Work Plan and Schedule

The Evaluation Committee will review and evaluate the work plan and schedule to determine if all tasks are included and if, for each task, a timeline and an identification of staff responsible for the task's accomplishment are indicated. The work plan must provide a logical sequence of tasks and a sufficient amount of time for their accomplishment.

7.2.3 Phase Three - Evaluation of Business/Cost Proposal

Only those proposals that satisfactorily completed Phase Two will be considered for Phase Three. DOM reserves the right to waive minor variances or reject any or all proposals.

Any proposed pricing determined by DOM to be unrealistically or unreasonably low may not be considered acceptable, as such a proposal has a high probability of not being accomplished for the cost proposed. The Offeror may be required to produce additional documentation to authenticate the proposal price.

The maximum 35 points will be assigned to the lowest and best acceptable proposal. All other proposals will be assigned points based on the following formula:

$$\frac{X}{Y} * 35 = Z$$

X = lowest bid price
Y = Offeror's bid price
Z = assigned points

7.3 Phase Four and Five - Selection

After the evaluation committee has completed the evaluation of the proposals, a summary report including all evaluations will be submitted to the Executive Director of DOM. The Executive Director will make the final decision regarding the winning proposal.

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Appendix A - Budget Summary

Section 1.0 and Section 6.0 address submission of the Budget Summary. Failure to follow the submittal instructions will immediately disqualify the Offeror. Operation Cost should not include any Implementation Cost.

Budget Summary Medicaid Utilization Management Program RFP #20170811						
Name of Offeror:						
Implementation Phase: 1/1/2018 – 7/31/2018					**Implementation Cost:**	**$**
Operations Phase **All fixed price bid calculations shall be based upon the Annual Volume Estimates attachment.** **Prior Authorization Services**	**Operations 8/01/18 – 12/31/18**	**Contract Year 2 1/01/19 – 12/31/19**	**Contract Year 3 1/01/20 – 12/31/20**	**Renewal Year 1 1/01/21 – 12/31/21**	**Renewal Year 2 1/01/22 – 12/31/22**	**Total**
Prior Authorization Services annual fixed price						
Peer Reviews						
Focused Studies						
Clinical/Medical Consultations						
Coding Validation Audits						
Quality Improvement Services						
Care Management Services						
Other Required Services annual fixed price						
Total Contract Price:						
	Total = Contract Year 1 (Implementation Cost + Operations) + Contract Year 2 + Contract Year 3 + Renewal Year 1 + Renewal Year 2					
I certify that I am legally obligating the above named Offeror to the conditions of this contract.						
Signature:					**Date:**	
Printed Name:						

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Appendix B is located on the DOM Procurement Website:
http://www.medicaid.ms.gov/resources/procurement/

Appendix B represents the standard file layouts of the information available from DOM's Fiscal Agent. It is provided only as context for the data fields that are available for a file transfer or interface. Technical specifics will be negotiated upon award of the contract/project initiation.

Appendix C References

REFERENCE 1
Name of Company: _____
Dates of Service: _____
Contact Person: _____
Address: _____
City/State/Zip: _____
Telephone Number: _____
Cell Number: _____
E-mail: _____
Alternate Contact Person (optional): _____
Telephone Number: _____
Cell Number: _____
E-mail: _____

REFERENCE 2
Name of Company: _____
Dates of Service: _____
Contact Person: _____
Address: _____
City/State/Zip: _____
Telephone Number: _____
Cell Number: _____
E-mail: _____
Alternate Contact Person (optional): _____
Telephone Number: _____
Cell Number: _____
E-mail: _____

REFERENCE 3
Name of Company: _____
Dates of Service: _____
Contact Person: _____
Address: _____
City/State/Zip: _____
Telephone Number: _____
Cell Number: _____
E-mail: _____
Alternate Contact Person (optional): _____
Telephone Number: _____
Cell Number: _____
E-mail: _____

Offeror may submit as many references as desired by submitting as many additional copies of Appendix C, References, as deemed necessary. References will be contacted in order listed until three (3) references have been interviewed and Reference Score Sheets completed for each of the three (3) references. No further references will be contacted; however, Offerors are encouraged to submit additional references to ensure that at least three (3) references are available for interview. DOM staff must be able to contact three (3) references within three (3) business days of proposal due date to be considered.

Appendix D Medicaid UM/QIO Data can be found on DOM's website https://medicaid.ms.gov/resources/procurement/.

EXHIBIT 1

DHHS CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS:

GRANTEES OTHER THAN INDIVIDUALS

Instructions for Certification

By signing and/or submitting this application or grant agreement, the grantee is providing the certification set out below.

1) This certification is required by regulations implementing the Drug-Free Act of 1988, 45 C.F.R. Part 76, Subpart F. The regulations, published in the May 25, 1990, Federal Register, require certification by grantees that they will maintain a drug-free workplace. The certification set out below is a material representation of fact upon which reliance will be placed when the Department of Health and Human Services (HHS) determines to award the grant. If it is later determined that the grantee knowingly rendered a false certification, or otherwise violates the requirements of the Drug-Free Workplace Act, HHS, in addition to any other remedies available to the Federal Government, may take action authorized under the Drug-Free Workplace Act.

2) Workplaces under grants, for grantees other than individuals, need not be identified on the certification. If known, they may be identified in the grant application. If the grantee does not identify the workplaces at the time of application, or upon award, if there is no application, the grantee must keep the identity of the workplace(s) on file in its office and make the information available for Federal inspection. Failure to identify all known workplaces constitutes a violation of the grantee's drug-free workplace requirements.

3) Workplace identifications must include the actual address of buildings (or parts of buildings) or other sites where work under the grant takes place. Categorical descriptions may be used (e.g., all vehicles of a mass transit authority or State highway department while in operation, State employees in each local unemployment office, performers in concert halls or radio studios).

4) If the workplace identified to DOM changes during the performance of the grant, the grantee shall inform DOM of the change(s), if it previously identified the workplaces in question (see above).

5) Definitions of terms in the Non-procurement Suspension and Debarment common rule and Drug-Free Workplace common rule apply to this certification. Grantees' attention is called, in particular, to the following definitions from these rules:

"Controlled substance" means a controlled substance in Schedules I through V of the Controlled Substances Act (21 U.S.C. 812) and as further defined by regulation (21 C.F.R. § 1308.11 through § 1308.15);

"Conviction" means a finding of guilt (including a plea of nolo contendere) or imposition of sentence, or both, by any judicial body charged with the responsibility to determine violations of the Federal or State criminal drug statutes;

"Criminal drug statute" means a Federal or non-Federal criminal statute involving the manufacture, distribution, dispensing, use, or possession of any controlled substance;

"Employee" means the employee of a grantee directly engaged in the performance of work under a grant, including (i) all direct charge employees; (ii) all indirect charge employees unless their impact or involvement is insignificant to the performance of the grant; and (iii) temporary personnel and consultants who are directly engaged in the performance of work under the grant and who are on the grantee's payroll. This definition does not include workers not on the payroll of

the grantee (e.g., volunteers, even if used to meet a matching requirement; consultants or independent contractors not on the grantee's payroll; or employees of sub recipients or subcontractors in covered workplaces).

The grantee certifies that it will or will continue to provide a drug-free workplace by

a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

b) Establishing an ongoing drug-free awareness program to inform employees about

1) The dangers of drug abuse in the workplace; 2) the grantee's policy of maintaining a drug-free workplace; 3) any available drug counseling, rehabilitation, and employee assistance programs; and 4) the penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a);

d) Notifying the employee in the statement required by paragraph (a) that, as a condition of employment under the grant, the employee will

1) Abide by the terms of the statement; and 2) notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

e) Notifying DOM in writing, within ten calendar days after receiving notice under paragraph (d) (2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d)(2), with respect to any employee who is so convicted:

1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or 2) requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e) and (f).

The grantee may insert in the space provided below the site(s) for the performance of work done in connection with the specific grant (use attachments if needed):

Place of Performance (street address, city, county, state, zip code)

Check if there are workplaces on file that are not identified here.

---->NOTE: Sections 76.630(c) and (d) (2) and 76.635(a)(1) and (b) provide that a Federal agency may designate a central receipt point for STATE-WIDE AND STATE AGENCY-WIDE certifications, and for notification of criminal drug convictions. For HHS, the central receipt point is Division of Grants Management and Oversight, Office of Management and Acquisition, HHS, Room 517-D, 200 Independence Ave, S.W., Washington, D.C. 20201

_____ _____

Signature Date

_____ _____

Title Organization

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EXHIBIT 2

DHHS Certification Regarding Debarment, Suspension, and Other Responsibility Matters
Primary Covered Transactions
45 CFR Part 76,

(1) The prospective primary participant certifies to the best of its knowledge and belief that it and its principals:

a. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;
b. Have not within a three-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
c. Are not presently indicted for or otherwise criminally or civilly charged by a government entity (Federal, State or local) with commission of any of the offenses enumerated in paragraph (1)(b) of this certification; and
d. Have not within a three-year period preceding this proposal had one or more public transactions (Federal, State or local) terminated for cause or default.

(2) Where the prospective primary participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

_____ _____
Signature Date

_____ _____
Title Organization