



REQUEST FOR PROPOSALS

Medicaid Utilization Management Programs RFP #20120629

Contact:

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Due Dates

Questions & Letter of Intent

E-MAIL or MAIL or HAND DELIVERY

5:00 PM Central Daylight Time, Friday, July 20, 2012

Answers Posted to Internet www.medicaid.ms.gov/bids.aspx

5:00 PM Central Daylight Time, Friday, July 27, 2012

Sealed Proposals

MAIL or HAND DELIVERY ONLY

5:00 PM Central Standard Time, Friday, August 10, 2012

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1. SCOPE of WORK

1.1. Purpose

The State of Mississippi, Office of the Governor, Division of Medicaid (DOM) issues this request for proposals (RFP) to solicit offers from experienced vendors to meet the Utilization Management (UM) needs of DOM. The Mississippi Division of Medicaid seeks responsible vendors wishing to provide UM and Quality Improvement Organization (QIO) services to DOM. DOM will contract with a single or multiple contractors to administer the following programs, which are represented as different “lots”:

- Lot A – Acute and Ancillary Care Utilization Management
- Lot B – Behavioral Health Utilization Management
- Lot C – Dental Services Utilization Management
- Lot D – Advanced Imaging Utilization Management

DOM requests proposals from experienced, responsive, responsible, and financially sound entities prepared to carry out one or more of the above referenced lots detailed in the following Scope of Work.

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 fulfill this responsibility, DOM has both contracted with a QIO and conducted UM activities with DOM staff. The incumbent UM/QIO contractor is Health Systems of Mississippi (HSM). Currently, HSM performs prior authorization certifications for the following services: inpatient hospital, psychiatric residential treatment facility, durable medical equipment, certain community mental health services, physical therapy, speech therapy, occupational therapy, home health, private duty nursing, durable medical equipment, orthotics, and prosthetics. The current contract with HSM ends June 30, 2013.

DOM also conducts UM internally for various services. These services include prior authorization requests for expanded Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefits and certain dental, hearing, and vision services. UM for these services is being shifted to a contracted vendor as part of this procurement.

Mississippi Coordinated Access Network Program (MississippiCAN)

In January, 2011, DOM established the Mississippi Coordinated Access Network (MississippiCAN), a coordinated care program for Mississippi Medicaid beneficiaries. DOM has contracted with two Coordinated Care Organizations (CCOs), Magnolia Health Plan and UnitedHealth Care Community Plan.

The 2012 Mississippi Legislative Session implemented changes to the current law governing the MississippiCAN program. The new law allows for an expansion of the program which will impact the

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level of UM services provided for Mississippi Medicaid fee-for-service (FFS) beneficiaries under the contract(s) resulting from the RFP.

Beneficiary participation in MississippiCAN **is mandatory** for the following populations:

- 001-SSI (ages 19-65)
- 025-Working Disabled (ages 19-65)
- 027-Breast and Cervical Cancer- (ages 19-65)
- 088-Pregnant Women and Infants (ages 0-1 and 8-65)
- 085-Family/Children-TANF (ages will be specified by DOM)
- 087-Child (ages 0-1)
- 091-Child (ages 0-1)

Beneficiary participation in MississippiCAN is **voluntary** for the following populations:

- SSI (ages 0-1 and 1-19)
- Disabled Child Living at Home (ages 0-1 and 1-19)
- Department of Human Services Foster Care Children (026 and 03)-(ages 0-1 and 1-19)

All Native Americans are **excluded** from the MississippiCAN program.

The CCOs process all prior authorizations for UM services for beneficiaries in the MississippiCAN program with the exception of inpatient hospital services (acute medical and all psychiatric settings). All other UM services identified in this RFP will be the responsibility of the CCOs for Mississippi CAN members.

The CCOs require notification from the Contractor of all inpatient authorizations. The contractor shall have the capability to provide on a daily basis a secure file identifying any inpatient (Acute and Psychiatric) Prior Authorizations that have been approved/or denied, all Concurrent Reviews and notification of any hospital discharges for the CCOs individual members.

This report includes Admissions, Concurrent Reviews and Discharges.

1.3. Procurement Overview

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

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Table 1: RFP and Procurement Timetable

Date	Process
June 29, 2012	Release RFP for Bids
July 20, 2012	Deadline for Letter of Intent and Written Questions
July 27, 2012	Response to Questions Posted
August 10, 2012 (5:00 p.m. CDT)	Proposal Deadline
August 13-31, 2012	Evaluation of Technical Proposal
August 27-31, 2012	Oral Presentations
September 4-6, 2012	Evaluation of Business Proposal
September 7-13, 2012	Executive Review and Award
October 16, 2012	PSCRB Meeting (proposed)
October 17-23, 2012	Contracts Signed and Notarized
November 1, 2012	Contract Start Date

1.3.1. Mandatory Letter of Intent

The Offeror is required to submit a Letter of Intent to bid. The Offeror should specify on which lot(s) it intends to bid in response to the RFP, and indicating whether the Offeror is a QIO or QIO-like entity. The Letter of Intent is due by 5:00 p.m. CDT, July 20, 2012, and should be sent to:

Melanie Wakeland
Procurement Officer
Division of Medicaid
Walter Sillers Building
550 High Street, Suite 1000
Jackson, Mississippi 39201
Email: melanie.wakeland@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, July 20, 2012, will not thereafter be eligible for the procurement.

Prior to July 20, 2012, all RFP amendments will be sent to all organizations that request an RFP and will be posted on DOM's procurement Website, www.medicaid.ms.gov/bids.aspx. After July 20, 2012, RFP amendments will only be distributed to Offerors that have submitted a Letter of Intent.

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1.3.2. Procedure for Submitting Questions

Multiple questions may be submitted using the template at www.medicaid.ms.gov/bids.aspx. Written answers will be available no later than 5:00 PM CDT, Friday, July 27, 2012, via DOM's procurement Website, www.medicaid.ms.gov/bids.aspx. Questions and answers will become part of the final Contract as an attachment. Written responses provided for the questions will be binding.

Questions should be sent to:

Melanie Wakeland
Procurement Officer
Division of Medicaid
Walter Sillers Building
550 High Street, Suite 1000
Jackson, Mississippi 39201
Email: melanie.wakeland@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 three-ring binders with components of the RFP clearly tabbed. An original and six (6) 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 Friday, August 10, 2012. 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. Any proposal received after this date and time will be rejected and returned unopened to the Offeror. Proposals should be delivered to:

Melanie Wakeland
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 # 20120629
Technical Proposal
(Name of Offeror)

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

RFP # 20120629
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 Prior Authorization Requirements

1. The Contractor must demonstrate high quality administrative and clinical leadership in UM services. The requirements in this section are applicable to all review functions.
2. Regardless of the mode of receipt, the Contractor shall have established procedures and sufficient capacity for intake staff to screen requests for completeness and request non-clinical information as appropriate for prior authorization and prepayment review.
3. The Contractor shall have the capability and established procedures to conduct prior authorization and prepayment review processes that include two levels of review. The first level of review is conducted by qualified health professional licensed in the State of Mississippi with clinical knowledge and experience in utilization review. Requests for not meeting criteria are referred to the second level review.
4. Completion of a first level determination is one (1) of the following:
 - a. Certification of services by the first level reviewer;
 - b. Certification through the automated rules system, when appropriate;
 - c. Referral to second level review;
 - d. Pending of the review based on a request 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. Certification of services by the second level reviewer;

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- b. Denial (or modification) of services by the second level reviewer;
 - c. Pending the review based on a request additional information from the provider; or
 - d. Technical denial of the request due to administrative policy rules, as defined by DOM.
- 6. The Contractor shall have the capability and established procedures to ensure that only physician reviewers licensed in the State of Mississippi can deny medical necessity or modification determinations for prior authorization and prepayment review as a result of second level review.
 - 7. The Contractor shall have the capability and established procedures to pend any services review request if the provider submits a request for certification 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 until additional information has been received.
 - 8. The Contractor shall have the capability and established procedures that allow for suspending 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.
 - 9. The Contractor shall have the capability and established procedures for issuing a technical denial for services when the case does not meet DOM policy or is technically insufficient (e.g., age, beneficiary not eligible, etc.).
 - 10. The Contractor shall have the capability and established procedures for generating a Treatment Authorization Number (TAN) when a case meets all policy and medical criteria necessary for certification of the services requested.
 - 11. Except as otherwise noted, the Contractor shall have the capability and established procedures to notify Medicaid beneficiaries of the denied requests in writing via U.S. Mail, including procedures sufficient to ensure that the beneficiary notice does not contain the medical basis for the denial.
 - 12. The Contractor shall provide written notices to providers online and via facsimile notifications, but the Contractor shall also have the capability and established procedures that allow for verbal notification of pended reviews to providers unable to receive written facsimile notification.
 - 13. The Contractor's written notice of adverse actions (denials 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 determination. The written notice shall also explain how a provider, attending physician, or beneficiary/representative/responsible party can request a reconsideration of the review outcome.

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14. The Contractor shall have the capability and established procedures for conducting reconsiderations and making a determination upholding, modifying, or reversing the denial of payment for requested services by taking into consideration any additional new information that may be presented at the reconsideration.
15. The Contractor must provide, at a minimum, a reconsideration process for all types of reviews in which the decision is:
 - a. Denial of all services/items based on medical necessity;
 - b. Reduction in services/items based on medical necessity;
 - c. Denial based on Mississippi Medicaid policy that excludes coverage;
 - d. Certain technical denials as defined by DOM;
 - e. A quality issue, or
 - f. Other adverse decisions as defined by DOM.
16. The Contractor shall have the capability to accept reconsideration requests by phone, facsimile, or mail, and shall have dedicated phone and facsimile numbers for reconsiderations.
17. The Contractor shall have established procedures to notify individuals requesting reconsiderations and afford the individual the opportunity to provide additional information within ten (10) business days.
18. The Contractor shall have the capability and established procedures to ensure a second physician that is 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 will be of the same specialty as the attending physician.
19. The Contractor shall have the capability and established procedures to provide written notification of reconsideration determinations within 20 business days for receipt of the request for a standard reconsideration.
20. 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 fair hearing from DOM.

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1.4.2. Lot-Specific Prior Authorization Requirements

1.4.2.1 Acute and Ancillary Services Technical Requirements (LOT A)

This lot is for the development, implementation, and operation of a UM program for acute and ancillary health services to include:

- Inpatient Medical/Surgical Services;
- Reporting Maternity Admissions for Delivery;
- Hospice Services;
- Organ Transplant Services;
- Vision Services;
- Hearing Services;
- Outpatient and School Health Related Physical Therapy, Occupational Therapy and Speech Therapy;
- Extended Physician Services/Office Visits;
- Extended Emergency Room Visits;
- Expanded Home Health Services; and
- Private Duty Nursing Services.

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 programs for acute and ancillary services for commercial and/or government health care programs.

An Offeror for this lot must be a QIO under contract with the Centers for Medicaid and Medicare Services (CMS) or a CMS designated QIO-like entity as designated by CMS, thereby enabling the State of Mississippi to qualify for the 75 percent federal financial participation as established in 42 CFR 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.

A. Inpatient Medical/Surgical Services Prior Authorization

1. Mississippi Medicaid covers inpatient medical/surgical services for all eligible beneficiaries. For additional information on coverage, see Administrative Code Title 23 Medicaid, Part 202 at <http://www.medicaid.ms.gov/AdminCode.aspx>.

As a condition for reimbursement, DOM requires that all inpatient hospital admissions receive prior authorization. Failure to obtain the prior authorization will result in denial of payment to all providers

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billing for services, including the hospital and the attending physician. Currently, DOM's contract QIO conducts prior authorization of hospital admissions. Historic information on the volume of prior authorizations is provided on DOM's procurement Website, www.medicaid.ms.gov/bids.aspx.

2. The Contractor shall develop, implement, and maintain a UM program that includes prior authorization and prepayment review of inpatient medical and surgical service 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 telephone, facsimile, mail and Web-based submissions from hospital providers and attending physicians.
 - a. The Contractor shall establish and maintain a dedicated telephone number, toll-free in Mississippi, for the receipt of prior authorization requests for inpatient medical/surgical 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 medical/surgical services submitted by facsimile.
 - c. The Contractor shall establish and maintain a physical mailing address in Jackson, Mississippi for the receipt of 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 prior authorization and prepayment review of inpatient medical/surgical services.
5. The Contractor shall have the capability and established procedures for determining the medical necessity for urgent/emergent and non-emergency inpatient admission prior authorizations, continued stays, and retrospective reviews for inpatient medical/surgical services to eligible Mississippi Medicaid beneficiaries utilizing DOM approved criteria and policies.
 - a. Urgent/Emergent Admission Reviews: Urgent/emergent 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

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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 urgent/emergent admission reviews post-admission for admissions that are not planned or elective and conduct prior authorizations when the beneficiary has not been discharged. The Contractor shall have the capability and established procedures to ensure determinations for urgent/emergent admission reviews are completed 98 percent of the time within 24 hours (one workday) of receipt.

- b. Non-Emergency Admission Reviews: Non-emergency admissions are admissions 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 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 24 hours (one workday) of receipt.
- c. Weekend and Holiday Admission Reviews: Weekend admissions are those admissions where the beneficiary was admitted on a weekend (Friday, Saturday, or Sunday). Holiday admissions are defined as those admissions where a beneficiary is admitted on a holiday defined in Section 1.5 of the RFP. The Contractor shall have the capability and established procedures to receive weekend and holiday admission review requests and conduct prior authorizations post-admission when the beneficiary has not been discharged. The Contractor shall have the capability and established procedures to ensure determinations for weekend and holiday admission reviews are completed 98 percent of the time within 24 hours (one workday) 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 certified and conduct prior authorizations on or before the next review point (i.e. the last certified day). The Contractor shall have the capability and established procedures to provide all hospital providers with a daily listing of beneficiaries whose certification 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 24 hours (one workday) of receipt when beneficiaries remain hospitalized and within 24 hours (one workday) when beneficiaries have been discharged.
- e. Retrospective Short Stay Reviews: A short stay is defined as those admissions where the length of stay was eight days or less and the admission was not previously certified. The Contractor shall have the capability and established procedures to receive retrospective short term stay review requests and conduct prepayment reviews as such conditions are identified. The Contractor shall have the capability and established procedures to ensure determinations for retrospective short stay reviews are completed 98 percent of the time within twenty (20) business days of receipt.

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- f. 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, certification 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 twenty (20) business days of receipt.
6. The Contractor shall develop and maintain a Web-based, electronic review request system for prior authorization and prepayment review of inpatient medical/surgical 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 certified 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 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, to apply DOM policy and DOM approved medical necessity criteria in order to approve inpatient medical/surgical services based on certification 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 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 have the capability and established procedures to ensure that all cases (including reductions) not meeting medical necessity criteria for inpatient medical/surgical services 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 verbal and written notification to the requesting provider of a pended review and for informing the provider of the information needed along with a timeframe for submission.

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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:

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

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

11. 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, or considered for denial.
12. The Contractor shall have the capability and established procedures for notification to providers and beneficiaries or legal guardians/representatives of review determinations for inpatient medical/surgical services requests.
- The Contractor shall have the capability and established procedures for issuing verbal and written notification of approved certification results to the hospital provider and attending physician.
 - The Contractor shall have the capability and established procedures for issuing verbal and written notification of denials (including modifications) to the hospital provider, attending physician, and beneficiary or, if a child, the legal guardian/representative.
 - Timeframes 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:

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

Review Type	Contractor Action	Time Standard
Urgent/Emergent Admission Reviews	Verbal Approval to Provider	Within 24 hours 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 24 hours from review determination
Continued Stay Reviews	Written Denial to Provider	Within one (1) business day from review determination
	Written 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

B. Reporting Maternity Admissions for Delivery

1. Mississippi Medicaid covers maternity services including, but not limited to, delivery services, the care involved in the actual birth, and continued care for two (2) months following the birth of the newborn. Hospitals must report all admissions for deliveries, both vaginal and Cesarean section, as required by DOM.

Medicaid 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 does not have inpatient benefit days remaining in the given state fiscal year. No report is required if the beneficiary has Medicare Part A and Part B coverage for the hospitalization timeframe and the Medicare benefits are not exhausted. No HSM review is required if the beneficiary's Medicaid eligibility is only for the family planning waiver.

2. Vaginal deliveries with length of stay up to three days in duration and cesarean deliveries with length of stay up to five days in duration do not require a clinical review; instead providers must report these hospitalizations within 15 days of discharge. For admissions exceeding three (3) days for a vaginal delivery or five (5) days for a Cesarean section delivery, the Contractor shall have the capabilities and established procedures to conduct continued stay reviews in accordance with the requirements of Section 1.4.2.1.A, Inpatient Medical/Surgical Services Prior Authorization.

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3. The Contractor shall develop, implement, and maintain a maternity admission for delivery reporting process in order to issue a TAN to cover up to three (3) days for a vaginal delivery or up to five (5) days for a Cesarean section delivery.
4. The Contractor shall have the capability and established procedures that allow for receipt of maternity admission for delivery reports via telephone, facsimile, mail and Web-based submissions from hospital providers and 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 Jackson, Mississippi 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.
5. 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 prior authorization and prepayment review of maternity admission for delivery services.
6. The Contractor shall have the capability and established procedures for issuing a written notification for issuance of a TAN to the hospital provider and attending physician within two (2) business days from receipt of completed report.

C. Organ Transplant Services Prior Authorization

1. Mississippi Medicaid covers organ transplant services for all eligible beneficiaries. For additional information on coverage, see Administrative Code Title 23 Medicaid, Part 202 (Chapter 4, specifically) at <http://www.medicaid.ms.gov/AdminCode.aspx>.

As a condition for reimbursement, DOM requires that heart, lung, liver, and small bowel transplants receive prior authorization. No prior authorization is required for kidney, cornea, and bone marrow/peripheral stem cell transplants. Failure to obtain the prior authorization will result in denial of payment to all providers billing for services, including the hospital and the attending physician. Currently, DOM's contract QIO conducts prior authorization of organ transplants that require prior authorization. Historic information on the volume of prior authorizations for organ transplant services is provided on DOM's procurement Website, www.medicaid.ms.gov/bids.aspx.

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

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3. The Contractor shall have the capability and established procedures that allow for receipt of prior authorizations requests and supporting information via 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 Jackson, Mississippi 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 (i.e. letter from transplanting physician), supporting clinical documentation, and other forms or documentation required for prior authorization of transplant services.
5. The Contractor shall have the capability and established procedures for determining the medical necessity of transplant applications and requests for extension of benefits for eligible Mississippi Medicaid beneficiaries utilizing DOM approved criteria and policies. The Contractor shall have the capability and established procedures to ensure determinations transplant applications and requests for extension of benefits are completed 98 percent of the time within three (3) business days of receipt. The Contractor shall have the capability and established procedures to ensure determinations for retrospective reviews are completed 98 percent of the time within twenty (20) business days of receipt.
6. The Contractor may develop and maintain and Web-based, electronic review request system for 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 certification system with manually review for prior authorization requests not certified by the Contractor's rules-based system for transplant 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, to apply DOM policy and DOM approved medical necessity criteria in order to approve transplant applications based on certification policy and criteria or refer requests that cannot be approved to a second level review.
 - a. 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.
8. The Contractor shall have the capability and established procedures that allow for a second level review conducted by physicians to make review determinations for transplant based on: 1)

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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 have the capability and established procedures to ensure that all cases (including reductions) not meeting medical necessity criteria for transplant services 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 verbal and written notification to the requesting provider of a pended review and informing the provider of the information needed along with a timeframe for submission that shall not exceed sixty (60) 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 attending physician to contact the Contractor's Medical Director to discuss transplant cases that have been denied, modified, or considered for denial.
 - a. The Contractor shall have the capability and established procedures for issuing a written notification of outcome to DOM. DOM issues the notification to the attending physician, transplant facility, and beneficiary or, if a child, the legal guardian/representative.
 - b. Timeframes for notification to DOM of review outcomes for prior authorization, requests for extensions and retrospective review of transplant services shall not exceed one (1) business day from the review determination.

D. Hospice Services Prior Authorization

1. Mississippi Medicaid covers hospice services 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 2009 for Hospice, children under the age of 21 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 may not receive hospice benefits simultaneously. For additional information on coverage, see Administrative Code Title 23 Medicaid, Part 205 at <http://www.medicaid.ms.gov/AdminCode.aspx>.

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As a condition for reimbursement, DOM requires that hospice services receive prior authorization. Failure to obtain the prior authorization will result in denial of payment to hospice providers billing for services. Currently, DOM's contract QIO conducts prior authorization of hospice services. Historic information on the volume of prior authorizations for hospice services is provided on DOM's procurement Website, www.medicaid.ms.gov/bids.aspx.

2. The Contractor shall develop, implement, and maintain a UM program, which includes prior authorization and prepayment review of hospice services requests.
3. The Contractor shall have the capability and established procedures that allow for receipt of prior authorizations requests and supporting information via facsimile and Web-based submissions 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 review requests, required forms, history and physical, and additional medical documentation and other forms or documentation required for prior authorization of hospice services.
5. The Contractor shall have the capability and established procedures for determining the medical necessity of precertification 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. Precertification Requests (Medicaid Only Beneficiaries): The Contractor shall have the capability and established procedures to receive precertification reviews for the initiation of a hospice enrollment period for a beneficiary with Medicaid only benefits. The Contractor shall have the capability and established procedures to ensure determinations for precertification requests are completed 98 percent of the time within 72 hours (three workdays) 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 have the capability and established procedures to ensure determinations for admission reviews are completed 98 percent of the time within 72 hours (three workdays) of receipt.
 - c. Recertification Requests (Medicaid Only Beneficiaries): The Contractor shall have the capability and established procedures to receive subsequent reviews to determine if continuation of a

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hospice benefit period is medically necessary for a beneficiary with Medicaid only coverage. The Contractor shall have the capability and established procedures to ensure determinations for recertification requests are completed 98 percent of the time within 72 hours (three workdays) of receipt.

- d. Continued Stay Reviews (Dual Eligible Beneficiaries): The Contractor shall have the capability and established procedures to receive subsequent reviews to determine if continuation of a hospice benefit period is medically necessary for a beneficiary with Medicare and Medicaid benefits. The Contractor shall have the capability and established procedures to ensure determinations for continued stay reviews are completed 98 percent of the time within 72 hours (three workdays) of receipt.
6. The Contractor shall develop and maintain a Web-based, electronic review request system for prior authorization of hospice 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 request received that is not certified by the Contractor's rules-based system, along with any required supporting documentation to support the need for hospice 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, to apply DOM policy and DOM approved medical necessity criteria in order to approve hospice services based on certification 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 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.
9. The Contractor shall have the capability and established procedures for verbal and written notification to the requesting provider of a pending review and informing the provider of the information needed along with a timeframe 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.

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11. 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, or considered for denial.
12. The Contractor shall have the capability and established procedures for notification to providers and beneficiaries or legal guardians/representatives of review determinations for hospice services requests.
 - a. The Contractor shall have the capability and established procedures for issuing verbal and written notification of approved certification results to the hospice provider.
 - b. The Contractor shall have the capability and established procedures for issuing verbal and written notification of denials (including modifications) to the hospice provider and beneficiary or, if a child, the legal guardian/representative.
 - c. Timeframes for notification to providers and beneficiaries of review outcomes for prior authorization of hospice services shall not exceed one (1) business day from the review determination.

E. Durable Medical Equipment, Orthotics, Prosthetics, and Supplies Prior Authorization

1. Mississippi Medicaid covers durable medical equipment (DME), orthotics, prosthetics, and medical supplies for all eligible beneficiaries. For additional information on coverage, see Administrative Code Title 23 Medicaid, Part 209 at <http://www.medicaid.ms.gov/AdminCode.aspx>.

As a condition for reimbursement, DOM requires that DME, orthotics, prosthetics, and some supplies require prior authorization. Diapers and underpads are the only medical supplies that require prior authorization. Specific items requiring prior authorization are identified in the DME-Orthotic-Prosthetic 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 providers billing for services. Currently, DOM's contract QIO conducts prior authorization of DME, orthotics, prosthetics, and supplies. Historic information on the volume of prior authorizations for DME, orthotics, prosthetics and supplies is provided on DOM's procurement Website, www.medicaid.ms.gov/bids.aspx.

2. The Contractor shall develop, implement, and maintain a UM program, which includes prior authorization and prepayment review of DME, orthotics, prosthetics, and supplies 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 facsimile and mail submissions from DME, orthotics, and prosthetics providers.

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- a. The Contractor shall establish and maintain a facsimile number, toll-free in Mississippi, for the receipt of review requests for DME, orthotics, prosthetics and supplies submitted by facsimile.
- b. The Contractor shall establish and maintain a physical mailing address in Jackson, Mississippi for the receipt of review requests for DME, orthotics, prosthetics, and supplies submitted by mail.
- c. The Contractor may establish and maintain a Web-based system for receipt of review requests for DME, orthotics, prosthetics and supplies 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, plans of care, and other forms or documentation, including itemized invoices for manually-priced procedures required for prior authorization and prepayment review of DME, orthotics, prosthetics, and supplies.
5. The Contractor shall have the capability and established procedures for determining the medical necessity of admission reviews and retrospective reviews for DME, orthotics, prosthetics, and supplies to eligible Mississippi Medicaid beneficiaries utilizing DOM approved criteria and policies.
 - a. Precertification Reviews: The Contractor shall have the capability and established procedures to ensure determinations for precertification reviews are completed 98 percent of the time within two (2) business days of receipt. In some cases delivery of DME, orthotics, prosthetics, and supplies will occur prior to precertification requests.
 - 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 twenty (20) business days of receipt.
6. The Contractor may develop and maintain a Web-based, electronic review request system for prior authorization and prepayment review of DME, orthotics, prosthetics, and supplies that allows for data input by the submitting providers. The Contractor's system may have the capability for automated criteria/rules-based certification system and manually review for prior authorization requests not certified by the Contractor's rules-based system for DME, orthotics, prosthetics, and supplies.
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, to apply DOM policy and DOM approved medical necessity criteria in order to approve DME, orthotics, prosthetics, and supplies 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.
8. The Contractor shall have the capability and established procedures that allow for a second level review conducted by physicians to make review determinations for DME, orthotics, prosthetics, and supplies 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

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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 ordering provider to obtain additional information when the documentation submitted does not clearly support medical necessity.
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 timeframe for submission that shall not exceed three (3) business day 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 DME, orthotics, and prosthetics provider, the ordering provider, and the attending physician to contact the Contractor's Medical Director to discuss DME, orthotics, prosthetics, and supplies 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 DME requests.
 - a. The Contractor shall have the capability and established procedures for issuing a written notification of approved certification results to the DME, orthotics, and prosthetics provider and the ordering provider.
 - b. The Contractor shall have the capability and established procedures for issuing a written notification of denials (including modifications) to the DME, orthotics, and prosthetics provider, the ordering provider, and beneficiary or, if a child, the legal guardian/representative.
 - c. Timeframes for notification to providers and beneficiaries of review outcomes for prior authorization and prepayment review of DME, orthotics, prosthetics and supplies shall not exceed the following standards:

Table 4: Notification of Review Outcomes for DME, Orthotics, Prosthetics, and Supplies

Review Type	Contractor Action	Time Standard
Precertification 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

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	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. Vision Services Prior Authorization

1. Mississippi Medicaid covers eyeglasses for all Medicaid beneficiaries who have: 1) had surgery on the eyeball or ocular muscle that results in a vision change for which eyeglasses is medically indicated within six (6) months of the surgery and is in accordance with policies established by DOM; or 2) one (1) pair of eyeglasses every five (5) years in accordance with policies established by DOM. Beneficiaries in the pregnancy only category (COE 88) the Healthier Mississippi Waiver category (COE 45), and the Family Planning Waiver category (COE 29), are not eligible for eyeglasses, frames, lenses, or contact lenses. As required by Title XIX of the Social Security Act, Mississippi's Medicaid program provides EPSDT services for Medicaid eligible beneficiaries less than 21 years of age. Eligible beneficiaries may receive one (1) complete pair of eyeglasses per fiscal year. Replacement glasses are covered if medically necessary. For additional information on coverage, see Administrative Code Title 23 Medicaid, Part 217 at <http://www.medicaid.ms.gov/AdminCode.aspx>.

As a condition for reimbursement, DOM requires prior authorization for the following benefits: 1) additional lenses, frames, or a complete pair of glasses for a child after they have received a second complete pair of glasses for the fiscal year; 2) contact lenses for children and adults; and 3) any manually priced items, such as polycarbonate and high index lenses.

Specific procedures requiring prior authorization are identified in the Vision Fee Schedule 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 providers billing for services. Currently, DOM staff conducts prior authorization of vision services.

2. The Contractor shall develop, implement, and maintain a UM program, which includes prior authorization and prepayment review of vision 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 facsimile, mail and Web-based submissions 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 Jackson, Mississippi for the receipt of review requests for vision services submitted by mail.

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- 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 prior authorization and prepayment review of vision services.
5. The Contractor shall have the capability and established procedures for determining the medical necessity of precertification and retrospective reviews for vision services to eligible Mississippi Medicaid beneficiaries utilizing DOM approved criteria and policies.
 - a. Precertification Reviews: The Contractor shall have the capability and established procedures to ensure determinations for precertification reviews 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 are completed 98 percent of the time within twenty (20) business days of receipt.
6. The Contractor shall develop and maintain a Web-based, electronic review request system for 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 certification system. The Contractor shall manually review each prior authorization and prepayment review request received that is not certified by the Contractor's rules-based system, along with any required supporting documentation to support the need for vision 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 experienced health professionals, to apply DOM policy and DOM approved medical necessity criteria in order to approve vision 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.
8. The Contractor shall have the capability and established procedures that allow for a second level review conducted by physicians 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.

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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 timeframe for submission that shall not exceed three (3) business day for precertification 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 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 vision services requests.
 - a. The Contractor shall have the capability and established procedures for issuing a written notification of approved certification results to the vision services provider.
 - b. The Contractor shall have the capability and established procedures for issuing a written notification of denials (including modifications) to the vision services provider and beneficiary or, if a child, the legal guardian/representative.
 - c. Timeframes for notification to providers and beneficiaries of review outcomes for prior authorization and prepayment review of vision services shall not exceed the following standards:

Table 5: Notification of Review Outcomes for Vision Services

Review Type	Contractor Action	Time Standard
Precertification 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

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G. Hearing Services Prior Authorization

1. Mississippi Medicaid covers hearing aids for beneficiaries eligible for services under the EPSDT Program. Eligible beneficiaries under age twenty-one (21) are covered for one (1) pair of hearing aids per fiscal year. Hearing aids are not covered for beneficiaries age twenty-one (21) and older. For additional information on coverage, see Administrative Code Title 23 Medicaid, Part 218 at <http://www.medicaid.ms.gov/AdminCode.aspx>.

As a condition for reimbursement, DOM requires prior authorization for the following benefits: binaural hearing aids; additional monaural aid(s) during the current fiscal year; earmolds (not inclusive of the first pair considered part of the hearing aid purchased during the current fiscal year); repairs to hearing aids; and manually priced equipment.

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 the prior authorization will result in denial of payment to providers billing for services. Currently, DOM staff conducts prior authorization of hearing services.

2. The Contractor shall develop, implement and maintain a UM program, which includes prior authorization and prepayment review of hearing 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 facsimile, mail, and Web-based submissions 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 Jackson, 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 documentation required, including itemized invoice for manually-priced procedures and other forms or documentation required for prior authorization and prepayment review of hearing services.
5. The Contractor shall have the capability and established procedures for determining the medical necessity of precertification and retrospective reviews for hearing services to eligible Mississippi Medicaid beneficiaries utilizing DOM approved criteria and policies.

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- a. Precertification Reviews: The Contractor shall have the capability and established procedures to ensure determinations for precertification reviews 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 are completed 98 percent of the time within twenty (20) business days of receipt.
6. The Contractor shall develop and maintain a Web-based, electronic review request system for 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 certification system. The Contractor shall manually review each prior authorization and prepayment review request received that is not certified by the Contractor's rules-based system, along with any required supporting documentation to support the need for hearing 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 experienced health professionals, to apply DOM policy and DOM approved medical necessity criteria in order to approve hearing 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.
8. The Contractor shall have the capability and established procedures that allow for a second level review conducted by physicians 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.
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 day 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 hearing service provider and attending physician to contact the Contractor's Medical Director to discuss hearing services cases that have been denied or modified.

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12. The Contractor shall have the capability and established procedures for notification to providers and beneficiaries or legal guardians/representatives of review determinations for hearing services requests.
- a. The Contractor shall have the capability and established procedures for issuing a written notification of approved certification results to the hearing provider and attending physician.
 - b. The Contractor shall have the capability and established procedures for issuing a written notification of denials (including modifications) to the hearing provider, attending physician, and beneficiary or, if a child, the legal guardian/representative.
 - c. Timeframes for notification to providers and beneficiaries of review outcomes for prior authorization and prepayment review of hearing services shall not exceed the following standards:

Table 6: Notification of Review Outcomes for Hearing Services

Review Type	Contractor Action	Time Standard
Precertification 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. Outpatient and School Health Related Physical, Occupational, and Speech Therapy Prior Authorization

1. Mississippi Medicaid covers outpatient physical, occupational, and speech therapy services for all eligible beneficiaries. Medicaid also provides expanded health related services through the EPSDT Program for children with disabilities or special needs as defined in Individuals with Disabilities Education Act and identified through the Individual Education Plan and the Individual Family Service Plan process and who are Medicaid eligible. For additional information on coverage, see Administrative Code Title 23 Medicaid, Part 213 at <http://www.medicaid.ms.gov/AdminCode.aspx>.

As a condition for reimbursement, DOM requires certain outpatient therapy services receive prior authorization. Specific items requiring prior authorization are identified in the Outpatient Therapy and School Health Related Code Lists which are posted on DOM's procurement Website, www.medicaid.ms.gov/bids.aspx.

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Failure to obtain the prior authorization will result in denial of payment to all providers billing for services. Currently, DOM's contracted QIO conducts prior authorization of outpatient and school health related physical, occupational, and speech therapy. Historic information on the volume of prior authorizations for therapy services is provided on DOM's procurement Website, www.medicaid.ms.gov/bids.aspx.

2. The Contractor shall develop, implement, and maintain a UM program, which includes prior authorization and prepayment review of therapy 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 facsimile, mail and Web-based submissions 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 Jackson, 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 prior authorization and prepayment review of therapy services.
5. The Contractor shall have the capability and established procedures for determining the medical necessity of precertification, recertification, and retrospective reviews for therapy services to eligible Mississippi Medicaid beneficiaries utilizing DOM approved criteria and policies.
 - a. Precertification Reviews: The Contractor shall have the capability and established procedures to 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 have the capability and established procedures to 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 have the capability and established procedures to ensure determinations for retrospective reviews are completed 98 percent of the time within twenty (20) business days of receipt.
6. The Contractor shall develop and maintain and Web-based, electronic review request system for prior authorization and prepayment review of therapy services that allows for data input by the submitting

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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 certified by the Contractor's rules-based system, along with any required supporting documentation to support the need for therapy 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, to apply DOM policy and DOM approved medical necessity criteria in order to approve therapy services based on certification 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 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 have the capability and established procedures to ensure that first and second level reviews have access to physical therapists, occupational therapists, and speech and language pathologists, for all cases under review (including reductions) 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 timeframe for submission that shall not exceed three (3) business day 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 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 therapy requests.
 - a. The Contractor shall have the capability and established procedures for issuing a written notification of approved certification results to the therapy provider and the attending physician.

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- b. The Contractor shall have the capability and established procedures for issuing a written notification of denials (including modifications) to the therapy provider, attending physician, and beneficiary or, if a child, the legal guardian/representative.
- c. Timeframes for notification to providers and beneficiaries of review outcomes for prior authorization and prepayment review of therapy shall not exceed the following standards:

Table 7: Notification of Review Outcomes for Physical, Occupational, and Speech Therapy

Review Type	Contractor Action	Time Standard
Precertification 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

I. Expanded Physician Services/Office Visits Prior Authorization

1. Mississippi Medicaid covers a total of twelve (12) physician office visits per fiscal year. This limit is inclusive of visits where services are rendered by a physician, nurse practitioner, or physician assistant, as well as those provided in Federally Qualified Health Centers and Rural Health Centers. However, Medicaid provides expanded health related services through the EPSDT Program. Expanded EPSDT services include any necessary Medicaid reimbursable health care to correct or ameliorate illnesses and conditions found on screening. Expanded services are available to children from birth to 21 years of age. Eligibility extends through the last day of the child's birth month only.

As a condition for reimbursement, DOM requires prior authorization for office visits that exceed service limits. Failure to obtain the prior authorization will result in denial of payment to all providers billing for services. Currently, DOM staff conducts prior authorization of reviews of expanded physician/office visit services.

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

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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 facsimile, mail, and Web-based submissions 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 Jackson, 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 prior authorization and prepayment review of expanded physician services.
5. The Contractor shall have the capability and established procedures for determining the medical necessity of precertification 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. Precertification Reviews: The Contractor shall have the capability and established procedures to ensure determinations for precertification reviews 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 are completed 98 percent of the time within twenty (20) business days of receipt.
6. The Contractor shall develop and maintain and Web-based, electronic review request system for 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 certification system. The Contractor shall manually review each prior authorization and prepayment review request received that is not certified 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 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, to apply DOM policy and DOM approved medical necessity criteria in order to approve expanded physician visits based on certification policy and criteria or refer requests that cannot be approved to a second level review.

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8. The Contractor shall have the capability and established procedures that allow for a second level review conducted by physicians 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 have the capability and established procedures to ensure that all cases (including reductions) 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 timeframe for submission shall not exceed three (3) business day for admission/precertification 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 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 expanded physician visits requests.
 - a. The Contractor shall have the capability and established procedures for issuing a written notification of approved certification results to the attending physician.
 - b. The Contractor shall have the capability and established procedures for issuing a written notification of denials (including modifications) to the attending physician and beneficiary or, if a child, the legal guardian/representative.
 - c. Timeframes for notification to providers and beneficiaries of review outcomes for prior authorization and prepayment review of expanded physician visits shall not exceed the following standards:

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Table 8: Notification of Review Outcomes for Expanded Physician Services/Office Visits

Review Type	Contractor Action	Time Standard
Precertification 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 Emergency Room Visits Prior Authorization

1. Mississippi Medicaid covers six (6) emergency room visits (revenue codes 450 through 459) per fiscal year. However, Medicaid provides expanded health related services through the EPSDT Program. Expanded EPSDT services include any necessary Medicaid reimbursable health care to correct or ameliorate illnesses and conditions found on screening. Expanded services are available to children from birth to 21 years of age. Eligibility extends through the last day of the child's birth month only.

As a condition for reimbursement, DOM requires prior authorization for emergency room visits that exceed service limits. Failure to obtain the prior authorization will result in denial of payment to all providers billing for services. Currently, DOM staff conducts prior authorization of reviews of expanded emergency room outpatient visit services.

2. The Contractor shall develop, implement, and maintain a UM program, which includes prior authorization and prepayment review of emergency room (ER) visit requests.
3. The Contractor shall have the capability and established procedures that allow for receipt of prepayment review requests and supporting information via facsimile, mail, and Web-based submissions from hospital providers.
 - a. The Contractor shall establish and maintain a facsimile number, toll-free in Mississippi, for the receipt of review requests for expanded ER visits submitted by facsimile.
 - b. The Contractor shall establish and maintain a physical mailing address in Jackson, Mississippi for the receipt of review requests for expanded ER visits submitted by mail.

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- c. The Contractor shall establish and maintain a Web-based system for receipt of review requests for expanded ER 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 requests, supporting clinical information, and other forms or documentation required for prepayment review of expanded ER visits.
5. The Contractor shall have the capability and established procedures for determining the medical necessity of retrospective reviews utilizing DOM approved criteria and policies for expanded ER visits to eligible Mississippi Medicaid beneficiaries who are children from birth to 21 years of age. The Contractor shall have the capability and established procedures to ensure determinations for expanded ER 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 prepayment review of expanded ER visits 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 prepayment review request received that is not certified by the Contractor's rules-based system, along with any required supporting documentation to support the need for expanded ER visits.
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, to apply DOM policy and DOM approved medical necessity criteria in order to approve expanded ER visits based on certification 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 to make review determinations for expanded ER visits 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.
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 timeframe for submission that shall not exceed fifteen (15) days.
10. The Contractor shall have the capability and established procedures for written notification to the requesting provider of a suspended review. Written notification to providers of suspended reviews shall occur within one (1) business day of the past due date for information requested.

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11. The Contractor shall establish and maintain a procedure for the attending physician to contact the Contractor's Medical Director to discuss expanded ER visit 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 expanded ER visit requests.
 - a. The Contractor shall have the capability and established procedures for issuing a written notification of approved certification results to the hospital provider and attending physician.
 - b. The Contractor shall have the capability and established procedures for issuing a written notification of denials (including modifications) to the hospital provider, attending physician, and beneficiary or, if a child, the legal guardian/representative.
 - c. Timeframes for notification to providers and beneficiaries of review outcomes for prepayment review of expanded ER visits shall not exceed three (3) business days from review determination.

K. Expanded Home Health Services Prior Authorization

1. Mississippi Medicaid covers home health services for beneficiaries who are essentially homebound, under the care of a physician, and in need of home health services on an intermittent basis. Home health visits are limited to 25 visits per fiscal year. As required by Title XIX of the Social Security Act, Mississippi's Medicaid program provides expanded EPSDT services for Medicaid eligible beneficiaries less than 21 years of age. For additional information on coverage, see Administrative Code Title 23 Medicaid, Part 215 at <http://www.medicaid.ms.gov/AdminCode.aspx>.

As a condition for reimbursement, DOM requires that all home health services receive prior authorization for beneficiaries under the age of 21 for home health services beyond the 25th visit per fiscal year. Failure to obtain the prior authorization will result in denial of payment to home health providers billing for services. Currently, DOM's contract QIO conducts prior authorization of home health services. Historic information on the volume of prior authorizations for home health services is provided on DOM's procurement Website, www.medicaid.ms.gov/bids.aspx.

2. The Contractor shall develop, implement, and maintain a UM program, which includes 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 prior authorizations and prepayment review requests and supporting information via facsimile, mail, and Web-based submissions 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 Jackson, Mississippi for the receipt of review requests for expanded home health services submitted by mail.

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- 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 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 precertification, concurrent stay, and retrospective reviews utilizing DOM approved criteria and policies for expanded home health services to eligible Mississippi Medicaid beneficiaries who are children from birth to 21 years of age.
 - a. Precertification Reviews: The Contractor shall have the capability and established procedures to ensure determinations for precertification 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 twenty (20) business days of receipt.
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 certification system. The Contractor shall manually review each prior authorization and prepayment review request received that is not certified 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, to apply DOM policy and DOM approved medical necessity criteria in order to approve expanded home health services based on certification 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 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

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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.
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 timeframe for submission shall not exceed three (3) business day for precertification 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 certification results to the HHA and attending physician.
 - b. The Contractor shall have the capability and established procedures for issuing a written notification of denials (including modifications) to the HHA, attending physician, and beneficiary or, if a child, the legal guardian/representative.
 - c. Timeframes for notification to providers and beneficiaries of review outcomes for prior authorization and prepayment review of home health services shall not exceed one (1) business day from review determination for precertification and three (3) business days from review determination for retrospective reviews.

L. Private Duty Nursing Services Prior Authorization

1. Mississippi Medicaid covers private duty nursing (PDN) services through the EPSDT Program for beneficiaries under the age of 21 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 prior authorization. Failure to obtain the prior authorization will result in denial of payment to providers billing for services. Currently, DOM's contract QIO conducts prior authorization of PDN services. Historic

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information on the volume of prior authorizations for PDN services is provided on DOM's procurement Website, www.medicaid.ms.gov/bids.aspx.

2. The Contractor shall develop, implement, and maintain a UM program, which includes prior authorization of PDN service 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 mail, facsimile, and Web-based submissions 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 Jackson, 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 prior authorization and prepayment review of PDN services.
5. The Contractor shall have the capability and established procedures for determining the medical necessity of precertification, concurrent stay, and retrospective reviews utilizing DOM approved criteria and policies for PDN services to eligible Mississippi Medicaid beneficiaries who are children from birth to 21 years of age.
 - a. Precertification Reviews: The Contractor shall have the capability and established procedures to ensure determinations for precertification reviews are completed 98 percent of the time within ten (10) 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 ten (10) business days of receipt.
6. The Contractor may develop and maintain a Web-based, electronic review request system for prior authorization 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 certification system and manually review for prior authorization requests not certified by the Contractor's rules-based system for PDN 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, to apply DOM

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policy and DOM approved medical necessity criteria in order to approve PDN services based on certification 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 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.
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 timeframe 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 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 PDN services requests.
 - a. The Contractor shall have the capability and established procedures for issuing a written notification of approved certification results to the PDN agency and attending physician.
 - b. The Contractor shall have the capability and established procedures for issuing a written notification of denials (including modifications) to the PDN agency, attending physician, and beneficiary or, if a child, the legal guardian/representative.
 - c. Timeframes for notification to providers and beneficiaries of review outcomes for prior authorization review of PDN Services shall not exceed one (1) business day from review determination.

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

1. Mississippi Division of Medicaid provides Medicaid benefits to children, age eighteen (18) or under, living "at-home" who qualify as disabled individuals provided certain conditions are met.

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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.

- a. There are currently 1014 children enrolled in this program. In 2011, 2725 level of care decisions were made.
1. The Contractor shall make Level of Care (LOC) determinations for eligibility in the DCLH category of eligibility.
2. 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 telephone, facsimile, mail and Web-based submissions..
3. The Contractor shall have the capability and established procedures for determining the institutional LOC utilizing DOM approved criteria and policies for the DCLH category of eligibility:
 - a. DCLH Level of Care Decisions: The Contractor shall have the capability and established procedures to ensure determinations for level of care decisions are completed 98 percent of the time within 20 calendar days of receipt.
 - b. Hospital LOC: This level of care 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.
 - c. ICF/MR LOC: This level of care 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 mentally retarded.
 - d. Nursing Facility LOC: This level of care 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

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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.

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, to apply DOM policy 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.
5. The Contractor shall have the capability and established procedures that allow for a second level review conducted by physician of the same specialty as that of 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.
6. 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.
7. The Contractor shall have the capability and established procedures for notification to providers and beneficiaries or legal guardians/representatives of review determinations for LOC determinations for eligibility in the DCLH category of eligibility.

N. Acute and Ancillary 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 inpatient medical/surgical services reviewed under the resulting Contract.
 - a. The Contractor shall maintain the capability to update the review criteria for inpatient medical/surgical 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 1.7 of this RFP.
 - b. The Contractor shall provide DOM with access to a complete set of materials associated with the criteria annually.

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- 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 a clinically sound, evidence-based, medical necessity criteria for expanded EPSDT services, including extended physician services and ER visits, prior to implementing the UM program for acute and ancillary services. The Contractor shall have the capability to develop an automated criteria/rules-based certification system that, with DOM approval of criteria to be employed, is expected to perform a significant number of reviews for expanded EPSDT services as automated/rules-driven approvals.
 4. 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 for expanded EPSDT services through a Web-based prior authorization system to achieve these objectives.

O. Failure to Meet Acute and Ancillary Services Performance Standards

1. DOM may assess liquidated damages in the amount of \$100 per workday for each failure to meet the performance standard of review determinations.
2. DOM may assess liquidated damages in the amount of \$100 per workday for each failure to meet the performance standard of review determinations.

P. Implementation of Hospital Prospective Payment and Coding Validation Audits

1. DOM is planning to implement a prospective payment system (PPS) for hospital services in October 2012. Under PPS, there is a predetermined payment for each hospital inpatient stay for each Diagnostic Related Group (DRG). The payment is based on a predetermined mean cost and mean length of stay for each DRG. The DRG assignment, which determines reimbursement, is based on the principal diagnosis that caused the patient to be admitted to the hospital, as well as the existence of additional complicating diagnoses or operating room procedures. In general, the inclusion of complicating diagnoses will result in the classification of a case to a higher-paying DRG.
2. PPS can create incentives to: 1) increase the number of admissions; 2) minimize the quantity of services provided within each admission; 3) discharge early; 4) structure diagnosis and procedure coding to improve DRG assignment; and 5) when close to an outlier threshold, increase charges and days in order to qualify for outlier payments. Given these incentives, the utilization review needs to

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shift away from determination of unnecessary services provided during an admission to: 1) a review of the need for each admission; 2) a determination of whether the decision to discharge or transfer occurred at an appropriate time and for medically sound reasons; 3) a verification of the accuracy of the case coding which determined the DRG assignment; and 4) a verification that medically necessary services were provided.

3. Prior authorization of inpatient hospital medical/surgical services is required for all admissions to the hospital except as indicated in Section 1.4.2.1.A of this RFP. In addition, the Contractor will be required to conduct PAs for inpatient stays beyond the 20th day. DOM paid 3,696 inpatient claims that exceeded 20 days in CY 2011. By January 15, 2013, the Contractor shall make recommendations to DOM regarding how to counterbalance the incentive to increase admissions under a prospective payment system with more intensified review of the need for admission at the point prior to admission, as well as the review of the appropriateness of readmissions. The Contractor shall also provide DOM with recommendations related to the providers' incentive to discontinue treatment at the point that hospitalization begins to be unprofitable. These recommendations may include retrospective reviews that examine the clinical appropriateness of the decision to discharge or transfer and the timing of the decision to discharge or transfer.
4. In addition to the above, the Contractor shall develop and implement retrospective reviews that validate the DRG assignment in order to counterbalance the incentive to arrange diagnosis codes in such a way as to cause a claim to be assigned to a higher-paying DRG. This review process shall consist of looking at representative sample DRGs that represent a potential for upcoding, or other billing errors, or higher than expected utilization to ensure the DRG used for payment is consistent and accurate with the DRG payment based on correct diagnostic and procedural information in the case of inpatient admissions.
5. The Contractor shall perform retrospective post-payment reviews as directed by DOM, including coding validation audits comparing the principal and all secondary diagnosis 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 DRGs.

1.4.2.2 Behavioral Health Services Utilization Management Technical Requirement (LOT B)

This lot is for the development, implementation, and operation of a UM program for behavioral health services to include:

- Inpatient Psychiatric Services;
- Hospital Outpatient Mental Health Services;
- Psychiatric Residential Treatment Facility Services;
- Mississippi Youth Programs Around the Clock (MYPAC) Services; and
- Therapeutic and Evaluative Services for Children.

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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 programs for behavioral health services for commercial and/or government health care programs.

Preference will be given to an Offeror that is a QIO under contract with CMS or a CMS designated QIO-like entity as designated by CMS, thereby enabling the State of Mississippi to qualify for the 75 percent federal financial participation as established in 42 CFR 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.

A. Inpatient Psychiatric Services Prior Authorization

1. Mississippi Medicaid covers inpatient psychiatric services for all eligible beneficiaries. For additional information on coverage, see Administrative Code Title 23 Medicaid, Part 202 at <http://www.medicaid.ms.gov/AdminCode.aspx>.

As a condition for reimbursement, DOM requires that all inpatient hospital admissions receive prior authorization. Failure to obtain the prior authorization will result in denial of payment to all providers billing for services, including the hospital and the attending physician. Currently, DOM's contracted QIO conducts prior authorization of hospital admissions. Historic information on the volume of prior authorizations is provided on DOM's procurement Website, www.medicaid.ms.gov/bids.aspx.

2. The Contractor shall develop, implement, and maintain a UM program, which includes prior authorization and prepayment review of inpatient psychiatric 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 telephone, facsimile, mail, and Web-based submissions 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 Jackson, Mississippi for the receipt of prior authorization and prepayment review requests for inpatient psychiatric services submitted by mail.

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- 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 prior authorization and prepayment review of inpatient psychiatric services.
5. The Contractor shall have the capability and established procedures for determining the medical necessity for urgent/emergent and non-emergency inpatient admission prior authorizations, continued stays, and retrospective reviews for inpatient psychiatric services to eligible Mississippi Medicaid beneficiaries utilizing DOM approved criteria and policies.
 - a. Emergency Admission Reviews: Emergency 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 permanently placing the beneficiary's mental health in jeopardy, a serious threat to the physical welfare of the beneficiary and/or others, or serious and permanent mental dysfunction or other serious medical or psychiatric consequence.

The Contractor shall have the capability and established procedures to receive urgent/emergent admission reviews post-admission for admissions that are not planned or elective and conduct prior authorizations when the beneficiary has not been discharged. The Contractor shall have the capability and established procedures to ensure determinations for urgent/emergent admission reviews are completed 98 percent of the time within 24 hours (one workday) of receipt.

- b. Non-Emergency Admission Reviews: Non-emergency admissions are admissions 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 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 24 hours (one workday) of receipt.
- c. Weekend and Holiday Admission Reviews: Weekend admissions are those admissions where the beneficiary was admitted on a weekend (Friday, Saturday, or Sunday). 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 prior authorizations post-admission when the beneficiary has not been discharged. The Contractor shall have the capability and established procedures to ensure determinations for urgent/emergent admission reviews are completed 98 percent of the time within 24 hours (one workday) of receipt.

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- 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 certified and conduct prior authorizations on or before the next review point (i.e. the last certified day). The Contractor shall have the capability and established procedures to provide all hospital providers with a daily listing of beneficiaries whose certification 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 24 hours (one workday) of receipt when beneficiaries remain hospitalized and within 24 hours (one workday) when beneficiaries have been discharged.
 - e. Retrospective Short Stay Reviews: A short stay is defined as those admissions where the length of stay was eight (8) days or less and the admission was not previously certified. The Contractor shall have the capability and established procedures to receive retrospective short term stay review requests and conduct prepayment reviews as such conditions are identified. The Contractor shall have the capability and established procedures to ensure determinations for retrospective short stay reviews are completed 98 percent of the time within twenty (20) business days of receipt.
 - f. 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, certification 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 twenty (20) business days of receipt.
- 6. The Contractor shall develop and maintain a Web-based, electronic review request system for 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 certification system. The Contractor shall manually review each prior authorization and prepayment review request received that is not certified 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 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, to apply DOM policy and DOM approved medical necessity criteria in order to approve inpatient psychiatric services based on certification 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 inpatient psychiatric services

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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.
9. The Contractor shall have the capability and established procedures for verbal and written notification to the requesting provider of a pending review and informing the provider of the information needed along with a timeframe 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 9: Notification of Suspended Review for Inpatient Psychiatric Services

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

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, or considered for denial.
12. The Contractor shall have the capability and established procedures for notification to providers and beneficiaries or legal guardians/representatives of review determinations for inpatient psychiatric services requests.
 - a. The Contractor shall have the capability and established procedures for issuing verbal and written notification of approved certification results to the hospital provider and treating clinician.

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- b. The Contractor shall have the capability and established procedures for issuing a written notification of denials (including modifications) to the hospital provider, treating clinician, and beneficiary or, if a child, the legal guardian/representative.
- c. Timeframes for notification to providers and beneficiaries of review outcomes for prior authorization and prepayment review of inpatient psychiatric services shall not exceed the following standards:

Table 10: Notification of Review Outcomes for Inpatient Psychiatric Services

Review Type	Contractor Action	Time Standard
Urgent/Emergent 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 to Beneficiary/ Parent/Representative	Within one (1) business day from review determination.
Retrospective Short Stay Reviews	Written Approval to Provider	Within one (1) business day from review determination.
Retrospective Reviews	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 Prior Authorization

1. Mississippi Medicaid covers mental health services when provided in an outpatient department of a general hospital for all eligible beneficiaries. For additional information on coverage, see Administrative Code Title 23 Medicaid, Part 202 (Chapter 2, specifically) at <http://www.medicaid.ms.gov/AdminCode.aspx>.

As a condition for reimbursement, DOM requires that all hospital outpatient mental health services receive prior authorization. Specific procedures requiring prior authorization are identified in the Outpatient Mental Health CPT® Codes Listing on DOM's procurement Website, www.medicaid.ms.gov/bids.aspx.

Failure to obtain the prior authorization will result in denial of payment to providers billing for services. Currently, DOM's contract QIO conducts prior authorization of hospital outpatient mental health services. Historic information on the volume of prior authorizations for hospital outpatient

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mental health services is provided on DOM's procurement Website, www.medicaid.ms.gov/bids.aspx.

2. The Contractor shall develop, implement, and maintain a UM program, which includes prior authorization and prepayment review of outpatient mental health 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 facsimile, mail, and Web-based submissions 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 Jackson, 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 prior authorization and prepayment review of outpatient mental health services.
5. The Contractor shall have the capability and established procedures for determining the medical necessity of admission precertification, 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 Precertification Reviews: The Contractor shall have the capability and established procedures to ensure determinations for admission precertification 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 twenty (20) business days of receipt.

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6. The Contractor shall develop and maintain a Web-based, electronic review request system for 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 certification system. The Contractor shall manually review each prior authorization and prepayment review request received that is not certified 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 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 or other qualified mental health professionals, to apply DOM policy and DOM approved medical necessity criteria in order to approve outpatient mental health services based on certification 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 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.
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 timeframe for submission shall not exceed three (3) business day 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 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 have the capability and established procedures for notification to providers and beneficiaries or legal guardians/representatives of review determinations for outpatient mental health services requests.

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- a. The Contractor shall have the capability and established procedures for issuing verbal and written notification of approved certification results to the hospital outpatient provider, treating clinician, and attending physician.
- b. The Contractor shall have the capability and established procedures for issuing verbal and written notification of denials (including modifications) to the hospital outpatient provider, treating clinician, attending physician, and beneficiary or, if a child, the legal guardian/representative.
- c. Timeframes for notification to providers and beneficiaries of review outcomes for prior authorization and prepayment review of outpatient mental health services shall not exceed the following standards:

Table 11: Notification of Review Outcomes for Hospital Outpatient Mental Health Services

Review Type	Contractor Action	Time Standard
Admission Precertification 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. Psychiatric Residential Treatment Facility Services Prior Authorization

1. Mississippi Medicaid covers psychiatric residential treatment facility (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, Part 207 (Chapter 4, specifically) at <http://www.medicaid.ms.gov/AdminCode.aspx>.

As a condition for reimbursement, DOM requires that PRTF 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 QIO conducts prior authorization of PRTF services. Historic

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information on the volume of prior authorizations for PRTF services is provided on DOM's procurement Website, www.medicaid.ms.gov/bids.aspx.

2. The Contractor shall develop, implement, and maintain a UM program, which includes prior authorization and prepayment review of PRTF 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 facsimile, mail, and Web-based submissions 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 Jackson, 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 prior authorization and prepayment review of PRTF services.
5. The Contractor shall have the capability and established procedures for determining the medical necessity of preadmission, continued stay, and retrospective reviews for PRTF services to eligible Mississippi Medicaid beneficiaries utilizing DOM approved criteria and policies.
 - a. Preadmission Reviews: The Contractor shall have the capability and established procedures to ensure determinations for preadmission 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 twenty (20) business days of receipt.
6. The Contractor may develop and maintain a Web-based, electronic review request system for 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

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certification system with manually review for prior authorization and prepayment review requests not certified by the Contractor's rules-based system for PRTF 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 or other mental health professionals, to apply DOM policy and DOM approved medical necessity criteria in order to approve PRTF services based on certification 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 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.
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 timeframe for submission shall not exceed one (1) business day 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 PRTF and treating clinician to contact the Contractor's Medical Director to discuss PRTF services cases that have been denied, modified, or considered for denial.
12. The Contractor shall have the capability and established procedures for notification to providers and beneficiaries or legal guardians/representatives of review determinations for PRTF services requests.
 - a. The Contractor shall have the capability and established procedures for issuing verbal and written notification of approved certification results to the PRTF provider and treating clinician.
 - b. The Contractor shall have the capability and established procedures for issuing verbal and written notification of denials (including modifications) to the PRTF provider, treating clinician, and beneficiary or, if a child, the legal guardian/representative.
 - c. Timeframes for notification to providers and beneficiaries of review outcomes for prior authorization and prepayment review of PRTF services shall not exceed the following standards:

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Table 12: Notification of Review Outcomes for Psychiatric Residential Treatment Facilities Services

Review Type	Contractor Action	Time Standard
Admission Precertification 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

D. Mississippi Youth Programs Around the Clock Services Prior Authorization

1. Mississippi Youth Programs Around the Clock (MYPAC) is Medicaid waiver program that provides provide home and community-based services to youth with serious emotional disturbance at immediate risk of requiring treatment in a PRTF or are already in a PRTF and are ready to transition back to the community. MYPAC admission reviews will end September 30, 2012. Continued stay recertifications may continue until all recipients are disenrolled from the program through attrition. For additional information on coverage, see Administrative Code Title 23 Medicaid, Part 206 (Chapter 2, specifically) at <http://www.medicaid.ms.gov/AdminCode.aspx>.

As a condition for reimbursement, DOM requires that all 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 QIO conducts prior authorization of MYPAC services. Historic information on the volume of prior authorizations for MYPAC services is provided on DOM's procurement Website, www.medicaid.ms.gov/bids.aspx.

2. The Contractor shall develop, implement, and maintain a UM program, which includes prior authorization for the MYPAC waiver.
3. The Contractor shall have the capability and established procedures that allow for receipt of prior authorizations requests and supporting information via facsimile and mail submissions from MYPAC providers.

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- a. The Contractor shall establish and maintain a dedicated facsimile number, toll-free in Mississippi, for the receipt of review requests for MYPAC waiver services submitted by facsimile.
- b. The Contractor shall establish and maintain a physical mailing address in Jackson, Mississippi for the receipt of review requests for MYPAC waiver services submitted by mail.
- c. The Contractor shall establish and maintain a Web-based system for receipt of review requests for MYPAC waiver 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 prior authorization and prepayment review of MYPAC waiver services.
5. The Contractor shall have the capability and established procedures for determining the medical necessity of admission reviews and continued stay reviews for MYPAC waiver services to eligible Mississippi Medicaid beneficiaries utilizing DOM approved criteria and policies.
 - a. Preadmission Reviews: The Contractor shall have the capability and established procedures to ensure determinations for preadmission reviews are completed 98 percent of the time within one (1) workday 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) workday of receipt.
6. The Contractor shall develop and maintain a Web-based, electronic review request system for prior authorization and prepayment review of MYPAC waiver 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 certified by the Contractor's rules-based system, along with any required supporting documentation to support the need for MYPAC waiver 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 other mental health professional, to apply DOM policy and DOM approved medical necessity criteria in order to approve MYPAC waiver services based on certification 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 MYPAC waiver 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

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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.
9. The Contractor shall have the capability and established procedures for verbal and written notification to the requesting provider of a pending review and informing the provider of the information needed along with a timeframe 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 waiver provider, treating clinician to contact the Contractor's Medical Director to discuss MYPAC waiver 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 MYPAC waiver services requests.
 - a. The Contractor shall have the capability and established procedures for issuing a written notification of approved certification results to the MYPAC waiver provider and attending physician.
 - b. The Contractor shall have the capability and established procedures for issuing a written notification of denials (including modifications) to the MYPAC waiver provider, attending physician, and beneficiary or, if a child, the legal guardian/representative.
 - c. Timeframes for notification to providers and beneficiaries of review outcomes for prior authorization of MYPAC waiver services shall not exceed the following standards:

Table 13: Notification of Review Outcomes for Mississippi Youth Programs Around the Clock Services

Review Type	Contractor Action	Time Standard
Preadmission 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

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E. Therapeutic and Evaluative Services for Children Prior Authorization

1. Mississippi Medicaid covers mental health services through the EPSDT Program that include therapeutic (bio-psycho-assessment, individual, family, and group therapy, day treatment) and evaluative (psychological, developmental, and neuropsychological evaluation) services. Expanded services are available to children from birth to 21 years of age. Eligibility extends through the last day of the child's birth month only. For additional information on coverage, see Administrative Code Title 23 Medicaid, Part 206 at <http://www.medicaid.ms.gov/AdminCode.aspx>.

As a condition for reimbursement, DOM requires prior authorization for the following therapeutic and evaluative mental health services for children:

- All evaluations (psychological, developmental, neuropsychological) for all beneficiaries. The preparatory (background/information gathering) and follow-up (feedback) requirements for evaluations do not require prior authorization.
- All psychotherapy (bio-psycho-social assessment, individual, family, and group therapy) services for children younger than three (3) years of age;
- Psychotherapy services for beneficiaries aged 3-20 that exceed the service standards; and
- Day treatment for all beneficiaries.

Failure to obtain the prior authorization will result in denial of payment to providers billing for services. Currently, DOM's contract QIO conducts prior authorization of day treatment for children five (5) and under. Historic information on the volume of prior authorizations is provided on DOM's procurement Website, www.medicaid.ms.gov/bids.aspx. DOM staff conducts prior authorization of all other therapeutic and evaluative mental health services for children.

2. The Contractor shall develop, implement, and maintain a UM program, which includes prior authorization and retrospective review of therapeutic and evaluative services requests.
3. The Contractor shall have the capability and established procedures that allow for receipt of prior authorizations and supporting information via facsimile, mail, and Web-based submissions 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 Jackson, 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.

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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 have the capability and established procedures for determining 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 one (1) workday 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) workdays 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) workdays 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 twenty (20) workdays of receipt.
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 certified 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 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 other mental health professional, to apply DOM policy 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. The Contractor shall have the capability and established procedures that allow for 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

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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 and/or day treatment clinical director to obtain additional information when the documentation submitted does not clearly support medical necessity.
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 timeframe 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 (and/or day treatment clinical director for day treatment) to contact the Contractor's Medical Director to discuss therapeutic and evaluative 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 therapeutic and evaluative services requests.
 - a. The Contractor shall have the capability and established procedures for issuing verbal and written notification of approved certification results to the treatment provider and treating clinician.
 - b. The Contractor shall have the capability and established procedures for issuing verbal and written notification of denials (including modifications) to the treatment provider, attending physician, and beneficiary or, if a child, the legal guardian/representative.
 - c. Timeframes 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 14: Notification of Review Outcomes for Therapeutic and Evaluation Services for Children

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

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Recertification Review		
	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

F. 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 1.7 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 certification system.

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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.

G. Failure to Meet Behavioral Health Services Performance Standards

1. DOM may assess liquidated damages in the amount of \$100 per workday for each failure to meet the performance standard of review determinations.
2. DOM may assess liquidated damages in the amount of \$100 per workday for each failure to meet the performance standard of review determinations.

1.4.2.3 Dental Services Utilization Management Technical Requirements (LOT C)

This lot is for the development, implementation, and operation of a UM program for dental services to include:

- Dental Services;
- Dental Surgery Services; and
- Orthodontic 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 programs for dental services for commercial and/or government health care programs.

Preference will be given to an Offeror that is a QIO under contract with CMS or a CMS designated QIO-like entity as designated by CMS, thereby enabling the State of Mississippi to qualify for the 75 percent federal financial participation as established in 42 CFR 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.

A. Dental Services Prior Authorization

1. All dental expenditures covered under Mississippi Medicaid are limited to \$2,500 per beneficiary (children and adults) per fiscal year. Mississippi Medicaid covers palliative dental services for beneficiaries age twenty-one (21) and over. As required by Title XIX of the Social Security Act, the Mississippi Medicaid program provides the EPSDT program for Medicaid eligible beneficiaries less than twenty-one (21) years of age. Medicaid will provide medically necessary services that are identified through the EPSDT screening process and that are covered under federal Medicaid law, even if they are not included in the Mississippi Medicaid State Plan. For additional information on coverage, see Administrative Code Title 23 Medicaid, Part 204 at <http://www.medicaid.ms.gov/AdminCode.aspx>.

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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) manually priced procedures.

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, DOM staff conducts prior authorization of dental services. DOM estimates the annual volume for dental services PAs to be 2,720, with approximately 43 percent received as Web-based submissions. The estimated denial rate for dental services PAs is 23 percent.

2. The Contractor shall develop, implement, and maintain a UM program, which includes prior authorization and prepayment review of dental services requests.
3. The Contractor shall have the capability and established procedures that allow for receipt of 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 services submitted by facsimile.
 - b. The Contractor shall establish and maintain a physical mailing address in Jackson, 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 have the capability and established procedures for determining the medical necessity of precertification utilizing DOM approved criteria and policies for dental services to eligible Mississippi Medicaid beneficiaries. The Contractor shall have the capability and established procedures to ensure determinations for precertification reviews are completed 98 percent of the time within seven (7) workdays of receipt. In rare cases, this could include retroactive reviews.
6. The Contractor may develop and maintain a Web-based, electronic review request system for 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 certification system with manually review for prior authorization requests not certified by the Contractor's rules-based system for dental services.

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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 qualified health professionals, to apply DOM policy 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.
8. The Contractor shall have the capability and established procedures that allow for 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.
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 timeframe for submission.
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 dental provider to contact the Contractor's Dental Director to discuss dental 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 dental services requests.
 - a. The Contractor shall have the capability and established procedures for issuing a written notification of approved certification results to the dental provider.
 - b. The Contractor shall have the capability and established procedures for issuing a written notification of denials (including modifications) to the dental provider and beneficiary or, if a child, the legal guardian/representative.
 - c. Timeframes for notification to providers and beneficiaries of review outcomes for prior authorization review of dental services shall not exceed the following standards:

Table 15: Notification of Review Outcomes for Dental Services

Review Type	Contractor Action	Time Standard
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Precertification 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

B. Dental Surgery Prior Authorization

1. Mississippi Medicaid 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, Part 204 (Chapter 2, specifically) at <http://www.medicaid.ms.gov/AdminCode.aspx>.

As a condition for reimbursement, DOM requires prior 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, DOM staff conducts prior authorization of dental surgery. DOM estimates the annual volume for oral surgery PAs to be 613, with approximately 29 percent received as Web-based submissions. The estimated denial rate for oral surgery PAs is seven (7) percent.

2. The Contractor shall develop, implement, and maintain a UM program, which includes prior authorization and prepayment review of dental surgery services requests.
3. The Contractor shall have the capability and established procedures that allow for receipt of 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 Jackson, 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 prior authorization review of dental surgery services.

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5. The Contractor shall have the capability and established procedures for determining the medical necessity of precertification utilizing DOM approved criteria and policies for dental surgery services to eligible Mississippi Medicaid beneficiaries. The Contractor shall have the capability and established procedures to ensure determinations for precertification reviews are completed 98 percent of the time within seven (7) workdays of receipt. In rare cases, this could include retroactive reviews.
6. The Contractor may develop and maintain a Web-based, electronic review request system for 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 certification system with manually review for prior authorization requests not certified by the Contractor's rules-based system for dental surgery 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 may include registered nurses or other trained staff, to apply DOM policy and DOM approved medical necessity criteria in order to approve dental surgery services based on certification 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 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.
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 timeframe for submission.
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 dental provider to contact the Contractor's Dental Director to discuss dental 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 dental surgery services requests.

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- a. The Contractor shall have the capability and established procedures for issuing a written notification of approved certification results to the dental provider.
- b. The Contractor shall have the capability and established procedures for issuing a written notification of denials (including modifications) to the dental provider and beneficiary or, if a child, the legal guardian/representative.
- c. Timeframes for notification to providers and beneficiaries of review outcomes for dental surgery services shall not exceed the following standards:

Table 16: Notification of Review Outcomes for Dental Surgery

Review Type	Contractor Action	Time Standard
Precertification 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

C. Orthodontia Services Prior Authorization

1. Mississippi Medicaid covers orthodontia-related services that are limited to \$4,200 per beneficiary per lifetime. Orthodontia-related services are only covered for beneficiaries under age twenty-one (21) who meet pre-qualifying criteria. For additional information on coverage, see Administrative Code Title 23 Medicaid, Part 204 at <http://www.medicaid.ms.gov/AdminCode.aspx>.

As a condition for reimbursement, DOM requires prior 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, DOM staff conducts prior authorization of orthodontia services. DOM estimates the annual volume for orthodontia services PAs to be 4,263, with approximately 14 percent received as Web-based submissions. The estimated denial rate for orthodontia services PAs is 17 percent.

2. The Contractor shall develop, implement, and maintain a UM program, which includes prior authorization and prepayment review of orthodontia services requests.
3. The Contractor shall have the capability and established procedures that allow for receipt of 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 orthodontia services submitted by facsimile.

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- b. The Contractor shall establish and maintain a physical mailing address in Jackson, 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 prior authorization review of orthodontia services.
 - 5. The Contractor shall have the capability and established procedures for determining the medical necessity of precertification and retrospective reviews utilizing DOM approved criteria and policies for orthodontia services to eligible Mississippi Medicaid beneficiaries. The Contractor shall have the capability and established procedures to ensure determinations for precertification reviews are completed 98 percent of the time within seven (7) workdays of receipt. In rare cases, this could include retroactive reviews.
 - 6. The Contractor may develop and maintain a Web-based, electronic review request system for 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 certification system with manually review for prior authorization requests not certified by the Contractor's rules-based system for orthodontia 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 qualified health professional, to apply DOM policy 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.
 - 8. The Contractor shall have the capability and established procedures that allow for a second level review conducted by an 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.
 - 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 timeframe for submission.

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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 dental provider to contact the Contractor's Dental Director to discuss dental 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 orthodontia services requests.
 - a. The Contractor shall have the capability and established procedures for issuing written notification of approved certification results to the dental provider.
 - b. The Contractor shall have the capability and established procedures for issuing written notification of denials (including modifications) to the dental provider and beneficiary or, if a child, the legal guardian/representative.
 - c. Timeframes for notification to providers and beneficiaries of review outcomes for orthodontia services shall not exceed the following standards:

Table 17: Notification of Review Outcomes for Orthodontia Services

Review Type	Contractor Action	Time Standard
Precertification 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

D. Dental 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 dental services reviewed under the resulting Contract.
2. The Contractor shall maintain the capability to update the review criteria for dental services reviewed under the resulting Contract. The Contractor shall make recommendations to DOM six months after implementation and annually thereafter, 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 1.7 of the RFP.

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3. The Contractor shall provide DOM with access to a complete set of materials associated with the criteria annually.
4. 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.
5. The Contractor is responsible for any cost associated with the purchase of any review criteria.
6. 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, if any.
7. The Contractor shall work with DOM to develop a clinically sound, evidence-based, medical necessity criteria for all dental services prior to implementing the UM program.
8. The Methodology section of the Technical Proposal must provide a detailed description of the Offeror's approach to medical necessity criteria for dental services that consider the following sources in the development and revision of dental policy: 1) current published medical literature from peer-reviewed publications; 2) evidence-based guidelines developed by national organizations and recognized authorities; and 3) generally accepted standards of dental practice.

E. Failure to Meet Dental Services Performance Standards

1. DOM may assess liquidated damages in the amount of \$100 per workday for each failure to meet the performance standard of review determinations.
2. DOM may assess liquidated damages in the amount of \$100 per workday for each failure to meet the performance standard of review determinations.

1.4.2.4 Advanced Imaging Utilization Management Technical Requirements (LOT D)

This lot is for the development, implementation, and operation of a radiology management program for prior authorization of non-emergency outpatient advanced imaging studies including, but not limited to, hospital outpatient, free standing clinics, and private physician offices covered under the Medicaid program. The Contractor shall develop a process to review requests for prior authorization for advanced imaging services based on DOM approved criteria for advanced imaging procedure and diagnostic codes.

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 programs for advanced imaging services for commercial and/or government health care programs.

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Preference will be given to an Offeror that is a QIO under contract with CMS or a CMS designated QIO-like entity as designated by CMS, thereby enabling the State of Mississippi to qualify for the 75 percent federal financial participation as established in 42 CFR 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.

A. General Advanced Imaging Prior Authorization Requirements

1. The Contractor must demonstrate high quality administrative and clinical leadership in UM services. The Contractor shall conduct reviews for the following non-emergency advanced imaging studies provided in outpatient settings, including, but not limited to, freestanding clinics, hospital outpatient, and private physician offices:
 - Computerized Tomography scans;
 - Magnetic Resonance Images;
 - Magnetic Resonance Angiograms;
 - Positron Emission Tomography scans;
 - Nuclear Cardiology; and
 - Other identified over utilized or high-cost radiology services.
2. The Contractor shall develop, implement, and maintain a UM program, which includes prior authorization or other prospective review of advanced imaging services requests.
3. The Contractor shall review prior authorization requests using DOM approved guidelines to determine medical necessity. Requests and approvals shall be based on specific imaging CPT codes. Historic volumes of advanced imaging services are on DOM's procurement Website, www.medicaid.ms.gov/bids.aspx.
4. The Contractor shall comply with the following timeframes. All requests for prior authorization must be reviewed and decisions made, or additional information requested, within two (2) business days of receipt of request.
5. The Contractor shall have the capability and established procedures that allow for receipt of prior authorizations and prospective review requests and supporting information via telephone, facsimile, mail, and Web-based submissions from clinics, outpatient hospital providers, and attending physicians.
 - a. The Contractor shall establish and maintain a dedicated telephone number, toll-free in Mississippi, for the receipt of prior authorization requests for advanced imaging services submitted by telephone.

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- 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 advanced imaging services submitted by facsimile.
 - c. The Contractor shall establish and maintain a physical mailing address in Jackson, Mississippi for the receipt of prior authorization and prepayment review requests for advanced imaging 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 advanced imaging services submitted electronically. This Web-based system must comply with the requirements in Section 1.6 of this RFP.
- 6. Regardless of the mode of receipt, the Contractor shall have established procedures and sufficient capacity for intake staff to screen requests for completeness and request non-clinical information as appropriate for prior authorization and prospective review of advanced imaging services.
 - 7. 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 advanced imaging services.
 - 8. The Contractor shall have the capability and established procedures to pend any advanced imaging services review request if the provider submits a request for certification to the Contractor 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. If additional information is requested, the Contractor shall initiate a process of placing a request on hold until additional information has been received.
 - 9. The Contractor shall have the capability and established procedures that allow for suspending a review for advanced imaging services when the reviews have been pended because additional information is required and the requested information is not submitted by the due date.
 - 10. The Contractor shall have the capability and established procedures for generating a TAN when a case meets all policy and medical criteria necessary for certification of the advanced imaging services requested. The Contractor shall have the capability and established procedures for issuing a technical denial for imaging services when the case does not meet DOM policy or is technically insufficient (e.g., age, beneficiary not eligible, etc.).
 - 11. The Contractor shall review requests for prior authorization for advanced imaging procedures as approved by DOM. Reviews will be conducted by licensed physicians and nurses using DOM approved guidelines for determining medical necessity.
 - 12. 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 timeframe for submission.

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13. The Contractor shall have the capability and established procedures for written notification to the requesting provider of a suspended review.
14. The Contractor shall establish and maintain a procedure for the attending physician to contact the Contractor's Medical Director to discuss imaging cases that have been denied or modified.
15. The Contractor shall have the capability and established procedures for notification to providers and beneficiaries or legal guardians/representatives of review determinations for advanced imaging services requests.
16. The Contractor shall educate prescribers when the Contractor denies or approves other than as "requested" requests for prior authorization of advanced imaging studies by explaining why the requested study is not medically necessary and, if applicable, which study is the appropriate one given the beneficiary's symptoms.

B. Advanced Imaging 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 advanced imaging services reviewed under the resulting Contract.
 - a. The Contractor shall maintain the capability to update the review criteria for advanced imaging 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 1.7 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 certification system, if any.

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3. The Contractor shall develop advanced imaging decision criteria and protocol for use in the review process, including development of a full list of CPT codes subject to review.
4. The Contractor shall recommend, for DOM's approval, prior authorization guidelines to be used to determine medical necessity for advanced imaging studies. Guidelines must be based on nationally accepted evidence-based clinical criteria. DOM reserves the right to modify the criteria of imaging study procedures subject to prior authorization over the term of the Contract.
5. The Contractor shall assist and support DOM in making the guidelines publically available, and in educating stakeholders regarding the guidelines and prior approval processes. Stakeholders may include, among others, beneficiaries, providers, advocacy groups, legislators, and DOM staff.

C. Provider Communications

1. The Contractor will develop a reference manual for providers 45 days prior to the initiation of the prior authorization program. The manual will provide guidelines for medical necessity of advanced imaging studies, as well as procedures to obtain prior authorization, seek clarification on guidelines, and procedures to file complaints.
2. The Contractor will develop and implement outreach program to train providers on the advanced imaging program. The Contractor will hold initial orientations and ongoing seminars with key stakeholders, as requested by DOM.

D. Monitor Trends in Advanced Imaging

1. The Contractor shall develop utilization profiles for referring Medicaid providers and the identification of providers demonstrating a pattern of inappropriate advanced imaging referrals. The Contractor will manage utilization through direct communication with providers to ensure evidence based care and the appropriate allocation of resources.
2. The Contractor must also develop and implement a process to monitor trends in the advanced imaging industry, including changes in nationally accepted clinical guidelines to determine medical necessity of advanced imaging studies. Based on its monitoring, the Contractor must recommend to DOM changes in clinical guidelines that DOM may want to consider for the prior authorization program and recommend clinical guidelines for the new advanced imaging studies that DOM will include in the prior authorization program.

E. Failure to Meet Imaging Services Performance Standards

1. DOM may assess liquidated damages in the amount of \$100 per workday for each failure to meet the performance standard of review determinations.
2. DOM may assess liquidated damages in the amount of \$100 per workday for each failure to meet the performance standard of review determinations.

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1.4.3. Peer Review Services

Healthcare practitioners 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 when DOM has identified, by data analysis or other means, a possible violation by a health care practitioner of one more of the obligations listed above. 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 Policy Section 7.05, Healthcare Practitioner Peer Review Protocol. Policy Section 7.05 can be accessed at:
<http://www.medicaid.ms.gov/Policy%20Amendments/AP2007-07%20final.stamped.4.4.07.pdf>.
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, and welfare of an individual is at risk directly to DOM within twenty four (24) hours of identification of potential cases.
4. DOM may assess liquidated damages in the amount of \$100 per workday per deliverable for each day a deliverable is unavailable or unacceptable.

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 make 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.

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- 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 acute and ancillary 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.
5. DOM may assess liquidated damages in the amount of \$100 per workday per deliverable for each day a deliverable is unavailable or unacceptable.

1.4.5. Clinical/Medical Consulting Services

1. The Contractor shall have the capacity and established procedures to clinical/medical consultation through the Contractor's Medical Director 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. 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 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 20 workdays of receipt of the case.
6. DOM may assess liquidated damages in the amount of \$100 per workday per deliverable for each day a deliverable is unavailable or unacceptable.

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1.5. Staffing Requirements

1. The Contractor must have sufficient physical, technological, and financial resources to conduct UM services for each lot proposed. The Contractor shall provide sufficient administrative and organizational staff to implement the provisions and requirements of the Contract and for fulfillment of the Contractual obligations.
2. The Contractor will provide sufficient staff to perform the required tasks within performance standards. At a minimum, the Contractor must employ the following key personnel: a) Project Manager; b) Medical/Dental Director; c) Education Manager; and d) Information Systems Manager.
3. 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.
 - a. 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 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.
 - 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) workdays of any temporary or permanent changes to personnel commitments made in the Contractor's proposal or DOM approved staffing plan.

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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. For administrative purposes, the Contractor shall have staff available at their office location during normal business hours. The Contractor’s designated office location shall be in Jackson, Mississippi. Normal business hours are defined as 8:00 a.m. to 5:00 p.m., Monday through Friday, excluding State observed holidays.
9. The Contractor shall maintain a sufficient (as defined by DOM) percentage of clinical review staff who will perform their job function under the resulting Contract in the designated office location. The Contractor must receive DOM approval in order to allow staff to telecommute. DOM reserves the right to approve or disapprove the number of staff allowed to telecommute.
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. Contractor staff availability must be from the hours of 8:00 a.m. to 5:00 p.m., Central Time, Monday through Friday. 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 or by telephone at the request of DOM, at least monthly, to discuss the status of the resulting Contract, Contractor performance, benefits to DOM, necessary revisions, reviews, reports, and planning.
7. DOM may assess liquidated damages in the amount of \$100 per workday for failure to fill key personnel vacancies within 60 days of a vacancy.
8. DOM may assess liquidated damages in the amount of \$100 per workday for failure to notify DOM in writing within five workdays of any temporary and permanent changes to personnel commitments made in the Contractor’s proposal or DOM approved staffing plan.

1.6. Systems Requirements

1.6.1. Management Information System Objectives

1. The Contractor will use available industry technologies to and reduce inefficiencies and errors in UM processes and activities. Such technologies will 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 allow for easier communication with providers.

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2. 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.
3. Many authorization requests are now submitted either through the current contracted 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 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 from DOM's fiscal agent. The Contractor shall work with the fiscal agent on any necessary file transfer changes.
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. DOM's contracted QIO interfaces with DOM's fiscal agent in order to generate a TAN. The Contractor shall generate an unsolicited 278 (U278) Transaction to the DOM's MMIS with the result of the authorization request.

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8. The Contractor shall have the ability to report the review status of a authorization request, the result of the authorization request, and the reason for the denial if the authorization request as 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 also have the capability to accept supporting documentation for prior authorization requests via facsimile transmission or via electronic upload through the Web based system. Where required in Section 1.0, Scope of Work, the Contractor shall develop and maintain a Web-based system for all prior authorization review activity. The Contractor shall establish, during the Implementation Period, a Web-based, electronic review request system accessible to providers and DOM staff, through which providers may submit requests and view certification.
2. The Contractor shall either design and develop a Web-based, electronic review request system, or customize its existing Web-based product, and implement it using thin-client architecture executed solely within the framework of a Web browser and based on guidance and input by DOM. The Contractor shall operate and maintain all components for the Web-based, electronic review request system, including hosting servers and services.
3. The Contractor's Web-based, electronic review request system shall include the ability for users to access the Web-based, electronic review request system via a secured logon, using a logon mechanism to provide users appropriate access to the data.
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 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 using a Health Insurance Portability and Accountability Act (HIPAA) 278 Transaction, for the 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 accept HIPAA-compliant attachment 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

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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 certification. 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 prior authorization 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 prior 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 and the equipment required 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 programs (at no additional cost to DOM.)
5. Upon DOM’s request, the Contractor shall make data samples available to DOM or its designee. 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. This data may be used for ad hoc reporting, program monitoring, and quality assurance activities by DOM. The Contractor shall provide the data in a format prescribed by DOM.

1.6.5. Other System Requirements

1. The Contractor shall have facsimile and scanning capability, 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.

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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 comply with HIPAA.
5. The Contractor shall have protocols and internal procedures for ensuring system security and the confidentiality of recipient identifiable data.
6. Administrative terminal functionality shall include multi-level access controls to ensure that only authorized individuals can process transactions or access recipient information. The Contractor shall provide administrative terminal support through a browser based administrative terminal that conforms to DOM communications 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 systems, provide prompt, on-going system support and accurate data access to DOM and its authorized agents and service providers. The Contractor shall have in-house MIS capability and may not subcontract for this function.

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 a prior authorization request 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.
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 calendar (30) days to provide a cost analysis of the changes and a timeline for completing the changes. If the Contractor's response is

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accepted by DOM, the change or modification shall be reduced to writing in an amendment to the resulting Contract.

1.7. Reporting Requirements

1. The Contractor shall provide DOM with written reports that are clear, concise, and useful for the audience for whom they are intended. The reports shall be composed in a manner consistent with DOM specifications and with the Contractor's stated criteria. All reports shall be provided in electronic formats compatible with software applications in use by DOM (i.e., MS WORD, Excel, etc.), as well as in hard copy, as specified by DOM. Where required, the Contractor shall provide supporting documents such as report appendices.
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 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 Certification, Continued Stay Workload, and Timeliness Summary per Review Type;
 - c. Monthly Retrospective Workload and Timeliness 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; and
 - h. Quarterly Report of All Activity Relating to Provider Non Compliance.
3. The Contractor must provide these reports due on or before the fifth (5th) workday of the month following the report period, unless otherwise agreed to by DOM.
4. 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:

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- 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 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 timeframes.
5. 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.
9. DOM may assess liquidated damages in the amount of \$100 per workday per deliverable for each day a deliverable is unavailable or unacceptable.

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 are to: 1) continuously improve the quality and safety of care and service provided to beneficiaries; 2) establish standards and performance goals for the delivery of care and service; 3) measure performance against the standards with a post utilization review program; and 4) take actions to improve performance.
2. The Contractor shall have a written program which outlines the program structure and accountability and includes, at a minimum:

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- a. Quality of care review process that is in accordance with local and national standards and approved 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 by DOM;
 - c. Procedures to perform a minimum five percent sample of all certifications and reviews performed by the Contractor, unless otherwise instructed by DOM;
 - d. Procedures for quality of care problems to be reviewed and confirmed by a physician in same specialty as the treating physician;
 - e. Procedures for applying and monitoring interventions for aberrant 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) workday 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 30 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,
 - understanding and adherence to the entire review process with required timeframes, 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.

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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 on the Contractor's location. All other medical records must be made available and retrievable within three (3) workdays for review at the request of DOM.
 - 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 expiration of 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 office at all reasonable times at no cost to DOM.
 - e. The Contractor must document and maintain policies and procedures to ensure privacy in accordance with all HIPAA regulations.

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- 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.

1.8.4. Failure to Meet Performance Standards

1. DOM may assess liquidated damages in the amount of \$5,000 per month for failure to implement and manage a continuous quality improvement program for each type review performed by the Contractor.
2. For failure to timely submit a DOM approved Corrective Action Plan (CAP), DOM may assess liquidated damages in the amount of \$500 per workday until the CAP is submitted.
3. For failure to successfully carry out a DOM approved CAP within the timeframes outlined in the CAP, DOM may assess \$500 per workday until the CAP is completed.

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. It is anticipated that Implementation may begin as early as November 1, 2013.

1. The Contractor shall create comprehensive plans, with DOM approval, prior to undertaking all facets of the development and implementation of the Contract. The work plan 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 in addition to a back-up and disaster recovery plan.
2. The Contractor shall submit a written report of program progress at a frequency to be determined by DOM. 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.
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

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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.

1.9.2. Operations Phase

1. Upon commencing the operations phase, the Contractor must fully capable and prepared to perform the responsibilities described in this RFP. It is expected that operations phase can begin as early as January 1, 2013. Dental services UM (LOT C) must be operational by January 1, 2013. UM for Acute and Ancillary Services (LOT A) and Behavioral Health (LOT B) must be fully operational no later than June 1, 2013. UM for Advanced Imaging (LOT D) must be fully operational no later than July 1, 2013.
2. The Contractor is subject to monitoring and evaluation by DOM as set forth in 42 CFR 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 the timeframe specified by DOM. Time lines for turnover activities will be specified by DOM.

1.9.4. Failure to Implement

1. If the Contractor awarded Lot A for acute and ancillary services utilization management does not meet the operational start date of June 1, 2013, the Contractor shall pay to DOM liquidated damages in the amount of \$1,000 per calendar day from June 1, 2013, until the Contractor becomes fully operational.
2. If the Contractor awarded Lot B for behavioral health utilization management does not meet the operational start date of June 1, 2013, the Contractor shall pay to DOM liquidated damages in the amount of \$1,000 per calendar day from June 1, 2013, until the Contractor becomes fully operational.
3. If the Contractor awarded Lot C for dental services utilization management does not meet the operational start date of January 1, 2013, the Contractor shall pay to DOM liquidated damages in the amount of \$1,000 per calendar day from January 1, 2013, until the Contractor becomes fully operational.

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4. If the Contractor awarded Lot D for advanced imaging utilization management does not meet the operational start date of July 1, 2013, the Contractor shall pay to DOM liquidated damages in the amount of \$1,000 per calendar day from July 1, 2013, until the Contractor becomes fully operational.

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 Budget Summaries (Appendices A – D). The payment schedule, based on milestones and deliverables, will be determined within 30 days of the contract signing. The total bid price for implementation must be entered in the appropriate block of Appendices A – D.

1.10.2. Operations Price

The Contractor shall be paid monthly in accordance with the Contractor's bid price proposal set forth in Budget Summaries (Appendices A – D), which shall be 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 unless amended by DOM based on increased review volume.

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 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 30 days

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following the notice. If payment is not made within 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 and its officers and employees 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.

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.”

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 10 years.
2. The Offeror must have experience in contractual services providing the type of services described in this RFP.
3. The Offeror must be able to provide all required components for each lot bid as detailed in the Scope of Work.

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 parts: 1) a Technical Proposal; and 2) a Business Proposal. Format and content requirements for each part are specified in Sections 5 and 6, respectively, 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

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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 and RFP Questions and Answers (following official written release) will be posted on the bids/proposals page of DOM's Website at www.medicaid.ms.gov/bids.aspx.

Information concerning services covered by Mississippi Medicaid and a description of DOM's organization and functions can also be found on the bids/proposals page of DOM's Website.

DOM's Website is <http://www.medicaid.ms.gov>. The Website 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://merlin.state.ms.us> under the Public Access query section.

The State of Mississippi portal is <http://www.mississippi.gov>.

Regulations of the State Personnel Board/Personal Services Contract Review Board can be found at <http://www.mspb.ms.gov>.

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3. PROCUREMENT

3.1. Approach

It is the intent of the procurement process to ensure the fair and equitable treatment of all persons and Offerors. The procurement process provides for the evaluation of proposals and selection of the winning proposal in accordance with federal law and regulations and State law and regulations. Specifically, the procurement process and resulting contract are governed by the applicable provisions of the State Personal Service Contract Review Board Regulations, which is available for inspection at 210 East Capitol Street, Suite 800, Jackson, Mississippi or on the Internet at www.spb.state.ms.us.

Separate Technical Proposals and Business Proposals must be submitted simultaneously but will be opened at different stages of the evaluation process. First, the Technical Proposals will be thoroughly evaluated in order to determine point scores for each evaluation factor. Following the complete evaluation of Technical Proposals, Business Proposals from responsive offerors will be evaluated. 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 Offerors

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, including 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. 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: 1) carry out the obligations of the Contract; 2) complete the work; or 3) furnish the items contemplated.

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The State of Mississippi reserves the right to: 1) reject any and all proposals; 2) request and evaluate “best and final offers” from some or all of the respondents 3) negotiate with the best proposed offer to address issues other than those described in the proposal 4) award the Contract to other than the low cost Offeror; or 5) not make any award, if it is determined to be in the best interest of the State to do so.

Discussions may be conducted with Offerors that submit proposals determined to be reasonably susceptible of being selected for award. Proposals may also be accepted without such discussions.

3.3. Rules of Procurement

To facilitate DOM’s procurement process, 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 a 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, Melanie Wakeland.

For violation of this provision, DOM shall reserve the right to reject any proposal.

3.3.2. Amendments

DOM reserves the right to amend this RFP at any time prior to the date for proposal submission. All amendments will be posted to DOM’s Website at <http://www.medicaid.ms.gov>. After July 20, 2012, Offerors submitting letters of intent will be notified when amendments are released.

Offerors shall acknowledge receipt of any amendment to the solicitation by signing and returning the amendment with the proposals, identifying the amendment number and date by letter. The acknowledgments 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 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 will be the responsibility of the Offerors and will in no way be billable to DOM. If site visits are made, DOM’s cost for such visits will be the responsibility of DOM and the Offeror’s cost will be the responsibility of the Offeror and will 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 any consultation, communication, or agreement with any other Offeror or competitor.

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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 vendor without negotiation.

All proposals properly submitted will be accepted by DOM. However, DOM reserves the right to request necessary amendments from all Offerors, reject any or all proposals received, or cancel this RFP, according to the best interest of DOM or the State of Mississippi. DOM also reserves the right to waive minor irregularities in proposals, providing such action is in the best interest of DOM or the State of Mississippi.

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 firm fixed-price Contract to the Offeror whose offer is responsive to the solicitation and is most advantageous to DOM and the State of Mississippi in price, quality, and other factors considered. DOM reserves the right to make the Contract award to an Offeror other than the Offeror bidding the lowest price when it can be demonstrated to the satisfaction of DOM, the Governor, the State Personal Service Contract Review Board, and to CMS, if necessary, that award to the low Offeror would not be in the best interest of DOM and the State of Mississippi.

3.3.6. Rejection of Proposals

Proposals 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:

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. An authorized representative of the party does not sign the proposal;
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 Services Contract Review Board Regulations;
7. The proposal ultimately fails to meet the announced requirements of the State of Mississippi in some material aspect;

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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 procedures for delivery of the proposal as set forth in the RFP; and/or
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 will result in the summary rejection of all proposals submitted.

An Offeror's proposal shall not include variable or multiple pricing options except as permitted in Section 6.3 of this RFP.

3.3.8. Proposal Amendments and Withdrawal

Prior to the proposal due date, a submitted proposal may be withdrawn by submitting a written request for its withdrawal to DOM, signed by the Offeror.

An Offeror may submit an amended proposal before the due date for receipt of proposals. Such amended 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 amendments, revisions, or alterations to proposals will be accepted after the proposal due date.

Any submitted proposal shall remain a valid proposal for 180 days from the proposal due date.

3.3.9. Disposition of Proposals

The proposal submitted by the selected vendor 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. DOM will have the right to use all concepts contained in any proposal and this right will not affect the solicitation or rejection of the proposal.

3.3.10. Responsible Contractor

DOM shall contract only with a responsible vendor that possesses the ability to perform successfully under the terms and conditions of the proposed procurement and implementation. In letting the Contract,

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consideration shall be given to such matters as the selected vendor'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 of Mississippi's best interest to conduct additional discussions or change the State's requirements and require submission of best and final offers from any Offeror. The Procurement Officer shall establish a date and time for any additional discussions or the submission of best and final offers. Otherwise, no discussion of or changes to the proposals shall be allowed prior to award of the Contract. Offerors shall also be informed that if they do not submit a notice of withdrawal or another best and final offer, the Offeror's immediate previous offer will be construed as their best and final offer.

3.4. State Approval

Approval from the State Personal Services Contract Review Board must be received before Contract signing. Every effort will be made by DOM to facilitate rapid approval and an early start date.

3.5. Intent to Award Notice

The notice of intended Contract award shall be sent by mail, email or fax first to the successful Offeror, and after acceptance of the award by the successful Offeror, to all remaining Offerors.

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.

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 request for proposals (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. In the event that an issue is addressed in one document that is not addressed in another document, no conflict in language shall be deemed to occur.

However, DOM reserves the right to clarify any Contractual relationship in writing, and such written clarification shall govern in case of conflict or ambiguity with the applicable requirements stated in the RFP or the Contractor's proposal. In all other matters not affected by the written clarification, if any, the RFP and its amendments shall govern.

The Contract shall be governed by the applicable provisions of the Personal Service Contract Review Board Regulations, a copy of which is available for inspection at 210 East Capitol St., Suite 800 Jackson, Mississippi or on the web at www.spb.state.ms.us.

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

Division of Medicaid: Executive Director

4.2. Performance Standards, Actual Damages, Liquidated Damages, and Retainage

DOM reserves the right to assess actual or liquidated damages, upon the Contractor's failure to provide timely services required pursuant to this Contract. Actual or liquidated damages for failure to meet specific performance standards as set forth in the scope of work may be assessed as specifically set forth in each performance standard. The Contractor shall be given 15 days notice to respond before DOM makes the assessment. The assessments will be offset against the subsequent monthly payments to the Contractor. Assessment of any actual or liquidated damages does not waive any other remedies available to DOM.

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pursuant to this Contract or state or 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.

4.3. Term of Contract

DOM will award a Contract based on proposals. The Contract period begins November 1, 2012, and shall terminate on December 31, 2015. DOM may have, under the same terms and conditions as the existing Contract, an option for up to a one-year extension, provided DOM obtains approval from the Personal Services Contract Review Board to allow an extension period.

4.3.1. Stop Work Order

1. Order to Stop Work - 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 an extension. 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 allowable to the work covered by the order during the period of work stoppage. Before the stop work order expires, or within an extension to which the parties shall have agreed, the 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 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, only if

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- a. The stop work order or extension 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 30 days after the end of the stop work order or extension.

3. Termination of Work - If a stop work order or extension is not canceled and the work covered by such stop work order or extension is terminated for default or convenience, adjustment to the Contract price will 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, or liquidation; or
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

DOM may immediately terminate this Contract in whole or in part whenever DOM determines that the Contractor has failed to satisfactorily perform its Contractual duties and responsibilities and is unable to resolve such failure within a period of time specified by DOM, after considering the gravity and nature of the default. Such termination shall be referred to herein as "Termination for Default."

Upon determination by DOM of any such failure to satisfactorily perform its Contractual duties and responsibilities, DOM may notify the Contractor of the failure and establish a reasonable time period in which to resolve such failure. If the Contractor does not resolve the failure within the specified time period, DOM will notify the Contractor that the Contract in full or in part has been terminated for default. Such notices shall be in writing and delivered to the Contractor by certified mail, return receipt requested, or in person.

If, after Notice of Termination for default, it is determined that the Contractor was not in default or that the Contractor's failure to perform or make progress in performance was due to causes beyond the control and without error or negligence on the part of the Contractor or any subcontractor, the Notice of Termination shall be deemed to have been issued as a termination for the convenience of DOM, and the rights and obligations of the parties shall be governed accordingly.

In the event of Termination for Default, in full or in part as provided by this clause, DOM may procure, upon such terms and in such manner as DOM may deem appropriate, supplies or services similar to those

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terminated, and the Contractor shall be liable to DOM for any excess costs for such similar supplies or services for the remainder of the Contract period. In addition, the Contractor shall be liable to DOM for administrative costs incurred by DOM in procuring such similar supplies or services.

In the event of a termination for default, the Contractor shall be paid for those deliverables which the Contractor has delivered to DOM. Payments for completed deliverables delivered to and accepted by DOM shall be at the Contract price.

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 the Contract.

4.3.2.2 Termination for Convenience

DOM may terminate performance of work under the Contract in whole or in part whenever for any reason DOM shall determine that such termination is in the best interest of DOM.

In the event that DOM elects to terminate the Contract pursuant to this provision, it shall notify the Contractor by certified mail, return receipt requested, or delivered in person. Termination shall be effective as of the close of business on the date specified in the notice, which shall be at least 30 days from the date of receipt of the notice by the Contractor.

Upon receipt of Notice of Termination for convenience, the Contractor shall be paid the following:

- The Contract price(s) for completed deliverables delivered to and accepted by DOM;
- A price commensurate with the actual cost of performance for partially completed deliverables.

4.3.2.3 Termination for the Contractor Bankruptcy

In the event that the Contractor shall cease conducting business in the normal course, become insolvent, make a general assignment for the benefit of creditors, suffer or permit the appointment of a receiver for its business or its assets, or shall avail itself of, or become subject to, any proceeding under the Federal Bankruptcy Act or any other statute of any state relating to insolvency or the protection of the rights of creditors, DOM may, at its option, terminate this Contract in whole or in part.

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.

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4.3.2.4 Availability of Funds

It is expressly understood and agreed that the obligation of DOM to proceed under this agreement 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 agreement are, at any time, not forthcoming or insufficient, either through the failure of the federal government to provide or 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 the State, the State shall have the right upon 10 working days written notice to the Contractor, to terminate this agreement without damage, penalty, cost, or expense to the State 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

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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 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 3.9.6) 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 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. 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

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.

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 conflicts 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.

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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
Contractor
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

8. Face to face interviews will be required before denial of a request in a range near the established threshold.

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.

Contractor's may proposed to subcontract services under the resulting Contract, but no portion of the services to be performed under the Contract shall be subcontracted 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.

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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 Contractor 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, The Department of Health and Human Services (DHHS), The Centers for Medicare and Medicaid Services (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 Contractors 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 independently 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

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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 must bind separately those provisions of the proposal which contain trade secrets or other proprietary data which they believe may remain confidential in accordance with Sections 25-61-9 and 79-23-1, et seq. of the Mississippi Code Annotated of 1972, as amended.

4.7.4. Right of Inspection

DOM, the Mississippi Department of Audit, The Department of Health and Human Services (DHHS), The Centers for Medicare and Medicaid Services (CMS), the Office of Inspector General (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 must 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. The Contractor has no liability when such claim is solely and exclusively due to the combination, operation or use of any article supplied hereunder with equipment or data not supplied by the Contractor or is based solely and exclusively upon DOM's alteration of the article. 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 is 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.

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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) workdays 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 five (5) years thereafter, unless an audit is in progress. When an audit is in progress or audit findings are unresolved, records shall be kept for a period of five (5) years or until all issues are finally resolved, whichever is later.

4.8. Representation Regarding Contingent Fees

The Contractor represents by executing this Contract 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 Contractor's bid or proposal.

4.9. Interpretations / Changes / Disputes

In the event of a conflict in language among any of the components of the Contract, the RFP shall govern. 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.

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4.9.2. Waiver

No covenant, condition, duty, obligation, or undertaking contained in or made a part of this Contract will be waived except by the written agreement of the parties, and forbearance or indulgence in any other form or manner by either party in any regard whatsoever shall not constitute a waiver of the covenant, condition, duty, obligation, or undertaking to be kept, performed, or discharged by the party to which the same may apply; and until complete performance or satisfaction of all such covenants, conditions, duties, obligations, and undertakings, the other party shall have the right to invoke any remedy available under law or equity, notwithstanding any such forbearance or indulgence.

4.9.3. Contract Variations

If any provision of the Contract (including items incorporated by reference) is declared or found to be illegal, unenforceable, or void, then both DOM and the Contractor shall be relieved of all obligations arising under such provision; if the remainder of the Contract is capable of performance, it shall not be affected by such declaration or funding and shall be fully performed.

4.9.4. Headings

The headings used throughout the Contract are for convenience only and shall not be resorted to for interpretation of the Contract.

4.9.5. 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 Dispute Clause of this Contract. Nothing in this case, 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 Section. Nothing in this clause shall in any manner excuse the Contractor from proceeding diligently with the Contract as changed.

The rate of payment for changes or amendments completed per Contract year shall be at the rates specified by the Contractor's proposal.

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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.

4.9.6. 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 unless within thirty (30) days from the date of receipt of such copy, the Contractor mails or otherwise furnishes to the Attorney General a written request to render an interpretation addressed to the Office of the Attorney General, 550 High St., Suite 1200, Jackson, Mississippi 39205. The interpretation of the Attorney General or his duly authorized representative shall be final and conclusive. The Contractor and DOM shall be afforded an opportunity to be heard and to offer evidence in support of their interpretations. Nothing in this paragraph shall be construed to relieve the Contractor of full and diligent performance of the Contract.

4.9.7. 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.

4.9.8. Attorney Fees

The Contractor agrees to pay reasonable attorney fees incurred by the State of Mississippi and DOM in enforcing this agreement 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.

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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 reasonable 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

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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.

4.11. 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 the Division of Medicaid except within the confines of its role as a Contractor for the Division of Medicaid. DOM's approval must be received in all instances in which the Contractor distributes publications, presents seminars, presents workshops, or performs any other outreach.

The Contractor shall not use DOM's name or refer to the Contract 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

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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 to employment by the Contractor of immediate family members of Medicaid providers.

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 must agree to 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

The Contractor shall not discriminate against any employee or applicant for employment because of race, color, religion, gender, national origin, age, marital status, political affiliations, or disability. The Contractor must act affirmatively to ensure that employees, as well as applicants for employment, are

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treated without discrimination because of their race, color, religion, gender, national origin, age, marital status, political affiliation, or disability.

Such action shall include, but is not limited to the following: employment, promotion, demotion or transfer, recruitment or recruitment advertising, layoff or termination, rates of pay or other forms of compensation, and selection for training, including apprenticeship. 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, religion, sex, national origin, age, marital status, political affiliation, or disability, 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 the Mississippi Human Rights Act of 1977.

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. 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:

4.13.1. Workers' Compensation

The Contractor shall take out and maintain, during the life of this Contract, workers' compensation insurance for all employees employed at the project 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

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Statute, the Contractor shall provide adequate insurance satisfactory for protection of his or her employees not otherwise protected.

4.13.2. 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.

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. The Contractor shall furnish to DOM certificates evidencing such insurance is in effect on the first working day following Contract signing.

4.14. Confidentiality of Information

4.14.1. 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/her attorney, or his/her responsible parent or guardian/representative, 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 notify DOM promptly of any unauthorized possession, use, knowledge, or attempt thereof, of DOM's data files or other confidential information. The Contractor shall promptly furnish DOM full details of the attempted unauthorized possession, use, or knowledge, and assist in investigating or preventing the recurrence thereof.

4.14.2. Confidentiality of Proposals and Contract Terms

After award of the Contract, all Offeror's proposals, including those terms bid in the Business Proposal, are subject to disclosure under the State's Access to Public Records Act and the Federal Freedom of Information Act. Information specified by an Offeror as proprietary information shall be available for disclosure as provided by State statute.

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In the event that either party to this agreement 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 this agreement. The parties agree that this provision is subject to and superseded by Miss. Code Ann. Section 25-61-1, et seq. regarding Public Access to Public Records.

4.15. The Contractor Compliance Issues

The Contractor agrees that all work performed as part of this Contract will 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.

4.15.1. 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.

4.15.2. 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.

4.15.3. HIPAA Compliance

The Contractor must ensure that all work supports the HIPAA Security Rules and sign a HIPAA Business Associate Agreement (Exhibit 3).

4.15.4. 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.

4.15.5. Environmental Protection

The Contractor shall be in compliance with all applicable standards, orders, or requirements issued under Section 306 of the Clean Air Act (45 USC 1857 [h]), Section 508 of the Clean Water Act (33 USC 1368), Executive Order 11738, and Environmental Protection Agency regulation (40 CFR Part 15) which

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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 U. S. EPA Assistant Administrator for Enforcement.

4.15.6. 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 Title 31, Section 1352, U.S. Code. 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.

4.15.7. 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 Contractor represents that it has not violated, is not violating, and promises that it will not violate the prohibitions against gratuities set forth in Section 6-204 (Gratuities) of the Mississippi Personal Service Contract Procurement Regulations.

4.15.8. 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

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dollars expended to date with such businesses, and the total dollars planned to be contracted for with such businesses on this Contract.

4.15.9. 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.

4.15.10. E-Payment

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 Purchase by Public Bodies," Mississippi Code Annotated § 31-7-301, et seq., which generally provides for payment of undisputed amounts by the agency within forty-five (45) days of receipt of invoice.

4.15.11. Compliance with the Mississippi Employment Protection Act

The Contractor represents and warrants that it will ensure its compliance with the Mississippi Employment Protection Act, Mississippi Code Annotated §§ 71-11-1 and 71-11-3, and will register and participate in the status verification system for all newly hired employees. 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 and, upon request of the State, to provide a copy of each such verification to the State. Contractor further represents and warrants that any person assigned to perform services hereunder meets the employment eligibility requirements of all immigration laws of the State of Mississippi. Contractor understands and agrees that any breach of these warranties may subject Contractor to the following: (a) Termination of this Agreement 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, or (b) 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 (c) Both.

In the event of such termination/cancellation, Contractor would also be liable for any additional costs incurred by the State due to Contract cancellation or loss of license or permit.

The Contractor certifies that it is not suspended or debarred under federal law and regulations or any other state's laws and regulations.

5. TECHNICAL PROPOSAL

5.1. Introduction

All proposals must 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 must be submitted on CD in a single document, Microsoft Word or Adobe Acrobat (.PDF) searchable format.

The Technical Proposal must include the following sections:

1. Transmittal Letter
2. Executive Summary
3. Corporate Background and Experience
4. Project Organization and Staffing
5. Methodology
6. Project Management and Control
7. 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. It shall be included in each Technical Proposal submitted in response to this RFP. The Transmittal Letter should identify all material and enclosures being submitted in response to the RFP. The Transmittal Letter shall also include:

1. A statement indicating that the Offeror is a corporation or other legal entity;
2. A statement confirming that the Contractor is registered to do business in the State of Mississippi and providing their corporate charter number to work in the State of Mississippi, if applicable;
3. A statement that 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;
4. A statement identifying the Offeror's federal tax identification number;

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5. 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;
6. A statement that the Offeror has or has not (select appropriate) retained any person or agency on a percentage, commission, or other contingent arrangement to secure this contract.
7. 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 Mississippi Personal Service Contract Procurement Rules and Regulations;
8. 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, or disability;
9. A statement that no cost or pricing information has been included in this letter or any other part of the technical proposal;
10. A statement identifying by number and date all amendments to this RFP issued by DOM that have been received by the Offeror, including a signed copy of each RFP amendment with each technical proposal. If no amendments have been received, a statement to that effect should be included;
11. A statement that the Offeror has read, understands, and agrees to all provisions of this RFP without reservation;
12. Certification that the Offeror's proposal will be firm and binding for 180 days from the proposal due date;
13. A statement naming any outside firms responsible for writing the proposal;
14. A statement agreeing that the Contractor and all subcontractors will sign the Drug Free Workplace Certificate (Exhibit 1);
15. 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;
16. 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; and
17. All proposals submitted must include a statement that the Offeror presently has no interest and shall not acquire any interest, direct or indirect, that 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.
18. If the proposal deviates from the detailed specifications and requirements of the RFP, the transmittal letter must identify and explain these deviations. DOM reserves the right to reject any proposal containing such deviations or to require modifications before acceptance.

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. A proposed work plan;
2. The staff organizational structure;
3. The key personnel; and
4. A brief discussion of the Offeror's understanding of the Mississippi environment and the Medicaid program requirements.

Also, Offerors may designate those provisions of the proposal that contain trade secrets or other proprietary data that they believe may remain confidential in accordance with Section 25-61-9 and 79-23-1 of the Mississippi Code.

The Executive Summary should be no more than five single-spaced typed pages in length.

5.4. Corporate Background and Experience

The Corporate Background and Experience Section shall include details of the background of the Offeror, its size and resources, details of corporate experience relevant to the proposed Contract, financial statements, and a list of all current or recent Medicaid or related projects. The timeframe to be covered should begin, at a minimum, in January 2008 (or earliest established year if 2008 or later) through present date.

5.4.1. Corporate Background

The details of the background of the corporation, its size, and resources, shall cover:

1. Date established (for a corporation).
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.
10. Professional accreditations pertinent to the services provided by this RFP.

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5.4.2. Financial Statements

Financial statements for the contracting entity shall be provided for each of the last five (5) years, including 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 any additional information to assure itself of an Offeror's financial status.

5.4.3. Corporate Experience

The corporate experience section must provide a narrative identifying if the Offeror is a QIO or QIO-like entity as well as describing the Offeror's experience providing services outlined in this RFP. The Offeror should present the details of its experience for each of the lot(s) proposed in response to the RFP.

A minimum of three (3) corporate references are required for each lot proposed. DOM will check references during the evaluation process. Each reference must 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.

The Offeror must provide for each experience:

1. The client's name;
2. Client references (including phone numbers and email addresses);
3. A description of the work performed;
4. The time period of the contract;
5. The total number of staff hours expended to date on the project;
6. Project personnel requirements;
7. The publicly funded contract cost; and
8. Any contractual termination within the past five (5) years.

5.5. Project Organization and Staffing

The Project Organization and Staffing section shall include: 1) project team organization; 2) charts of proposed personnel and positions; 3) estimates of the staff-hours by major task(s) to be provided by proposed positions; and 4) 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 must submit résumés of all proposed key staff persons identified in Section 1.5 of the RFP, and any 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. Knowledge and 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, and phone numbers of a minimum of three persons who can give information on the individual's experience and competence.

The résumés of proposed managers shall include:

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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 must 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 individual performed, as well as a brief description of the project and the individual's responsibilities.

5.5.3. Responsibilities

This section should discuss the anticipated roles of personnel and subcontractors 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 program and specify how it will improve clinical quality, promote beneficiary and provider satisfaction, and achieve savings for the State. Additional requirements for this section include the following:

1. The description shall encompass the requirements of this RFP applicable to each lot the Offeror has proposed in response to the RFP as outlined in Scope of Work;
2. The section must describe the methodology to accomplishing each requirement applicable to each lot the Offeror has proposed in sufficient detail to demonstrate the Offeror's direction and understanding of this RFP;
3. The section must summarize how State of Mississippi agency staff will be used as resources in this project. It is the State's desire that agency staff be advised of all aspects of the engagement; and
4. The section should include information about past performance results and a plan for evaluating the proposed project.

The Offeror must respond to the requirements for each applicable lot offered.

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 supervise correction of problems. Specific explanation must be provided if solutions vary from one phase to another. This section covers:

1. The Offeror's project management approach;
2. The Offeror's project control approach;
3. The Offeror's manpower and time estimating methods;
4. Proposed sign-off procedures for completion of all deliverables and major activities;
5. The Offeror's proposed management of performance standards, milestones, and/or deliverables;
6. An assessment of project risks and the Offeror's approach to managing them;
7. Anticipated problem areas and the Offeror's approach to management of these areas, including loss of key personnel and loss of technical personnel;
8. The Offeror's internal quality control monitoring;
9. The Offeror's approach to problem identification and resolution;
10. Proposed project status reporting for the Contract, including examples of types of reports; and
11. A proposed approach to DOM's interaction with Contract management staff.

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) working days for DOM approval of each submission or re-submission of each deliverable. 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's 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; and

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6. A schedule for all deliverables providing a minimum of five (5) days review time by DOM.

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 180 days following the proposal due date. Pricing will be considered as a separate criteria of the overall bid package.

Offerors must propose a firm fixed price for each of the requirements contained on the pricing schedules for individual lots offered and a cumulative pricing schedule (Appendices A through D).

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 law, federal regulations, state law, state regulations, state policies, or state 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 coverage in effect on the issuance date of this RFP, unless this RFP is amended in writing to include changes prior to the closing date for receipt of proposals.

6.3. Business Proposal

6.3.1. Business Proposal Content

The Business Proposal shall include only the following:

1. Appendices A through D – A Budget Summary must be completed for each lot offered in accordance with instructions in Section 6.3.2 below.
2. Additional detailed worksheet(s) to sufficiently describe pricing methodology as it pertains to the Contractor Responsibilities and Deliverables as found in Section 1.0 of the RFP.
3. Each pricing schedule must be signed and dated by an authorized corporate official.
4. All proposals submitted by corporations must 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 will be rejected. Proposals that contain any material other than the above will be rejected.

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6.3.2. Business Proposal Instructions

Offerors must complete a Budget Summary for each lot offered in response to this RFP:

1. Offerors bidding on Lot A, Acute and Ancillary Services, must complete Appendix A and submit this Budget Summary with their proposal.
2. Offerors bidding on Lot B, Behavioral Health Services, must complete Appendix B and submit the Budget Summary with their proposal.
3. Offerors bidding on Lot C, Dental Services must complete Appendix C and submit this Budget Summary with their proposal.
4. Offerors bidding on Lot D, Advanced Imaging Services must complete Appendix D and submit this Budget Summary with their proposal.

Each of the Budget Summaries for individual lots must be completed to show proposed pricing that assumed only that specific lot is awarded to the Offeror.

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7. PROPOSAL EVALUATION

7.1. General

An evaluation committee comprised of DOM staff will be established to judge the merits of eligible proposals. The team will be appointed by the Executive Director of DOM and will include members who have extensive experience in the Medicaid program and its UM activities. The team will be responsible for the evaluation of the technical and business proposals. A standard evaluation form will be utilized by the evaluation committee to ensure consistency in evaluation criteria.

7.2. Evaluation of Proposals

A maximum of 1,000 points will be available for each specific lot which shall be comprised of a technical and a business proposal for each specific lot offered. The points awarded per phase by the evaluation committee will be totaled to determine the points awarded per proposal by lot as illustrated below.

Table 18: Total Points Per Proposal By Lot

EVALUATION COMPONENT	MAXIMUM SCORE			
	Lot A Acute & Ancillary	Lot B Behavioral Health	Lot C Dental	Lot D Advanced Imaging
Technical Proposal Evaluation	700	700	700	700
Business/Cost Proposal Evaluation	300	300	300	300
TOTAL	1,000	1,000	1,000	1,000

Evaluation of eligible proposals will be conducted in five 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. Phase Five is the award decision of the Executive Director.

At its option, the State of Mississippi may request an interview from Contractors in a competitive range in the evaluation. Contractors must be prepared to meet with DOM staff within five (5) days of notification. All costs associated with the interview will be the responsibility of the Contractor.

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7.2.1. Phase One - Evaluation of Offerors' Responses to RFP

In this phase, the Procurement Officer reviews each proposal to determine if each proposal is sufficiently 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.

7.2.2. Phase Two - Evaluation of Technical Proposal

Only those proposals that meet the requirements in Phase One will be considered in Phase Two.

Any Technical Proposal that is incomplete or has significant inconsistencies or inaccuracies may be rejected. 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 Technical Proposal to determine if it sufficiently addresses all of the RFP requirements and that the Offeror has developed a specific approach to meeting each requirement.

Technical Proposals may earn up to 700 points for their responses to the requirements of the RFP. The maximum number of points that may be awarded for each lot under the technical evaluation is provided below. Points awarded for Executive Summary, Corporate Background and Experience, and Organization and Staffing sections are applied to each lot under the technical evaluation.

Table 19: Technical Proposal Points by Lot

RFP SECTION	MAXIMUM SCORE			
	Lot A Acute & Ancillary	Lot B Behavioral Health	Lot C Dental	Lot D Advanced Imaging
Executive Summary/Understanding of Project	15	15	15	15
Corporate Background and Experience	55	55	50	50
Organization and Staffing	200	200	200	200
Methodology	310	295	290	290
Project Management	70	70	60	60
Work Plan and Schedule	40	55	85	85
TOTAL	700	700	700	700

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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 the RFP, demonstrates an adequate understanding of the Mississippi environment and the Medicaid program requirements, and is five pages or less in length.

7.2.2.2 Corporate Background and Experience

The Evaluation Committee will evaluate the experience, performance on similar Contracts, resources, and qualifications of the Offeror to provide the services required by the RFP. The evaluation criteria will address:

1. Experience of Offeror in providing the requested services.
2. Corporate experience providing similar services.
3. Amount and level of resources proposed by the Offeror.
4. Specific qualifications that evidence the Offeror's ability to provide the services requested.
5. Current financial position and cash flow of the Offeror and evidence that the Offeror has a history of financial solvency.
6. Any Contract terminations or non-renewals within the past five years.

7.2.2.3 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), timelines, job descriptions including job qualifications, 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.

7.2.2.4 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 protected health information.
4. Processes for development and submission of required deliverables.

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5. Scope of services provided through partnerships or subcontractors.
6. Relevant experience that indicates your organizational qualifications for the performance of the potential Contract.

7.2.2.5 Project Management and Control

The evaluation committee will evaluate the Offeror's Technical Proposal to determine if all of the elements required by Section 5.7 of the RFP are addressed. Specifically, the committee will evaluate:

1. The 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. The 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 that occur;
3. The Offeror's methods for estimating and documenting personnel hours spent by staff on project activities to be sure they are sound and fair;
4. The 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. The Offeror's understand 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 of necessary tasks to meet the Offeror's proposed implementation date.

7.2.3. Oral Presentations

The oral presentation is part of the technical proposal evaluation. If desired by DOM, all Offerors receiving a minimum of 50 percent (350 points) of the total score on the Technical Phase of the evaluation will be given the opportunity to make an oral presentation. 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. Technical proposal evaluations may be adjusted based on information gathered during the oral presentations, if held.

The presentation will occur at a State office location in Jackson, Mississippi. The determination of participants, location, order, and schedule for the presentations is at the sole discretion of DOM and will be provided during the evaluation process. The presentation will include slides, graphics, and other media selected by the Offeror to illustrate the Offeror's Proposal.

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The presentations are tentatively scheduled for August 27 - 31, 2012. The Offeror's presentation team shall include, at a minimum, the proposed Project Manager, Medical Director, and other key management staff necessary to implement the Contract requirements. However, DOM reserves the right to limit the number of participants in the Offeror's presentation. Questions and answers will be recorded and transcribed. DOM reserves the right to limit the time period for the presentation.

7.2.4. Phase Three - Evaluation of Business/Cost Proposal

Proposals must score a minimum of 70 percent (490 points) of the total score on the Technical Phase of the evaluation in order to proceed to the Business/Cost phase of the evaluation. Proposals receiving less than 70 percent will not be considered for the Business/Cost evaluation or Contract award. DOM reserves the right to waive minor variances or reject any or all proposals.

Any bid price 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 300 points will be assigned to the lowest and best acceptable proposal. All other proposals will be assigned points based on the following formula:

$$\frac{X}{Y} * 300 = Z$$

X = lowest bid price

Y = Offeror's bid price

Z = assigned points

7.2.5. Phases 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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Appendices and Exhibits

Appendices:

Appendix A – Lot A, Acute and Ancillary Services, Budget Summary

Appendix B – Lot B, Behavioral Health Services, Budget Summary

Appendix C – Lot C, Dental Services, Budget Summary

Appendix D – Lot D, Advanced Imaging Services, Budget Summary

Exhibits:

Exhibit 1 – DHHS Certification Regarding Drug-Free Workplace Requirements: Grantees Other Than Individuals

Exhibit 2 – DHHS Certification Regarding Debarment, Suspension, and Other Responsibility Matters Primary Covered Transactions

Exhibit 3 – Business Associate Agreement

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Appendix A – Lot A, Acute and Ancillary Services, Budget Summary

Section 6.0 addresses submission of the Budget Summaries. Failure to follow the submittal instructions will immediately disqualify the Offeror.

Lot A Budget Summary Medicaid Utilization Management Programs RFP# 20120629				
Name of Offeror:				
Implementation Phase				
Proposed Implementation Date:		Implementation Cost:		
Operations Phase	1st Year 1/1/13 – 12/31/13	2nd Year 1/1/14 – 12/31/14	3rd Year 1/1/15 – 12/31/15	Total
Prior Authorization Services				
Peer Review Services				
Focused Studies				
Clinical/Medical Consultation				
Coding Validation Audits				
Total:				
TOTAL COST WITH IMPLEMENTATION FEE:				
Offerors may provide additional detailed worksheet(s) to sufficiently describe pricing methodology as it pertains to the Contractor Responsibilities and Deliverables as found in Section 1.0 of the RFP.				
I certify that I am legally obligating the above named Offeror to the conditions of this contract.				
Signature:		Date:		
Printed Name:		Title:		

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Appendix B – Lot A, Behavioral Health Services, Budget Summary

Section 6.0 addresses submission of the Budget Summaries. Failure to follow the submittal instructions will immediately disqualify the Offeror.

Lot B Budget Summary				
Medicaid Utilization Management Programs				
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Name of Offeror:				
Implementation Phase				
Proposed Implementation Date:		Implementation Cost:		
Operations Phase	1st Year 1/1/13 – 12/31/13	2nd Year 1/1/14 – 12/31/14	3rd Year 1/1/15 – 12/31/15	Total
Prior Authorization Services				
Peer Review Services				
Focused Studies				
Clinical/Medical Consultation				
Total:				
TOTAL COST WITH IMPLEMENTATION FEE:				
Offerors may provide additional detailed worksheet(s) to sufficiently describe pricing methodology as it pertains to the Contractor Responsibilities and Deliverables as found in Section 1.0 of the RFP.				
I certify that I am legally obligating the above named Offeror to the conditions of this contract.				
Signature:		Date:		
Printed Name:		Title:		

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Appendix C – Lot C, Dental Services, Budget Summary

Section 6.0 addresses submission of the Budget Summaries. Failure to follow the submittal instructions will immediately disqualify the Offeror.

Lot C Budget Summary Medicaid Utilization Management Programs RFP# 20120629				
Name of Offeror:				
Implementation Phase				
Proposed Implementation Date:		Implementation Cost:		
Operations Phase	1st Year 1/1/13 – 12/31/13	2nd Year 1/1/14 – 12/31/14	3rd Year 1/1/15 – 12/31/15	Total
Prior Authorization Services				
Peer Review Services				
Focused Studies				
Clinical/Medical Consultation				
Total:				
TOTAL COST WITH IMPLEMENTATION FEE:				
Offerors may provide additional detailed worksheet(s) to sufficiently describe pricing methodology as it pertains to the Contractor Responsibilities and Deliverables as found in Section 1.0 of the RFP.				
I certify that I am legally obligating the above named Offeror to the conditions of this contract.				
Signature:		Date:		
Printed Name:		Title:		

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Appendix D – Lot D, Advanced Imaging Services, Budget Summary

Section 6.0 addresses submission of the Budget Summaries. Failure to follow the submittal instructions will immediately disqualify the Offeror.

Lot D Budget Summary				
Medicaid Utilization Management Programs				
RFP# 20120629				
Name of Offeror:				
Implementation Phase				
Proposed Implementation Date:		Implementation Cost:		
Operations Phase	1st Year 1/1/13 – 12/31/13	2nd Year 1/1/14 – 12/31/14	3rd Year 1/1/15 – 12/31/15	Total
Prior Authorization Services				
Peer Review Services				
Focused Studies				
Clinical/Medical Consultation				
Total:				
TOTAL COST WITH IMPLEMENTATION FEE:				
Offerors may provide additional detailed worksheet(s) to sufficiently describe pricing methodology as it pertains to the Contractor Responsibilities and Deliverables as found in Section 1.0 of the RFP.				
I certify that I am legally obligating the above named Offeror to the conditions of this contract.				
Signature:		Date:		
Printed Name:		Title:		

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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 CFR 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 the agency changes during the performance of the grant, the grantee shall inform the agency of the change(s), if it previously identified the workplaces in question (see above).

5) Definitions of terms in the 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 CFR 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 subrecipients 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

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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 the agency 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, Appendix A

(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

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EXHIBIT 3

Business Associate Agreement

This Business Associate Agreement ("Agreement") is entered into between Mississippi Division of Medicaid, a State Agency ("DOM") and **(enter name of Contractor here)**, a corporation qualified to do business in Mississippi ("Business Associate").

I. RECITALS

- a. DOM is a State Agency that acts both as an employer and as a health plan for public benefit with a principal place of business at 550 High Street, Suite 1000, Jackson, MS 39201.
 - b. Business Associate is a corporation qualified to do business in Mississippi that will act to perform consulting services for DOM with a principal place of business at **(enter address of Contractor here)**.
 - c. DOM, as a Covered Entity defined herein under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is required to enter into this Agreement to obtain satisfactory assurances that Business Associate, a Business Associate under HIPAA, will appropriately safeguard all Protected Health Information ("PHI") as defined herein, disclosed, created or received by Business Associate on behalf of, DOM.
 - d. DOM desires to engage Business Associate to perform certain functions for, or on behalf of, DOM involving the disclosure of PHI by DOM to Business Associate, or the creation or use of PHI by Business Associate on behalf of DOM, and Business Associate desires to perform such functions, as set forth in the contracts or agreements which involve the exchange of information, and wholly incorporated herein.
 - e. The terms used in this Agreement shall have the same meaning as those terms in the Privacy Rule.
- In consideration of the mutual promises below and the exchange of information pursuant to this agreement and in order to comply with all legal requirements for the protection of this information, the parties therefore agree as follows:

II. OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE

- a. Business Associate agrees to not use or disclose Protected Health Information other than as permitted or required by this Agreement or as Required by Law.
- b. Business Associate agrees to use appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this Agreement.
- c. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement.
- d. Business Associate agrees to report to DOM any use or disclosure of the Protected Health Information not provided for by this Agreement of which it becomes aware.
- e. Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by Business Associate on behalf of DOM, agrees to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information.
- f. Business Associate agrees to provide access, at the request of DOM, and in the time and manner determined by DOM, to Protected Health Information in a Designated Record Set, to DOM or, as directed by DOM, to an Individual in order to meet the requirements under 45 CFR § 164.524.

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- g. Business Associate agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that DOM directs or agrees to pursuant to 45 CFR § 164.526 at the request of DOM or an Individual.
- h. Business Associate agrees to make internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, and available to DOM, or to the Secretary of the Department of Health and Human Service, in a time and manner designated by the Secretary, for purposes of the Secretary determining DOM's compliance with the Privacy Rule.
- i. Business Associate agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for DOM to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR § 164.528.
- j. Business Associate agrees to provide to DOM or an Individual, an accounting of disclosures of Protected Health Information in accordance with 45 CFR § 164.528.

III. PERMITTED USES AND DISCLOSURES BY BUSINESS ASSOCIATE

General Use and Disclosure Provisions

Refer to underlying agreements and contracts:

Except as otherwise limited in this Agreement, Business Associate may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, DOM as specified in the service agreements and contracts, provided that such use or disclosure would not violate the Privacy Rule if done by DOM or the minimum necessary policies and procedures of DOM.

IV. OBLIGATIONS OF DOM

a. Provisions for DOM to Inform Business Associate of Privacy Practices and Restrictions

- i. DOM shall notify Business Associate of any limitation(s), as set forth in the Notice of Privacy Practices attached hereto as Exhibit "A" and wholly incorporated herein, in accordance with 45 CFR § 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of Protected Health Information.
- ii. DOM shall notify Business Associate of any changes in, or revocation of, permission by Individual to use or disclose Protected Health Information, to the extent that such changes may affect Business Associate's use or disclosure of Protected Health Information.
- iii. DOM shall notify Business Associate of any restriction to the use or disclosure of Protected Health Information that DOM has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of Protected Health Information.

b. Permissible Requests by DOM

DOM shall not request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by DOM.

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V. TERM AND TERMINATION

- a. Term. The Term of this Agreement shall be effective as of the effective date of the agreements and contracts entered into between DOM and Business Associate, and shall terminate when all of the Protected Health Information provided by DOM to Business Associate, or created or received by Business Associate on behalf of DOM, is destroyed. If it is infeasible to destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this Section.
- b. Termination for Cause. Upon DOM's knowledge of a material breach by Business Associate, DOM shall, at its discretion, either:
 - i. Provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Agreement and the associated Contracts or Agreements. If Business Associate does not cure the breach or end the violation within the time specified by DOM; or
 - ii. Immediately terminate this Agreement and the associated Contracts or Agreements if Business Associate has breached a material term of this Agreement and cure is not possible; and
 - iii. In either event, DOM shall report the violation to the Secretary of Health and Human Services as required.
- c. Effect of Termination.
 - i. Except as provided in paragraph (2) of this section, upon termination of this Agreement, for any reason, Business Associate shall destroy all Protected Health Information received from DOM, or created or received by Business Associate on behalf of DOM. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.
 - ii. In the event that Business Associate determines that destroying the Protected Health Information is infeasible, Business Associate shall provide to DOM notification of the conditions that make destruction infeasible. Upon notification in writing that destruction of Protected Health Information is infeasible, Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

VI. MISCELLANEOUS

- a. Regulatory References. A reference in this Agreement to a section in the Privacy Rule means the section as in effect or as amended.
- b. Amendment. The Parties agree to take such action as is necessary to amend this Agreement as is necessary to effectively comply with the terms of any agreements or contracts, or for DOM to comply with the requirements of the Privacy Rule and the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191. Such modifications signed by the parties shall be attached to and become part of this Agreement.
- c. Survival. The respective rights and obligations of Business Associate under the Section, "Effect of Termination" of this Agreement shall survive the termination of this Agreement.
- d. Interpretation. Any ambiguity in this Agreement shall be resolved to permit DOM to comply with the Privacy Rule.
- e. Indemnification. Business Associate will indemnify and hold harmless DOM to this Agreement from and against all claims, losses, liabilities, costs and other expenses incurred as a result of, or arising directly or indirectly out of or in conjunction with:
 - i. Any misrepresentation, breach of warranty or non-fulfillment of any undertaking on the part of the party under this Agreement; and

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- ii. Any claims, demands, awards, judgments, actions and proceedings made by any person or organization arising out of or in any way connected with the performance of the Business Associate under this Agreement.
- f. Business Associate's Compliance with HIPAA. DOM makes no warranty or representation that compliance by Business Associate with this Agreement, HIPAA or the HIPAA regulations will be adequate or satisfactory for Business Associate's own purposes or that any information in Business Associate's possession or control, or transmitted or received by Business Associate, is or will be secure from unauthorized use or disclosure. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI.
- g. Notices. Any notice required to be given pursuant to the terms and provisions of this Agreement shall be in writing and may be either personally delivered or sent by registered or certified mail in the United States Postal Service, Return Receipt Requested, postage prepaid, addressed to each party at the addresses which follow or to such other addresses as the parties may hereinafter designate in writing:

DOM: **Office of the Governor**

Division of Medicaid

550 High Street, Suite 1000

Jackson, MS 39201

Business Associate:

(enter Contractor information here)

Any such notice shall be deemed to have been given, if mailed as provided herein, as of the date mailed.

- h. Change in Law. In the event that there are subsequent changes or clarifications of statutes, regulations or rules relating to Agreement, DOM shall notify Business Associate of any actions it reasonably deems are necessary to comply with such changes, and Business Associate promptly shall take such actions. In the event that there shall be a change in the Federal or State laws, rules or regulations, or any interpretation or any such law, rule, regulation or general instructions which may render any of the material terms of this Agreement unlawful or unenforceable, or materially affects the financial arrangement contained in this Agreement, Business Associate may, by providing advanced written notice, propose an amendment to this Agreement addressing such issues.
- i. Severability. In the event any provision of this Agreement is held to be unenforceable for any reason, the unenforceability thereof shall not affect the remainder of this Agreement, which shall remain in full force and effect and enforceable in accordance with its terms.
- j. Counterparts. This Agreement may be executed in counterparts, any of which is considered to be an original agreement.
- k. Governing Law. This Agreement shall be construed broadly to implement and comply with the requirements relating to the HIPAA laws and regulations. All other aspects of this Agreement shall be governed under the laws of the State of Mississippi.
- l. Assignment/Subcontracting. This Agreement shall inure to the benefit of and be binding upon the parties hereto and their respective legal representatives, successors and assigns. Except as otherwise provided in the contract and any proposal or RFP related thereto and agreed upon between the parties,

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Business Associate may not assign or subcontract the rights or obligations under this Agreement without the express written consent of DOM. DOM may assign its rights and obligations under this Agreement to any successor or affiliated entity.

- m. Entire Agreement. This Agreement contains the entire agreement between parties and supersedes all prior discussions, negotiations and services for like services.
- n. No Third Party Beneficiaries. Nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer, upon any person other than DOM, Business Associate and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.
- o. Assistance in Litigation or Administrative Proceedings. Business Associate shall make itself and any agents, affiliates, subsidiaries, subcontractors or employees assisting Business Associate in the fulfillment of its obligations under this Agreement, available to DOM, at no cost to DOM, to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against DOM, its directors, officers or employees based upon claimed violation of HIPAA, the HIPAA regulations or other laws relating to security and privacy, except where Business Associate or its agents, affiliates, subsidiaries, subcontractors or employees are a named adverse party.

IN WITNESS WHEREOF, the parties hereto have duly executed this agreement to be effective on the date first herein written.

DOM

BUSINESS ASSOCIATE

By: _____

By: _____

Name:

Name:

Title: Executive Director

Title:

Date:

Date: