NM HSD Responses to Questions for BMS RFP #20-630-8000-0002   **430 Questions and Responses**   **October 11, 2019**

Ques. #	RFP SECTION	RFP SECTION TITLE	RFP PAGE	OFFEROR'S QUESTION	HSD'S RESPONSE
1	Appendix G		88	The RFP states that "The benefit plan parameters and rates developed by the Contractor and approved by the State will update the FS claim adjudication Solution…." Does this indicate that the BMS vendor does not need to provide any systems or tools to update Reference type information for claims processing?	No. The BMS Contractor is responsible for storing and maintaining the code set and rate data required to support claim adjudication. The data developed by the Contractor and approved by the State must be stored in the Contractor's Benefit Plan Management Solution, which will be the system of record for all such data. The BMS Contractor will also be expected to work with the FS Contractor to review and verify configuration changes associated with benefit plan updates, although FS staff will be responsible for the configuration itself and the FS claim adjudication system will be the system of record for benefit plans and associated rules. Please see Amendment 2.
2	Appendix G		88	The RFP states that "The benefit plan parameters and rates developed by the Contractor and approved by the State will update the FS claim adjudication Solution…." Does this indicate that the BMS vendor only needs to provide the staff and processes required to make updates, and not the actual technical solution itself?	No. The BMS Contractor is expected to provide the technical solution to fulfill all requirements. See the response to #1 above.
3	Appendix H	Benefit Plan management requirement 4.23	139	The requirement indicates that the vendor services must make updates to rates and all indicators affecting claims processing. Are any systems or tools to be provided by the BMS vendor to do these updates, or are all of these updates done in the system(s) provided by the Financial Services vendor?	The BMS Contractor is expected to provide the technical solution to fulfill all requirements. See the response to #1 above.
4	General			Is the BMS Vendor expected to provide a reference system or other benefit plan system repository?	The BMS Contractor is expected to provide the technical solution to fulfill all requirements. See the response to #1 above.

5	General			What is the estimated cost of the HHS 2020 Medicaid Enterprise Benefit Management Services project?	The State will not provide this information.
6	General			Has the Department allocated funding for the HHS 2020 Medicaid Enterprise Benefit Management Services yet? If so, through which source (budget, CIP, state/federal grant etc.)?	The State has an approved Advanced Planning Document from the Center for Medicare and Medicaid Services (CMS).
7	General			What is the number of users anticipated for the HHS 2020 Medicaid Enterprise Benefit Management Services?	Our estimation is up to 3,500 users.
8	General			Who is the technical contact and/or project manager for the HHS 2020 Medicaid Enterprise Benefit Management Services?	The position is in the process of being filled.
9	I. C.	I.C. Scope of Procurement	12	The term of the contract is 4 base years with (4) 1 year extension options. Does the base term include the DDI or is the DDI in addition to the base term?	The assumption is that the base term includes the DDI and M&O activities necessary to implement and maintain the BMS Module. Proposals should include an associated project plan outlining these activities.
10	II. A. C. and Appdx M	II.A.C & Appendix M	14 & 220	Page 14 indicates that the SI is responsible for data conversion. Appendix M page 220 seems to support that premise. Please confirm.	The State confirms the SI Contractor is responsible for data conversion. However, the State expects the BMS Contractor to participate in all data conversion activities that involves BMS. The BMS Contractor will have to ingest the data into the BMS solution that is provided by the SI Contractor and perform any actions necessary to be able to use that data.
11	Appendix G, 2.2.2	Appendix G, 2.2.2	81	"This process will support providers enrolling in the FFS program and enable enrollment in non-Medicaid programs, interface with each MCO's credentialing and contract process." Please confirm this includes providers of social services such as housing, meals, drug counseling, psychologists, etc.	The current scope of provider enrollment will focus on Medicaid providers as well as other providers from our external partners, however, the BMS Module is expected to be scalable and flexible to include all potential providers of the HHS 2020 Enterprise.
12	Appendix A, 1	Appendix M, 1. Care/Case Management Services and Approach	222	In the Statement of Work, the C/CMS is titled as BPO Services. Please confirm the scope for C/CMS is systems and operations of the systems only, and any process use will be conducted by other Stakeholders.	Please refer to Appendix M, 1.1 on page 223 – Complete BPO Services. The State expects the Contractor to provide tools and operations of those tools, in addition to services that the

					State identifies or services the Contractor offers and recommends to the State.
13	Procurement Library	Procurement Library HHS 2020 Background Information NM HHS and Medicaid	5	90% of New Mexico's Medicaid population is covered by MCO's. The 10% of the population that is eligible for FFS coverage also have chronic health conditions, co-morbidities and require medical and transitional care services. Is the C/CMS expected to support this type of case management functionality in addition to Personal Care Services associated with the FFS and waiver programs?	Yes.
14	Appendix M, 2.2.2	Appendix M, 2.2.2	226	Appendix M, Section 2.2.2 references, "Transition management and coordination between settings, providers and programs". Traditionally transition management means managing care settings that include hospitals, nursing homes, assisted living facilities, skilled nursing facilities, and the home environment. Is this the transitional care management you are requiring?	Yes, Per Section 2.2.1, the RFP references Transition Management. In addition to the items stated, it also includes transition management between providers and programs.
15	Appendix M, 2.2.2	Appendix M, 2.2.2	228	Section 2.2.2 lists all the programs and agencies this solution included in the scope for C/CMS. Is it your expectation the C/CMS will be case managing the members of these individual programs and if yes how many members are in each program (average enrollment per month – unduplicated annual count) and how many other members are expected in the 'not limited to category'?	The C/CMS will be the tool used to case manage participants in these individual programs. The following information is available. **ALTSD** • Ombudsman: 916 per month/11,001 per year • Consumer & Elder Rights Division (CERD) programs – 611 per month/7,341 per years • Adult Protective Services – 3,333 per month/40,000 per yea • Office of Indian Elder Affairs – 3,500 per month/42,000 per year • Community Benefit Central Registry – 16,700 total **CYFD** • Behavioral Health Services – 2,500 in FY19 • Juvenile Justice – 10,2999 referrals in FY19

					• Protective Services – 907 foster care entries in FY19 and 4,373 subsidized adoptions **DOH** • DD Waiver – 3,183 as of June 2019 • Mi Via Waiver – 1,580 as of June 2019 • Supports Waiver (new) – 2,000 per year until everyone on the wait list has been allocated to the DD or Mi Via waiver • Family Infant Toddler – 14,000 served in FY19Medically Fragile Waiver - - 256 as of June 256 • Waiting List – 5,030 as of April 2019
16	Appendix M, 2.2.2	Appendix M, 2.2.2	228	For the programs defined in this section, are there existing systems in place? If so, please provide the systems, or identify if they are manual processes.	ALTSD uses WellSky Human Services, Wellsky Aging & Disability, and OmbudManager. CYFD uses the FACTS system, SARA, ADE, and EPICS. DOH uses Therap, UNM CDD, FOCoS, JIVA TPA system, and Central Registry. HSD uses FOCoS for Mi Via and Falling Colors' BHSDStar for administration of non-Medicaid behavioral health services.
17	Appendix M, 2.2.2	Appendix M, 2.2.2	228	Are you expecting each of the 20 programs to be converted during the 20 month implementation window, described in MMISR E2E 8-21-19 V7.2, in to the new C/CMS?	No. All HSD programs, including all Medicaid functions, will be the first to be implemented. The other participating Enterprise programs will follow.
18	General	General		Please confirm all claims processing for Medicaid and non-Medicaid and Social Services programs will be made in third party systems like MCO's, Financial Services, etc. and not as an extension of any of the case management systems.	Confirmed.
19	2.2.1	C/CMS Minimum functionality: A.	226	Electronic submission of required documents; - Please confirm the purpose of this requirement is to allow for electronic upload of documents into the C/CMS?	Confirmed.
20	2.2.1	C/CMS Minimum functionality: A.	226	Budget creation, management, monitoring and reporting.	The State expects the C/CMS to provide the functionality for budget creation, management,

				- Please provide clarification on the budget creation requirements. Is the intention the system be leveraged as a case management flow for budgeting process?	monitoring and reporting for programs that are listed within the RFP and future programs that are added.
21	9.3	Location Requirements	242	9.3 Logistical Requirements The State requires that the C/CMS Contractor maintain a physical site located within seventy-five (75) miles of Santa Fe, New Mexico. At a minimum, staff in this location shall include the Project Manager and staff supporting customer service functions, and coordination with other BPO module Contractors. The final location of the Contractor's New Mexico facility must be approved by the State. - Would HSD make an exception to the need for location requirements within the 75 mile proximity for the customer service functions considering that the C/CMS solution is predominately a SaaS solution - Please confirm for the C/CMS Customer Service that this implies [applies] to the HelpDesk and Administration functions within the scope of work.	 No. Yes.
22	9.3	Location Requirements Work Hours and HSD Broadband Connection	242	The Contractor must request, and the State shall provide at Contractor's expense a broadband circuit to the Contractor, enabling connectivity to the HSD network. - If this is a hosted solution, how would a broadband circuit be leveraged?	This requirement has been revised in Amendment 2.
23	10.1	Training Plan		How many concurrent users are expected to be leveraging the C/CMS?	There may be as many as 3,000 users of the C/CMS system (approximate and subject to change), and it is not known how many will use the system concurrently.
24	Appendix N, 12.08	12.08	273	Offeror shall describe how its proposed Solution reduces false-positive results based on previous results.	Amendment 2 deleted this requirement.

				- Please provide additional context/clarity on what false-positive results may be referenced. Unable to identify results in Addendum 25 or references within the RFP.	
25	Appendix N, 12.019	12.019	274	Offeror shall describe how its proposed Solution provides qualitative analytics. - Was NM intending to reference "quantitative" versus "qualitative", monitoring the volume of cases and transactions among the cases.	No. The State expects the BMS Contractor to provide data to the DS Contractor to assist in qualitative analytics for the BMS module.
26	Appendix N, 12.019	12.019	274	Offeror shall describe how its proposed Solution provides qualitative analytics -Are the analytics referenced related to the contract performance/SLAs?	No.
27	Appendix N, 12.041	12.041	276	Offeror shall describe how its proposed Solution performs check-digit verification on any data item that contains a self-checking digit. - Please define/clarify the circumstances where a check-digit would be required? - Would check-digit also relate to physical records included with a bar code?	Amendment 2 deleted this requirement.
28	Appendix O, 16-22	16-22	285	The Care/Case Management Contractor shall ensure that incoming calls receiving a blocked call (busy signal) does not exceed 1.25 percent for both the Care/Case Management call center and help desk, to be computed daily and, at a minimum, reported monthly and notify the Enterprise when the SLA is not met. - Please clarify if the "call center" was an incidental reference from the BMS portion carried over, considering this scope of work was it intended to reference the help desk functionality.	The reference to "call center" and "help desk" is intentionally left vague for the State didn't know what vendors call the department(s) that provides help and resolves inquiries from various individual types and/or organizations.
29	Appendix O, 18	18	285	The Care/Case Management Contractor shall not exceed one percent of daily unresolved calls past one	The C/CMS Help Desk is responsible to quickly resolve inquiries even for software/technically focused issues.

				week, to be computed on a weekly basis and, at a minimum, reported monthly. - Typically these would all be solutions associated within the Member & Provider scopes of BMS. As a C/CMS system is primary software/technically focused, should this be related to Help Desk support?	
30	Appendix M, 10.048	10.048	261	Offeror shall describe how its proposed Solution provides eligibility management and enrollment for Family, Infants and Toddlers (FIT), State General Fund (SGF), Programs of All-Inclusive Care for the Elderly (PACE), ICF/IID and PASRR, including at a minimum: - Considering the eligibility system would monitor and track the progression of member eligibility, would this not be more appropriate within the module? As this would result in duplicative task and multiple systems of records.	The State intends to use the Care/Case Management Solution to determine eligibility for some non-Medicaid Stakeholder programs, in addition to using the system for case management of the participants eligible for those programs. Those include some of the programs listed in requirement 10.048 and others that may be identified in the future.
31	D.2.a	Response Format and Organization	42-43	Page 42 states: a. Binder 1: one (1) original and one (1) identical hard copy of their Technical proposal and required additional forms and material and twelve (12) electronic versions. Acceptable formats for the electronic version of the proposal are Microsoft Word, Excel and PDF. Page 43: In addition, the entire proposal including all materials in Binder 1 (not Binder 2) shall be submitted on a single CD. Contents of Binder 2 must be submitted on a separate CD. Please confirm the number of CDs requested for both Binder 1 and Binder 2. Does the State require 1 copy of each or 12?	See Amendment 2 for revised Response Format and Organization requirements.
32	Procurement Library			The diagram reflects "BMS provides a software package that acts as an EMR for smaller physician practices" as part of BMS solution yet this doesn't seem to be in the	Addendum 6 has been updated, as this functionality is no longer in scope for BMS.

				RFP requirements. Please clarify whether this is an oversight or provide specifics on requirements.	
33	Throughout			We noticed that the Sample Contract contains several alternative "Choice" clauses. Will HSD please confirm that these clauses will be mutually agreed upon between the Offeror and the Procuring Agency during contract negotiations?	Yes.
34	Throughout			Will HSD please confirm the Offeror will have the opportunity to negotiate intellectual property terms (including without limitation ownership, licensing, source code, and escrow terms (if applicable)) to ensure that they are appropriate for the Offeror's proposed solution (e.g. COTS, SaaS, etc.)?	Confirmed. The Offeror will have the opportunity to negotiate intellectual property terms.
35	V. MMISR Procurement Library		25	Would the State please confirm that the MMISR E2E Timeline (v.7.2) reflects the dates the offeror should use for the BMS proposal and pricing unless the State issues an official RFP Amendment?	Confirmed. The MMISR E2E Timeline (v.7.2) is a high-level project timeline.
36	Table 2 – Sequence of Events		27	The Sequence of Events shows a Contract Award date of April 1, 2020. Would the state please clarify when Project Start would take place, assuming all prior events execute as scheduled?	At contract execution.
37	Section VI (Conditions Governing the Procurement), item C (General		34	Will HSD please confirm that submission of a proposal in response to this RFP does not constitute a binding offer (i.e., that a binding obligation only comes into effect when the two parties agree and sign a final contract)?	Confirmed.
38	D. Response Format And Organization, 2. Number Of Copies		38-39	Can signed forms be submitted in PDF format (scanned with signatures)?	No, forms must have original signatures in Binder 1. PDF's are acceptable in Binder copies.
39	D. Response Format And Organization, 2. Number Of Copies		38-39	Is it permissible for Bidders to submit documents not available in Microsoft Office format in Adobe PDF format only (e.g., audited financial statements, insurance documentation, etc.)?	Yes.

40	D.Response Format And Organization, 3. Proposal Format		39-40	Several requested documents/samples do not comply with font restrictions and they are not available in a native MS Office format for font adjustments. Please confirm that it is permissible to submit those documents as is.	Yes.
41	D. Response Format and Organization; 2. Number of Copies, b. Binder 2		43	The MMISR E2E Timeline (v 7.2) in the Bidders Library includes a parallel run that is less than three months in duration. Please clarify what dates and duration of the parallel run should be for proposal preparation.	The minimum duration will be 3 months. The timeline in the procurement library will be revised once the implementation schedules of the FS and BMS contractors are finalized.
42	3 – Proposal Format		44	Would the State please define Detailed Work Plan versus Detailed Implementation Schedule?

Can the State also confirm these artifacts should be submitted with the Sample Plans? | In general, Work Plans are much more detailed than higher-level Implementation Schedules.

See RFP proposal requirements, which have been revised in Amendment 2. |
| 43 | 3 – Proposal Format | | 44 | Would the State please define Summary Work Plan versus Summary Implementation Schedule?

Would the State also please indicate where the Summary Work Plan with Milestones and Summary Implementation Schedule should be placed?

Is this the same as the Work Plan Timetable required in the Appendix G response? | The concise Work Plan should be included in the Statement of Work Response, and a more detailed Work Plan included in the Requirements Response.

See Amendment 2 for revisions to this section. |
44	VII – Response Specifications		46	Would the State please confirm that this Work Plan Timetable, including milestones and assumptions, is required within the 4-5 page response to Appendix G?	Yes, a concise summary Work Plan should be included in the Statement of Work Response. Note that Amendment 2 increased the page limit for this response to 10 pages.
45	VII – Response Specifications		46	Given the detail required to respond to these requirements and the weight of the evaluation points assigned to this section, would the State consider allowing 10 pages for the Appendix G response?	Yes. Amendment 2 increased the page limit for the Statement of Work Response to 10 pages.
46	VIII – Evaluation		51	The Vision for BMS is scored separately from Statement of Work (Appendix G). However, can the State confirm it is responded to specifically within the 2nd bullet of Appendix G, "Describe Offeror's methodology, plan, approach to the services and vision for BMS?"	Amendment 2 revised the language in Section VII. "Response to Specifications" and Section VIII. "Evaluation" to clarify the responses to Vision and Statement of Work (Appendix G).

47	4. Required Sample Documents		53	The paragraph describing required sample documents lists a few minimum/required samples. Then there are additional sample documents in bullets under the initial paragraph. Are these additional items simply examples of potential samples?	Amendment 2 revised the language in Section VII. "Response to Specifications" and Section VIII. "Evaluation" to clarify the response to Required Sample Documents.
48	Appendix G – Statement of Work		74	Where must this acknowledgment be presented in the proposal?	This acknowledgement should be included in the Statement of Work Response.
49	2.2.3 Utilization Management (UM) /Utilization Review (UR)		84	Please confirm that the BMS vendor is not responsible for authorization of pharmacy services.	Confirmed. The FS vendor is responsible for authorization of pharmacy services as part of that contract's PBM scope.
50	Appendix G—2.2.4 Benefit Plan Management		87	Will the state or legislative budget office provide the budgetary information?	No.
51	Appendix G—2.2.4 Benefit Plan Management		88	The FS contractor or the BMS contractor will do direct entry?	The BMS contractor is responsible for direct entry of reference file updates.
52	2.2.4 Benefit Plan Management		88	Is there any kind of required frequency that existing administrative code, benefit plans, and policy must be reviewed by the BMS contractor?	The State's expectation is that programs and policies will be reviewed on an ongoing basis, with the specific programs to be reviewed determined jointly by State and contractor staff.
53	4 – BMS Data Governance		93	The listed tools here appear to be just examples. Would the State please indicate where we can find a complete list of approved DGC tools?	The SI Contractor Data Architect will identify the tools to be used for the end-to-end data migration including the SMR (System Migration Repository) and will present the architecture to the DGC (Data Governance Council) and ARB (Architecture Review Board) for approval. These tools will be used by the Data Analysts and Solution Engineers implementing the SMR and executing the migration. **Tools for SMR**

					• The DAM (Data Access Module) component of the SMR depends on the readiness of the source systems to participate in the migration activities. It also depends on the source system specification as identified above.
					Tools will be selected based on these factors:
					  o If a source system plans to periodically migrate file extracts, Oracle Managed File Transfer (MFT)] will be used to deliver the file securely for ingestion into the SMR. The SI Contractor will migrate Omnicaid using MFT.
					  o If a source system needs to be bulk-extracted and is equipped with a standard Java Database Connectivity (JDBC)/Open Database Connectivity (ODBC), the Oracle Data Integrator (ODI) tool will be used. ASPEN (Automated System Program Eligibility Network) and CSES (Child Support Enforcement System)data will be extracted using this tool.
					  o If a source system is willing to integrate with the SMR in real-time via web services APIs (Application Program Interface), the SMR will establish appropriate Hyper Text Transfer Protocol (HTTP)/Simple Object Access Protocol (SOAP) listener infrastructure. SMR will use the MarkLogic REST (Representational State Transfer)/SOAP connector

libraries for this purpose.
• The DIM (Data Ingestion Module) component will be built using the following tools:
   o MLCP (MarkLogic Content Pump).
   o CoRB (Content Reprocessing in Bulk).
   o Data Movement SDK (Software Development Kit).
   o REST Server.
• The SIM (Source Integration Module) component will be developed within the SMR using libraries provided by MarkLogic:
   o XQuery programming language will be used to process the XML content.
   o JavaScript programming language will be used for processing the JavaScript Object Notation (JSON) content.
• The Deliver Component will provide access to the connecting modules by:
   o File dump using MLCP.
   o RESTful Web APIs for real-time access to the database.

Data modeling tools
• Sparx Enterprise Architect that supports XMI output.
• Microsoft Visio and other MS Office programs for UML (Universal Markup Language) and presentation.

Developer tools
• Java APIs and various ARB approved libraries.
• SoapUI or Postman for test automation.
• SQLDeveloper Oracle/IBM DB2 client for data profiling.
• R Programming language, R Studio and R Server for data profiling activities.

					Collaborative tools • Jira for development collaboration. • BitBucket for version control. • JAMA for requirements management. • Jenkins or Bamboo for build automation.
54	Appendix G – BMS Detailed Requirements		107	Would a requirement that is met without the use of a technical solution e.g., requires professional services only, be an example of a requirement that is not applicable	Yes.
55	Table 6 – Member Management Requirements	1.01	109	Please identify how many years of history will be initially processed and must be maintained.	Seven years will be initially processed. Additional years based on State and Federal regulations will be maintained.
56	Table 6 – Member Management Requirements	1.01	109	Please confirm that the BMS contractor is only responsible for processing enrollment and not determining eligibility for Medicaid or non-Medicaid programs.	The BMS Contractor is not responsible for eligibility determination nor member enrollment. The BMS Contractor is expected to capture, manage and maintain Medicaid and Non-Medicaid member data as a result of Member eligibility and enrollment in programs from source systems as defined by the State.
57	Table 6 – Member Management Requirements	1.01	109	Is the BMS contractor responsible for resolving conflicts regarding members who are in multiple programs (Medicaid or non-Medicaid), and notifying source partners for those programs where membership was overridden by another program? If not, who does this?	No. Conflicts will be resolved within the Master Data component provided by SI. The BMS Contractor will not be expected to resolve any conflicts.
58	Table 6 – Member Management Requirements	1.01	109	1. Is the BMS contractor responsible for being the member source of truth for the Enterprise 2. and essentially providing the FS contractor with 'sanitized' member data through the SI where the FS contractor will just be able to accept and process the member data as-is? 3. If not, what types of updates might the FS make to member data that the BMS contractor have to accept?	1.No. 2. Yes, for member data that is maintained by the BMS Contractor; ASPEN is also a source of member data for the FS. 3. FS would not make updates to member data.

59	Table 6 – Member Management Requirements	1.01	109	Will any of the member management information have to be either sent or received in a HIPAA X12 270/271 format?	Yes.
60	Table 6 – Member Management Requirements	1.01	109	If X12 is required, please indicate whether it is the BMS or SI who is responsible for the translation. Please explain which partners are expected to use this format versus other formats.	Refer to p. 133 UM/UR 3.49 under requirements. BMS is responsible for HIPAA transaction 278. This would include any X12 translations.
61	Table 6 – Member Management Requirements	1.01	109	Please explain how ID merges and unmerges will work in member management? Is member management responsible for identifying and/or performing these? Or will it be the MDM making these decisions? If so, how will these be communicated throughout the Enterprise	The MDM Solution will be responsible for merges and unmerges of Member data. When such activity occurs, the MDM will provide updates to the modules/systems that are expected to receive such updates in their respective module/system. All modules will be responsible for identifying potential duplicates and providing notifications. The state will provide a notification/ communication tool.
62	Table 6 – Member Management Requirements	1.01	109	For non-Medicaid programs, what key identifiers are expected to track membership? Will there be unified identifiers across all programs Medicaid and non-Medicaid?	A unique identifier will be assigned for every individual in the system and stored in our MDM repository. Yes.
63	Table 6 – Member Management Requirements	1.04	109	Please explain how the data from the FS RFP requirement "2.035 Offeror shall describe how its proposed Solution adjudicates claims with EPSDT services and flags the claim for reporting" should interact with this requirement? Do you expect the member management solution to operate independently of this FS requirement or do you expect it to use the data?	The State expects the BMS Contractor to obtain EPSDT data that is collected from the claims adjudication process in order to fulfil the business functions that is stated in requirement1.04 No, the State expects the BMS Contractor to work with the FS Contractor and the DS Contractor to obtain data through the SI's ESB

					when such data is needed for EPSDT services that will be performed by the BMS Contractor.
64	Table 6 – Member Management Requirements	1.08		110	Please clarify the role of the BMS versus the CCM for generating and distributing correspondence. Is the BMS primarily responsible for identifying the correspondence to be sent, drafting the format of it, and identifying the target audience and the CCM does the actual dynamic generation upon request and distributes it to all communication channels?	The BMS Contractor is responsible for identifying the correspondence that will be sent based on business functionality, drafting the format of the correspondence with approval by the State, identifying the target audience and integrating with the CCM for generation upon request and sent via the appropriate communication channel.
65	Table 6 – Member Management Requirements

2.2.1 Member Management | 1.08 | | 110

81 | Please explain the data ownership between the MDM and the member management solution.

Which system will be the source of truth?

Does each keep its own copy of the data?

Which can be overwritten by the other? | Reference the Statement of Work page 81.

For demographic data the "source of truth" is the MDM.

The Offeror/Contactor must propose what data it needs to retain for the efficiency of its underlying system.

To be determined. The Contractor will participate in decisions regarding data governance rules. |
| 66 | Table 6 – Member Management Requirements | 1.09 | | 110 | For data quality objectives, we have been unable to locate any HHS 2020 Addendums that directly relate. If there is additional documentation, please provide. Otherwise are there any government or industry standards you are considering using when identifying data quality objectives? | The HHS 2020 Data Governance Council will be developing a data quality plan. The plan will identify any standards that will apply for data quality.

We are currently applying FHIM to our persistence model and are planning to apply FHIR to our messaging / canonical model. Data quality objectives will stem from FHIM and FHIR. For MDM, both FHIM and FHIR standards will be applied as they are inherited from the physical data and canonical / messaging models. |

67	Table 6 – Member Management Requirements	1.13	110	Do you have any already identified languages other than English that you would expect the BMS contractor would be prepared to support in the course of its activities? If so, please provide a list.	In order of usage: English, Spanish, Navajo, Vietnamese, German, Chinese, Arabic, Korean, Tagalog-Filipino, Japanese, French, Italian, Russian, Hindi, Farsi, Thai. The BMS Contractor must have sufficient bilingual staff to support Spanish-speaking members. The use of a translation service (including Native American languages) is acceptable for any other member interaction request requiring a translator.
68	Table 7 – Provider Management Requirements	2.01	112	For network adequacy, do you have any particular standard you are aiming for? (i.e. NAIC)	Centennial Care established distance standards that distinguish between primary care providers (PCPs) and pharmacies versus other providers, and between urban, rural and frontier counties. The standard for PCPs (including Internal Medicine, General Practice, and Family Practice,) Pharmacies, and FQHC-based PCPs is as follows: Urban: 90% of members are within 30 miles of a provider Rural: 90% within 45 miles Frontier: 90% within 60 miles The standard for all other provider types is as follows: Urban: 90% within 30 miles Rural: 90% within 60 miles Frontier: 90% within 90 miles
69	Table 7 – Provider Management Requirements	2.03	112	Please further define 'Enterprise defined provider information'.	Please see the Procurement Library for provider data and valid values maintained by the current MMIS. Additional data may be defined during DDI.
70	Table 7 – Provider Management Requirements	2.04	112	Does the BMS contractor have any responsibility for EDI trading partner enrollment? If so, please explain.	No.

71	Table 7 – Provider Management Requirements	2.04	112	Please confirm that the MCOs will continue to be responsible for the capture and verification of information related to provider credentialing.	The BMS Contractor will be responsible for receipt and verification of the materials required for enrollment, whether for Medicaid or Enterprise programs. Providers will be instructed to send all enrollment materials to the BMS Contractor. The State's expectation is that data from providers required to support credentialing will be supplied by providers as part of the initial application for enrollment. However, any verification required specifically for MCO credentialing (as opposed to FFS enrollment) will be the responsibility of the MCO.
72	Table 7 – Provider Management Requirements	2.06	112-113	Please define what 'other' screening rules will be required.	Rules required by the Enterprise program for which the provider is applying for enrollment, such as business licenses, insurance coverage, etc.
73	Table 7 – Provider Management Requirements	2.15	113	Do you have a specific electronic signature standard you are looking for an offeror to provide?	No.
74	Provider Management	2.08	113	Is the Offeror expected to receive and process provider enrollment application fees? If yes, please describe the provider application fees.	In accordance with the approved State Plan, New Mexico Medicaid does not impose provider application fees.
75	Provider Management	2.09	113	Please provide frequency of renewal provider applications.	Providers are required to revalidate their enrollment every three years.
76	Table 7 – Provider Management Requirements	2.16	114	Is it your expectation or desire that the provider management services use the C/CMS for this workflow?	No.
77	Table 7 – Provider Management Requirements	2.22	114	Is the workflow integration ultimately with the capability described in the C/CMS requirements? If not, please explain this.	No, the integration is with the SI-maintained Enterprise framework. The Contractor is responsible for implementing its own workflow tool within its solution, which must be able to receive messages from and send messages to

						the Enterprise Service Bus using the canonical data model.
78	Appendix H 2.22 Provider Management	2.22		114	Would the State please confirm that the Contractor is not responsible for storing electronic pictures and other biometric identifiers of members?	Confirmed.
79	Table 7 – Provider Management Requirements	2.22		115	Will ECM also be the location where all documents and attachments should be stored?	Yes.
80	Table 7 – Provider Management Requirements	2.24		115	Will the MDM be the source of truth for the MPI? Or will that be the provider management service that manages the MPI?	Yes.
81	Table 7 – Provider Management Requirements	2.33		116	Is the BMS contractor providing the web portal pages that support provider enrollment activities and those pages will be encapsulated inside of your UPI? If not, will we be receiving the enrollment data from the SI in some kind of agreed upon format to process?	Yes.
82	Provider Management	2.43		117	Please provide enrollment requirements for non-Medicaid providers. Please provide current enrollment statistics on non-Medicaid providers.	This information is not available at this time.
83	Table 7 – Provider Management Requirements	2.39		117	If we are required to use the workflow capabilities of the Enterprise, will we also have access to workflow reporting tools?	Workflow is not an Enterprise service provided by the SI. The Contractor is responsible for implementing its own workflow tool within its solution.
84	Provider Management	2.47		118	Is the BMS vendor responsible for contracting with a vendor such as Gemalto to provide this service? Or, is the BMS vendor to establish the interfaces/processes with the existing entities the State currently utilizes?	HSD utilizes Gemalto to initiate fingerprint-based criminal background checks. If permitted by the federal government, HSD will delegate its Gemalto access to the BMS Contractor as

					well as the responsibility for verifying background check results; otherwise, HSD will continue to handle this activity. Regardless, the BMS vendor's solution must be able to capture the status and result of such background checks. Note that the volume of this activity is extremely low since the few providers who require fingerprint-based criminal background checks have generally passed such a check via Medicare or another State Medicaid Agency.
85		2.57	119	Please clarify if this is a requirement for the development of a Statewide provider directory for members to access? Or just to provide the data for utilization in a provider directory.	The requirement is to provide the data to support a searchable provider directory available via the Unified Portal that will allow members to identify providers by location, specialty and other criteria.
86	Table 7 – Provider Management Requirements	2.54	119	Please explain what assignment means in this context. Is it a PCP relationship? Also please explain what types of administrative fees needed to be calculated that are assignment-based.	BMS Requirement 2.54 has been revised in Amendment 2.
87	Table 7 – Provider Management Requirements	2.56	119	Are there any Enterprise training delivery resources (i.e. LMS) available to the BMS contractor for fulfilling these requirements? If so, please provide information about these.	No.
88	Table 7 – Provider Management Requirements	2.60	120	This section spells out requirements that appear to be duplicative of others in the RFP – particularly 2.06 regarding CMS-mandated screening and 2.07 regarding screens and monitoring of Medicaid/Medicare actions. As this regards the NPDB within 2.60, it seems that this particular requirement would potentially result in in additional costs on the part of the State that may be duplicative of other more timely resources. For example, NPDB provides licensing and sanction efforts of individual states, however, NPDB picks up on these actions *downstream* of the original, primary originating source resulting in *delayed* duplicate information.	No. That is not New Mexico's intent; the reference to the National Practitioner Data Bank may be disregarded. It has been deleted in Amendment 2.

				NPDB requires a direct cost per provider over-and-above the requirements referenced above, and even others within 2.60. In analyzing the data available in NPDB, it appears that it offers only the following additional data over-and-above existing requirements to make direct contact with the primary reporting sources: • Medical Malpractice actions • Clinical privileges actions • Health plan actions • Peer review organization actions Is it New Mexico's intent that this additional review occur from NPDB, over-and-above the existing requirements to check and monitor against the primary, originating sources of information?	
89	Table 7 – Provider Management Requirements	2.57	120	Please explain if you are expecting a provider directory here and whether it will be expected to be provided by the UPI and the BMS just provides information updates. If you expect the BMS to provide an online provider directory please clarify that.	The BMS vendor must provide the data to support a searchable provider directory available via the Unified Portal that will allow members to identify providers by location, specialty and other criteria.
90	Table 7 – Provider Management Requirements	2.66	121	Please provide the definition of a "secondary provider".	BMS Requirement 2.66 has been deleted in Amendment 2.
91	Table 7 – Provider Management Requirements	2.69	121	Please clarify the role of the provider management services with respect to grievance and appeals. There appear to be requirements in C/CMS to provide a grievance and appeal solution. Is the requirement for provider management to use the C/CMS to process grievance and appeals?	The State anticipates that the BMS vendor will use the C/CMS to capture, document and track grievances and appeals.
92	Table 7 – Provider Management Requirements	2.72	121	Please explain the scope of these provider audits and provide expected volumes.	These audits include Payment Error Rate Measurement (PERM) audits, the Single Audit conducted annually by the State's contracted audit firm, and occasional audits initiated by other State or federal entities. New Mexico is a PERM Cycle 1 state; its most recent review was

					Review Year (RY) 2019. The most recent Single Audit selected 30 provider records.
93	Table 7 – Provider Management Requirements	2.86	123	Is the Offeror responsible for any costs associated with obtaining venues?	Yes. Although the State may be able to provide venues if available.
94	Table 7 – Provider Management Requirements	2.92	125	Please confirm that the Offeror is not responsible for hosting a website for provider training, but will make the web-based training available through the UPI.	Confirmed.
95	Table 7 – Provider Management	2.94	125	Please clarify if the provider management services should be using the training solution required under the C/CMS requirements or if the provider management services need to include a separate training solution.	The BMS vendor is responsible for providing its own training solution.
96	Table 7 – Provider Management		125	Is this FAQ intended to be for internal (contractor and State) users for the provider management solution? If not, please clarify.	The FAQ is intended for both internal and external users.
97	Appendix H Table 8 ID 3.01 and 3.02		126	Is the expectation with ID 3.01 and 3.02, that even if a claim has already been processed, you want the prior authorization file to update the claim for the remaining days/units not paid on the claim?	Yes.
98	Appendix H Table 8 ID 3.03		126	Will access/interface be granted to allow for viewing of service plan of member?	Yes.
99	Appendix H Table 8 ID 3.04		126	When referral is mentioned in 3.04 does it mean service referrals for actual healthcare and referrals for prior authorization?	Yes.
100	Appendix H Table 8 ID 3.06		126	How will notification occur for electronic revisions?	Revisions will be communicated to the BMS Contractor by the entity (such as a provider) that originated the original request. Revisions may be initiated via any media acceptable for initial requests.
101	Appendix H Table 8		126-136	Please define and clarify differences between "referral" and "preauthorization"	A preauthorization is the approval of a service that, as defined by the State Plan, requires approval prior to the rendering and/or payment of the service. A referral is made by a

					physician who believes that a patient requires specialized treatment out of state; such a referral must be submitted for review and approval.
102	Appendix H Table 8 IDs 3.01 thru 3.69		126-136	1. Please provide additional information describing the types and volumes of prior authorizations and utilization reviews the State expects the Contractor to handle/process?	Prior Authorizations for the following (see the response to Question 370 for volume data): • Alternative Benefit Plan • Behavioral Health • Contact Lenses • Dental Services • Durable Medical Equipment (DME), Prosthetics and Orthotics, and Nutrition Services • EPSDT Personal Care • General Hospital • Hearing Aid Services • Home and Community Based Services (Development Disability Waiver, Medically Fragile and Supports Waiver) • Home Health Services • Out of State Services • Private Duty Nursing Services • Rehabilitation Services (In/Out Patient) • Transplant Services Utilization Reviews for the following: • Emergency Medical Services for Aliens (EMSA) • ICF-IID • 1915 c Home and Community Based Services to include Mi Via, Development Disability, Medically Fragile, and Supports Waivers • PACE

			2. Specially, what changes to the 1915 waiver population are predicted that would increase volumes or rule changes that would change the TPAs current workflow?		The State of NM is anticipating the 1915 c Home and Community-Based Service Waivers to increase within the next 4 years due to: • The definition of disability being modified, which could potentially make more individuals eligible for the 1915 c Waivers. • The State of NM will be implementation a new 1915 c waiver, which will be known as the Supports Waiver. Effective date of implementation is scheduled for July 1, 2020. The current plan for the Supports Waiver is to release 2,000 allocations each year for the next 3 years.
103	Appendix H Table 8 ID 3.08		127	Please define "globally".	Enterprise-wide.
104	Appendix H Table 8 ID 3.19		128	Please clarify the State's expectation of electronic authorizations for providers without electronic capability. Please clarify what you mean by no cost exception process.	Although the State's intent is that authorization requests be submitted electronically, the Contractor must be able to accept authorization requests via paper, fax and telephone, and providers may not be charged or penalized for submitting requests in this manner.
105	2.07		133	This section requires checks against data that is owned and managed by CMS. Will New Mexico facilitate access to this data on behalf of the contractor? Will that access allow the contractor to link this data in an automated fashion to applying and existing providers in New Mexico's network, to enable a single-stop data screen of all required elements? Or will checks against this data require a separate, manual process, per CMS direction?	No. It is the Contractor's responsibility to access this information. CMS would have to answer this. CMS would have to answer this.

106	Table 9 – Benefit Plan Management Requirements	4.01	137	Do you have any already identified activities that you have not had the opportunity to follow up on that you would expect the BMS contractor to take action on early in the contract? If so, please describe.	No.
107	Table 9 – Benefit Plan Management Requirements	4.01	137	Our understanding is that these functions are currently performed by the State. Please provide us with information about the number of people and types of credentials for the staff required to perform the work today that the benefit plan management services would be replacing.	HSD will not provide a number.
108	Table 9 – Benefit Plan Management Requirements	4.01	137	Please identify any contractors engaged in performing this work today and please either point us to their contracts or summarize their scope of work.	Please refer to the HSD website at https://www.hsd.state.nm.us/LookingForInformation/medical-assistance-division.aspx for HSD's current contracts. They can also be found on the State's "Sunshine Portal".
109	Table 9 – Benefit Plan Management Requirements	4.01	137	Is the BMS contractor primarily responsible for the development of medical policy related to program benefit coverage? If yes, please indicate required clinical credentials.	No, only for making recommendations to the State. The BMS Contractor should have appropriate staff available for the development of medical policy related to benefit coverage.
110	Table 9 – Benefit Plan Management Requirements	4.01	137	Do you have any either historical or expected number of policy initiatives you expect to occur each year?	No.
111	Table 9 – Benefit Plan Management Requirements Ext Partner Rule Promulgation NMAC 14 FS' (Procurement Library)	4.01	137	Will benefit plan management initiatives be reviewed and approved through the process described in 'Ext Partner Rule Promulgation NMAC 14 FS'? If so, will the Enterprise provide the solutions related to electronic signatures, chat, etc. referred on the first slide to automate and expedite the review process?	The Enterprise will provide all tools necessary to expedite the rules process.
112	Table 9 – Benefit Plan Management Requirements	4.08	137	For tasks such as this requirement where we are tracking changes or making recommendations, do you expect we'll track activities within your HHS 2020 tools so that any system impacts can be traced through implementation?	Yes. The BMS Contractor will be able to leverage HHS 2020 tools.

				Or does the BMS contractor need to provide a solution to do this?	
113	Appendix H—Table 9 Benefit Plan Management Requirements	4.06	137	What is the current and anticipated volume of these non-Medicaid program updates?	This information is not available.
114	Appendix H—Table 9 Benefit Plan Management Requirements	4.28	140	Does the State mean 5 business days from date the request has been fully analyzed and approved by the State?	It is five (5) business days from the date of the State's request.
115	Appendix H—Table 9 Benefit Plan Management Requirements	4.41	141	Please describe the reconciliation process used currently. Is this reconciliation performed by the State currently or by a consultant?	This reconciliation is performed by the State. The process varies across programs.
116	Appendix H—Table 9 Benefit Plan Management Requirements	4.43	142	Describe what is meant by final reports? Are these legislative or federal reports on waivers or state initiatives?	Final reports can include, but are not limited to, all legislative and federal reports and/or State initiatives.
117	Appendix H—Table 9 Benefit Plan	4.46	142	Please confirm that the State will be responsible for MCO negotiations.	The State will be responsible; however, the State may utilize the BMS Contractor as a consultant.
118	Appendix H—Table 9 Benefit Plan Management Requirements	4.46	142	For managed care contract updates, is the BMS responsible for drafting contract updates or just providing input to the process?	For providing input to the process.
119	Table 9 – Benefit Plan Management Requirements	4.43	142	Is the BMS contractor primarily responsible for updates to your Manuals and Guides such as the 'Behavioral	No. However, the State may request that the contractor develop language regarding specific benefit plan changes that HSD staff may incorporate in its manuals and guides. In

				Health Policy and Billing' and 'Home Health Policy Manual'? Please identify manuals and guides the BMS contractor is responsible for maintaining related to benefit plan management services.	addition, the contractor must work with the State to develop educational materials that help Members understand their benefits and how to access them (see 4.32).
120	Table 9 – Benefit Plan Management Requirements	4.43	142	Is the State expecting to maintain its existing provider manual structure? We have found where there is an overall Managed Care Manual; however, the FFS information appears to be spread across several policy manuals and the administrative code. If there is expected to be a change, please explain.	The State must maintain provider manuals. The State will look to the BMS Contractor for suggestions on how best to compile and distribute the manuals.
121	Table 9 – Benefit Plan Management Requirements	4.43	142	Is the BMS contractor responsible for drafting updates for the administrative code?	No.
122	Table 9 – Benefit Plan Management Requirements	4.46	142	Is the BMS contractor the party primarily responsible for maintaining your Managed Care Policy Manual?	Yes.
123	Strategy and Project Management 5.05		143	Not all of these bulleted items have clear equivalent templates in NM DoIT site under https://www.doit.state.nm.us/oversight.html. Would the state please advise as to how the Offeror should describe current compliance if a standard or template is not available (e.g., Data Conversion Planning)? Alternatively, would the State offer a different or additional location for EPMO standards?	The State will share the EPMO plans and templates during the onboarding process.
124	Table 10 – General Requirements	5.16	145	Please confirm that the use of industry typical tools and company standard tools that may not be the exact tools already approved by the HHS 2020 EPMO tools and processes is allowed.	Alternative tools may be agreed upon.
125	Table 10 – General Requirements	6.36	148	Please confirm this is not a requirement for a SaaS solution.	Please refer to 45 CFR 95.617.

126	Support and Maintenance	7.02	149	Which types of Tier 3 calls should the BMS vendor expect? From the CCSC Module would these apply? Are there others? • Non-Medicaid • Provider Registration • Obtain Member Eligibility • Claims (Inquiry) • Claims (Updates) • Claims (Submission) • Provider Account Maintenance • Provider Portal Maintenance • Specialized Providers	In most cases, the CCSC will be able to handle the majority of inquiries once it is fully functional and trained. A list of Tier 3 inquiries that require a transfer will be determined during the CCSC design sessions. This list will be vetted with the BMS Contractor before being implemented.
127	Article 6 (Termination), paragraph A (Grounds) of the Sample Contract (Appendix I)		163	Would HSD please confirm that, in the event the HSD terminates the Agreement for convenience, the Contractor shall be entitled to payment for all services performed and products delivered under the Agreement through the effective date of the termination and reimbursement for all reasonable costs related to or incurred as a result of the termination plus a reasonable profit? Additionally, in the event the parties cannot agree on the termination settlement amount, that HSD will promptly pay the Contractor the undisputed amount?	This is boilerplate language in the sample contract that could be negotiated. Offerors must submit red-line versions of proposed changes in the sample contract for negotiations. Those are to be placed in Tab 15 (Additional Items) in Binder 1. See Amendment 2.
128	Article 11 (Warranties), paragraph B (Software) of the Sample Contract		168	Since the warranty period duration is blank, will HSD please specify the required warranty period for this RFP?	To be negotiated.
129	Article 18 (Liability) of the Sample Contract		172	Would the HSD consider adding a reasonable limitation on Contractor's liability including an overall cap on Contractor's liability equal to the fees paid to Contractor by the HSD in the twenty four months	To be negotiated.

				preceding the claim for damages and a disclaimer of indirect and consequential damages?	
130	Appendix K (BMS Performance Measures		207	Would the HSD consider adding language to Appendix K (BMS Performance Measures) such that the total liquidated damages assessed against Contractor will not exceed ten percent (10%) of Contractor's applicable monthly invoice?	To be negotiated.
131	Appendix K (BMS Performance Measures)		207	Would the HSD consider adding language to Appendix K (BMS Performance Measures) such that liquidated damages would not be assessed during a reasonable stabilization period of the first six (6) months following Go-Live?	To be negotiated.
132	Appendix K (BMS Performance Measures)		207	Would the HSD consider adding language to Appendix K (BMS Performance Measures) such that Contractor would have at least ten (10) business days to cure any deficiency before the assessment of liquidated damages?	To be negotiated.
133	Appendix K (BMS Performance Measures)		207	Would the HSD consider adding an earn back mechanism to Appendix K (BMS Performance Measures) such that Contractor would earn back any liquidated damage assessment if Contractor corrects the deficiency and meets the performance measure for two consecutive months following the month in which the failure originally occurred?	To be negotiated.
134	Deliverables		250	Will HSD confirm that: (i) the parties will mutually agree upon the acceptance criteria for each deliverable; (ii) the parties will mutually agree on a reasonable duration for HSD review of deliverables; (iii) once Contractor delivers a deliverable, within the agreed HSD review period, HSD shall either (a) accept the deliverable if it substantially meets its acceptance criteria or (b) reject the deliverable and notify Contractor of the unmet acceptance criteria upon which its rejection is based; and (iv) If HSD does not	To be negotiated.

					reject the deliverable and notify Contractor of the specific acceptance criteria that is unmet within the review period, then the deliverable shall be deemed automatically accepted.	
135	General				What is the current overall MMIS budget and what proportion of the overall MMIS program budget / effort is planned to align with the C/CMS work stream? Are there any not-to-exceed amounts to consider in the supplier response and associated pricing / staffing?	Budgets will not be provided.
136	General				Do you expect any extension to the C/CMS proposal submission deadline?	Yes. Amendment 1 to this RFP changed the proposal submission deadline to Nov. 22, 2019.
137	General				What is the total number of member lives to be considered for pricing for this contract, for each year of the contract (i.e., Years 1 – 4 of contract, potential extension years 5 – 8)?	Please see the response to Question 15 for information about the programs that will be supported by the C/CMS. For Medicaid eligibility statistics, please see the current Medicaid Eligibility Reports (http://www.hsd.state.nm.us/LookingForInformation/medicaid-eligibility.aspx), which provide member counts by program and MCO/FFS. Future forecasts are not available.
138	General				What is the estimated number of care and case managers? How many concurrent users are expected to use the technology portion of the C/CMS?	There may be as many as 10,200 (approximate and subject to change). This number is unknown.
139	General				Is there an existing governing body and governance process to review insights and recommendations in order to make decisions and drive informed strategic improvements to positively impact population health?	Yes. HHS 2020 has several governance structures in place to oversee strategic decisions.
140	General				Have past efforts been conducted to align stakeholder vision for the future C/CMS functions and solution?	Yes.

141	General				Have program success metrics been defined including any medical cost goals or target administrative efficiencies? If so, can they be shared?	MCO performance metrics can be found in their contracts (Section 4.12). Other metrics can be found in EQRO, Evaluation Design, and CMS reports, all found through the following links: MCO Contract section 4.12 references Quality management and Quality improvement contractual requirements for 2.0 https://www.hsd.state.nm.us/uploads/files/Looking%20For%20Information/General%20Information/Contracts/Medical%20Assistance%20Division/MCO's%20Centennial%20Care%202.0/BCBS%20Contract%20PSC%2018-630-8000-0033%20A1.pdf 1115 Demonstration Waiver Evaluation Design Plan for Centennial Care: https://www.hsd.state.nm.us/LookingForInformation/nm-centennial-care-evaluation-design-05-18-17-.pdf 1115 Demonstration Waiver Interim Report for DY1 through DY2 https://www.hsd.state.nm.us/LookingForInformation/nm-interim-report_final_20171013.pdf 1115 Demonstration DY4 Waiver Annual Report https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nm/Centennial-Care/nm-centennial-care-dy4-annl-rpt.pdf 1115 Demonstration Waiver Quarterly Reports https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-

					Topics/Waivers/1115/downloads/nm/Centennial-Care/nm-centennial-care-qtrly-rpt-jan-mar-2014.pdf https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nm/Centennial-Care/nm-centennial-care-qtrly-rpt-apr-june-2014.pdf https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nm/Centennial-Care/nm-centennial-care-qtrly-rpt-oct-dec-2014.pdf https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nm/Centennial-Care/nm-centennial-care-qtrly-rpt-jan-mar-2015.pdf https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nm/Centennial-Care/nm-centennial-care-qtrly-rpt-jan-mar-2016.pdf https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nm/Centennial-Care/nm-centennial-care-qtrly-rpt-jul-sep-2016.pdf External Quality Review Organization reports:

						https://www.hsd.state.nm.us/LookingForInformation/external-quality-review-organization.aspx NM Quality Strategy https://www.hsd.state.nm.us/providers/2017-nm-quality-strategy-final.pdf CMS Medicaid and Chip quality measure reporting https://www.medicaid.gov/state-overviews/stateprofile.html?state=new-mexico
142	General				Outside of the integration with the ESB, what are the additional data sources and/or systems that the C/CMS will be required to integrate with in order to receive and/or send out data? Please provide the number of internal and external systems/integrations and whenever possible, name of each internal and external system. (I.e., will it be a subset of the Legacy MMIS Interfaces plus the Legacy Enterprise Partner Interfaces?)	All external interfaces will go through the SI's ESB.
143	General				To what extent is robotic process automation or other forms of automation (i.e. artificial intelligence) used in the C/CMS environment today? Any limitations on their use as a part of the solution?	RPA (Robotic Process Automation) or AI (Artificial Intelligence) are not currently in use by the State or its contractors. Offerors are encouraged to provide responses to how they would use and implement automation, including RPA and AI.
144	General				What is the desired go-live date for the C/CMS?	The State expects go-live to occur in calendar year 2021. Offerors should propose go-live date in their Implementation Plans.
145	Addendum 25 – HHS 2020 DOH Requirements Mapping				As per description on page 249 (of 285) under Appendix N – C/CMS Detailed Requirements (2nd paragraph), offerors are asked to include in their Proposal "…assurance that the detailed requirements in Addendum 25…can be met through the C/CMS proposed." May such assurance be an overall	An overall statement will suffice.

				statement of assurance or does offeror need to provide assurance for each line item/requirement (i.e., in a table similar to that in Addendum 25)?	
146	Table 14 – Care/Case Management Solution (C/CMS)	10.021		Please provide clarification regarding the portion of requirement 10.021 stating "…route the proposed SPA for review and approval." Does the Enterprise want cases of this type to be pended until the SPA is approved by CMS or is the request for additional review of cases of this type? Or something else?	Proposed SPAs undergo various levels of internal; review prior to being submitted to CMS. The Enterprise requires that a SPA case be captured by the C/CMS and track its flow through the internal review and approval steps as well as when it has been fully approved internally and been sent to CMS.

147	Table 14 – C/CMS	10.028		Please clarify if the Office of Inspector General:
				 1. Performs its own investigation tracking using system from which it wants to push information to the C/CMS or if the Enterprise requires the C/CMS to be the system of record for investigation tracking;
				    a. If the former, please identify the system/source of investigation data
				 2. Performs its own financial tracking using a system from which it wants to push information to the C/CMS or if the Enterprise requires the C/CMS to be the system of record for financial tracking;
				    a. If the former, please identify the system/source of financial data
				 To whom/where/what other agency a case, or partial case, would need to be transferred.
					No.
					
					 No.
					
					 To be determined.

148	Table 14 – C/CMS	10.032		Please clarify if the Enterprise requires the C/CMS to: 1. Include fields to capture member legal information 2. Or if the member legal information can be consumed by the C/CMS through integration from another data source Who will be responsible for evaluation and payment?	Legal information will be entered by system users so fields must be available to capture this data. Please see response #188.
149	Table 14 – C/CMS	10.036		Please provide clarification regarding: 1. Spending plan creation and monitoring	Examples:

				a. Are spending plans to be created on behalf of members? b. Who creates the plan? c. Is there a standard template? d. By whom and how are spending plans monitored? 2. Integration with the Administration for ACL State Program Reporting Tool requirements – is this a requirement for integration with a tool/system, or confirmation of the ability to conform to some other set of requirements? If the latter, please provide or direct us to those requirements for review.	**For ALTSD:** 1. Spending plans are created for Metro and non-Metro AAA's by ALTSD staff utilizing a standard template. Spending plans are monitored by ALTSD staff utilizing performance measures. 2. Yes, it is a requirement as the report will need to interface with the SAMS data base. No other requirements outside of the tool are required. **For DOH, DDSD:** Please review Chapter 6: Individual Service Plan (ISP) and Chapter 7: Available Services and Individual Budget Development of the DD Waiver Service Standards Reissue December 28, 2018; Effective date January 1, 2019. Starting on page 60-73. The link to DDSD Standards: https://nmhealth.org/publication/view/regulation/4173/
150	Table 14 – C/CMS	10.038		Please clarify: 1. Investigation, monitoring, and tracking – who is expected to perform these activities, is the request for the C/CMS to provide tools for these activities, if so, please describe tools. 2. Compliance with OMB NO.: 0985-0005-Instructions Part I: - please specify what compliance is require of the C/CMS technology platform, i.e., creation of complaint form, tracking of opened/closed complaints, etc., or other. 3. Spending plan creation and monitoring – who is the plan for (i.e., member?), who creates the plan, who and how is the plan monitored? Electronic submission forms – does this mean the ability to upload and push electronic forms to other	Electronic submission forms: Yes, we would like ability to push forms/referrals to other programs internally and externally.

				end points, i.e., requires integration with end point systems?	
151	Table 14 – C/CMS	10.040		Please clarify: 1. Eligibility fair hearings tracking and monitoring a. Is there an external data source with the information to be tracked, or Is the information to be entered and tracked through the C/CMS?	The expectation is the information will have the ability to be entered and tracked through the C/CMS.
152	Table 14 – C/CMS	10.042		Please provide additional information regarding the last bullet/ requirement "Providing notification to Child Support Enforcement of Non-Custodial parent(s)" (i.e., based upon Enterprise-defined business rules, etc.).	HSD-CSED needs information about Non-Custodial Parents (NCPs). Having good and accurate "Locate" information about NCPs- is an important aspect of child support establishment and enforcement. If the system can return that information back to CSED, it assists the State in increasing collections.
153	Table 14 – C/CMS	10.043		Please elaborate on references to "budgets". Are these budgets for individual members? Who/what system creates them or is the C/CMS required to provide the capability to create, monitor, and approve/deny budget components?	 Yes. The C/CMS Contractor is required to provide the capability for authorized users (case manager or consultant) to create, monitor and modify budgets.
154	Table 14 – C/CMS	10.044		Please clarify, is Provider selection to be undertaken by the Enterprise staff on behalf of the Member to select a service provider? Or does the Enterprise anticipate Members using the C/CMS to undertake this activity? Or would this activity be performed through the UPI and therefore integration with that module is required of the C/CMS to support this activity?	The UPI and therefore integration is required of the C/CMS to support this activity.
155	Table 14 – C/CMS	10.047		Please confirm: 1. Providers are to have access to the C/CMS 2. How many Providers does HDS anticipate having access to the C/CMS?	1. Some providers may have access to the C/CMS if they are also participating as case managers for one of the programs supported by the tool.

					2. That number is not known.
156	Table 14 – C/CMS	10.051		Please clarify: 1. Who defines the budget? 2. What is the budget for specifically? 3. What are the data sources enabling management/updates/tracking/monitoring of budget? Is Enterprise staff (i.e., Case Manager) meant to monitor and track a Member's budget?	As an example, for the DOH DDSD program: Please review Chapter 6: Individual Service Plan (ISP) and Chapter 7: Available Services and Individual Budget Development of the DD Waiver Service Standards Reissue December 28, 2018; Effective date January 1, 2019. Starting on page 60-73. The link to DDSD Standards: https://nmhealth.org/publication/view/regulation/4173/
157	Table 14 – C/CMS	10.056		Please elaborate on the geo-mapping portion of this requirement. What is being requested of the C/CMS in terms of geo-mapping?	C/CMS Contractor is expected to fulfill the requirements in 10.056 using the geo-mapping tool provided by the DS Contractor. C/CMS Contractor must be able to display the client residences and service locations.
158	Table 14 – C/CMS	10.057		Regarding the following portion of the requirement "…provides the capability to identify and annotate auto populated fields which are incorrect and must be updated in the source system": 1. Does this requirement refer to updating fields in the C/CMS that are incorrect based on the data from the source system, meaning the source system is the system of truth/system of record? 2. Or does this mean the data in the fields in the C/CMS is presumed to be correct and the data from the source system, if different, is presumed to be incorrect? If the data in the C/CMS is presumed to be correct (i.e., the C/CMS is considered the source of truth), does this requirement mean the Enterprise desires for the bi-directional transfer of data to update the source system with the data from the C/CMS?	The Enterprise requires bi-directional transfer of data and updating the system based on which system has been identified as the source of truth for that particular data element.
159	Table 14 – C/CMS	10.058		Please provide additional details and specifications regarding the bullet "Calculation and creation of budget" I.e., Is it for individual members? What	As an example, for the DOH DDSD program: Please review Chapter 6: Individual Service Plan (ISP) and Chapter 7: Available Services and

				information/data/source is the calculation based on? Is there a calculation algorithm? Who creates the budget? What is it required to include, etc.	Individual Budget Development of the DD Waiver Service Standards Reissue December 28, 2018; Effective date January 1, 2019. Starting on page 60-73. The link to DDSD Standards: https://nmhealth.org/publication/view/regulation/4173/
160	Table 14 – C/CMS	10.060		Please clarify the definition "contract" for this requirement or confirm that "contract" refers to the plan a member is enrolled in.	Contract refers to any binding contract HSD and other Enterprise partners are in with any entity, including Professional Service Contract.
161	Table 14 – C/CMS	10.061		Please clarify the amount of member health history desired for this requirement. I.e., 3 years, 5 years, etc.	See the response to #55.
162	Table 14 – C/CMS	10.064		Please clarify what system(s) will be supplying the external case type specific workflows. Does the external system(s) offer APIs?	Various systems will be supplying case-type workflows to the C/CMS solution. The Contractor is responsible for implementing its own workflow capability within its solution, which must be able to receive external messages from and send messages to the Enterprise Service Bus using the canonical data model. The ESB will direct the message to the external system. The State anticipates that APIs and Web services will be developed for these systems.
163	Table 14 – C/CMS	10.083		Please clarify regarding the following requirements: 1. "Record and **perform** the appropriate services…" – is the Enterprise asking for the C/CMS to perform services or just support recording of services performed by agency staff? "Serve as the State Case Registry for the New Mexico Title IV-D Program" – is the Enterprise asking for the C/CMS to become source system for this registry for the State of NM?	CSED is not asking for this immediately. CSED has separate process and timeline for software upgrades and improvements. It is important that the system has the capability to provide Case Management services that are compliant with OCSE for possible future use. The Vendor should look at the OCSE documentation for understanding of Child Support process areas such as case initiation, management, etc.

164	Table 14 – C/CMS	10.085		As we did not locate the following acronyms in Addendum 7 – HHS 2020 Acronyms or on the CYFD website, for this requirement: 1. Please confirm acronym CMHS stands for Center for Mental Health Services a. If not, please provide correct definition Please provide definition of acronym SPT	CMHS = Community Mental Health Services Regarding SPT, the correct acronym is SAPT, which stands for Substance Abuse Prevention and Treatment.
165	Table 14 – C/CMS	10.086		Please clarify the statement "…provides services for CYFD…" – is the Enterprise asking the C/CMS to staff to provide services or is this requirement referring to supporting the activities/services provided by CYFD staff via the C/CMS?	The activities/services provided by CYFD staff via the C/CMS.
166	Table 14 – Strategy and Project Management (S&PM)	11.011		Please provide or direct us to SI's processes, standards and description of Shared Services so that we may review and describe how we will comply with same. (Please note, we were not able to find the SI RFP at the Open Requests for Proposals (RFPs) site or Closed Requests for Proposals (RFPs) site provided by the State.)	The Concept of Operations document, which describes planned Shared Services, has been added to the Procurement Library. The SI System Design Document has also been added to the Procurement Library. Finally, the SI RFP has been restored to the Closed Requests for Proposals site.
167	Table 14 – Strategy and Project Management (S&PM)	11.016		Please provide or direct us to the complete list of HHS 2020 EPMO tools and processes that are/will be utilized by the enterprise so that we may review and describe how we will comply with each.	The EPMO is using the HSD toolset to manage the project including: • SharePoint for Risks Issue Decisions and Action Items and Deliverable reviews; • Requirements Traceability leverages Jama; • Test Management leverages Jira; • The Enterprise Project Schedule is in MS Project; • MS Teams is being used to support collaborative communication; • Vendor Contract Management leverages Jira.

168	Table 14 – Service Expectations (SE)	12.001		Please provide or direct us to SI's Integration Platform requirements, standards, and/or process so that we may review and describe how we will provide secure and reliable data exchange.	The SI System Design Document has been added to the Procurement Library.
169	Table 14 – Service Expectations (SE)	12.010		Is there additional documentation illustrating Enterprise architecture that we may review in order to better describe how we will comply? We have reviewed Addendum 20 – HHS 2020 Vision and Architecture which provides an illustration of Technology Architecture, but only high-level descriptions of Business and Information Architecture.	The Reference Architecture document has been added to the Procurement Library.
170	Table 14 – Service Expectations (SE)	12.011		Please provide or direct us to the State-approved Data Governance directives/policies so that we may review and better describe how we will comply. (We do not find this documentation among the addendums provided in the Procurement Library.)	The Data Governance Council Charter has been added to the Procurement Library.
171	Table 14 – Service Expectations (SE)	12.031		Please provide or direct us to a copy of the State specified style guide so that we may review in order to better respond to this requirement.	We will not provide a style guide at this time.
172	Table 14 – Service Expectations (SE)	12.034		Please provide or direct us to the standards, processes, and any relevant information on the State's Legacy System so that we may review and describe how we will convert all applicable data and produce comparative reports for previous periods of operation from the converted data.	It is the responsibility of the SI to convert the data. The selected Offeror will consume the converted data.
173	Table 14 – Service Expectations (SE)	12.035		Please provide or direct us to a copy of the State and Federal data retention policies referenced in this requirement so that we may review in order to better respond to this requirement.	The State's expectation is the offerors will be familiar with federal data retention requirements. State requirements for Medicaid are found in the New Mexico Administration Code, Title 1, Chapter 21, Part 2, Section 814 (1.21.2.814 NMAC):

					ASSISTANCE - MEDICAL: A. Category: Public health and social services - family and aging B. Description: Records related to medical assistance. C. Retention: destroy six years from date audit report released Record retention requirements for other Enterprise agencies are in various sections of the New Mexico Administration Code, Title 1, Chapter 21, Part 2 but may not all be relevant to MMISR or HHS 2020.
174	Table 14 – Service Expectations (SE)	12.036		Please clarify what the State means by "…transfer to the State…all…software…" as it pertains to a SaaS based solution.	Please refer to 45 CFR 95.617.
175	Table 14 – Service Expectations (SE)	12.040		Please provide or direct us to the standards, processes, and any relevant information on the State's common business rules repository so that we may review and describe how our proposed solution will integrate its standardized business rules data.	These are not available at this time.
176	Table 14 – Certification	14.001		Please confirm that the State is describing 508 compliance for the C/CMS which will be used by internal State and other State agency staff. Or does this requirement pertain to portions of the solution which will be used by individual members?	Any user-facing solution must be 508 compliant.
177	C. GENERAL REQUIREMENTS 32. No Resources Provided by NM HSD to the MMISR BMS or C/CMS Contractors		42	Will NM HSD provide any physical location facilities for activities such as meetings with NM HSD staff to conduct activities required to configure/deliver the C/CMS Solution or to provide training to C/CMS users?	Yes, when available.

178	APPENDIX N – C/CMS Detailed Requirements		249	For the requirements in Table 14, should the Offeror provide both the responses indicated in the instructions (e.g. "Product Type", "Currently Deploy") and also provide narrative responses to the detailed requirements?	Narrative responses in this section may also be provided as long as the required response format is maintained.
179	General			Will NM HSD consider increasing the page count limit on responses?	Yes. Amendment 2 increased page limits for some responses.
180	General			What is the estimated number of users that will use the C/CMS across the Enterprise?	There may be as many as 3,000 users on the C/CMS system (approximate and subject to change).
181	2.2.3 Utilization Management (UM) / Utilization Review(UR)		83	Do the UM/UR requirements apply to non-Medicaid health services, such as through BHSD or through CYFD?	Yes. All HSD programs, including MAD, will be the first to be implemented. The other participating Enterprise programs will follow.
182	APPENDIX H – BMS DETAILED REQUIREMENTS Requirement 1.08	1.08	110	Please provide the location to find a detailed definition and description of the "Customer Communication Management (CCM)".	Customer Communication Management (CCM): Customer communications management (CCM) is defined as the strategy, mechanisms and technologies used to improve the creation, delivery, storage and retrieval of outbound communications, including those for marketing, new product introductions, renewal notifications, claims correspondence and documentation, and bill and payment notifications.
183	APPENDIX H – BMS DETAILED REQUIREMENTS Requirement 3.02	3.02	126	Please define authorization request in the context of this requirement and what attributes of the authorization are being "updated"?	An authorization request has been approved for specific services, quantities, costs and/or timeframe, and the provider wishes to update one or more of these attributes. For example, the timeframe during which the services will be rendered may be extended or a quantity of services increased.
184	APPENDIX H – BMS DETAILED REQUIREMENTS	3.03	126	In the context of UM/UR, what is the scenario where a Member has a service plan given that Service Plans are typically seen in Home and Community-based Services?	The BMS Contractor is responsible for the review and approval of initial and annual service and support plans and budgets for member in the Developmental Disabilities DD)

	Requirement 3.03				and Medically Fragile (MF) Waiver Programs, as well as revisions to such plans and budgets.
185	APPENDIX H – BMS DETAILED REQUIREMENTS Requirement 3.49	3.49	133	Is there a complete list of HIPAA transaction sets (e.g. 278) that HSD intends to use within the HHS 2020 Enterprise?	Yes. See below.

270/271 – Eligibility Inquiry and Response
276/277 – Claim Status Inquiry and Response
278 – Service Review (Authorization Request)
820 – Premium Payment
834 – Benefit Enrollment and Maintenance
835 – Claim Payment/Advice
837 – Health Care Claim
TA1 – Interchange Acknowledgement
997 – Functional Acknowledgement
999 – Implementation Acknowledgment
NCDPD 1.2 – Pharmacy Claim Batch Transaction
NCPDP D.0 – Pharmacy Claim Real-time Transaction |
| 186 | APPENDIX H – BMS DETAILED REQUIREMENTS Requirement 3.63 | 3.63 | 135 | Please provide the location within the solicitation or procurement library that lists the Enterprise and federal policy requirements for this requirement. | The State's expectation is the offerors will be familiar with federal data retention requirements. State policy requirements are found in the New Mexico Administration Code, Title 8, various chapters. Offerors may wish to review the contract of the current Utilization Review contractor, Qualis (now known as Comagine Health), which is available on the HSD website: https://www.hsd.state.nm.us/LookingForInformation/medical-assistance-division.aspx |
| 187 | APPENDIX N – C/CMS Detailed Requirements Requirement 10.021 | 10.021 | 253 | Will a State Plan case type be a data element within a Member/Client record that is being managed in the C/CMS or is the State Plan and State Plan Amendment process not part of a Member/Client workflow but rather a separate business function supported by the C/CMS? Please provide details. | It is a data element in the Client record.

The State expects to use the C/CMS system for tracking SPAs. |

| 188 | APPENDIX N – C/CMS Detailed Requirements Requirement 10.032 | 10.032 | 254 | Please provide more details including what Division/business unit requires this, what are date segment records, what is being evaluated and what entity is being paid and by whom? | The capability was originally requested by ALTSD/Adult Protective Services (APS), although multiple agencies may use this functionality. "Member legal information" includes any interaction with law enforcement, police reports, etc. Date segment records allow the user to document specific incidents.

The C/CMS Contractor will not be required to issue payment; payments will be made by the FS contractor. However, the C/CMS must be able to capture the payment source for any referrals made to service providers, such as Medicaid or the agency itself. |
| --- | --- | --- | --- | --- | --- |
| 189 | APPENDIX N – C/CMS Detailed Requirements Requirement 10.058 | 10.058 | 262 | Is NM HSD seeking a BPO firm to provide staff that will perform these functions (e.g. perform a PASRR workflow)? | Yes. |
| 190 | General | | | Is HSD's expectation that all functional requirements specified in the solicitation and associated documents within the procurement library for the C/CMS be fully deployed by the end of calendar year 2021, or are phased "go-live events" permitted beyond this date in accordance with an agreed upon project plan? | Yes. The state expects all requirements to be fully deployed within calendar year 2021. |
| 191 | APPENDIX N – C/CMS Detailed Requirements Requirement 12.034 | 12.034 | 273 | Approximately how many legacy data systems are expected to be in scope for data migration? | Each Enterprise agency has at least two systems, possibly more. |
| 192 | APPENDIX N – C/CMS Detailed Requirements Requirement 12.034 | 12.034 | 271 | Please provide more details regarding the business objective sought in this requirement. | This requirement is in reference to data conversion and producing comparative reports in order to make sure that data consumed into the Contractor's system from the data conversion process was successful. |

193	APPENDIX L – C/CMS COST RESPONSE FORM #1		217	So to enable HSD with the ability to accurately compare Offeror's cost responses, will HSD consider revising its cost response form to require more details regarding one-time implementation costs in addition to ongoing Maintenance and Operation costs?	Details on costs are to be provided in the narrative part of the cost proposals, which are to include detailed budgets.
194	APPENDIX N – C/CMS Detailed Requirements Requirement 10.042:	10.042	260	Will the ESB be available at the time of implementation? If not, what is the planned timeframe for when the ESB will be available for both testing and production use?	The ESB is planned to be available by the time of module integration. While some services will be available on the ESB at that time, the System Integrator will work with the selected offeror to expose and/or accept additional services to/from the BMS module.
195	APPENDIX N – C/CMS Detailed Requirements Requirement 10.042:	10.042	260	If the ESB already exists, is there any information that can be provided around end points that are available and the functionality that they provide?	The ESB is not yet fully operational but use the Oracle Fusion Middleware ESB solution Oracle Service Bus. End points will be developed based on the service-enabled capabilities of each of the modules. Other planned endpoints include the ability to store and retrieve electronic documents through the Electronic Document Management service, the ability to validate addresses through the Address Standardization and Validation service, the ability to generate or retrieve correspondence through the Customer Correspondence Module, and gather and submit data from and to the Operational Data Store and/or the Master Data Management solution. Please see the SI System Design Document for more information.
196	APPENDIX N – C/CMS Detailed Requirements Requirement 10.064:	10.064	264	Can you share information the external case type specific workflows that are needed?	Various systems will be supplying case-type workflows to the C/CMS solution during implementation. The State expects the Contractor to work with the Enterprise on improved and more efficient workflows. The Contractor is responsible for implementing its own workflow capability within its solution,

					which must be able to receive external messages from and send messages to the Enterprise Service Bus using the canonical data model. The ESB will direct such messages to the external system.
197	APPENDIX N – C/CMS Detailed Requirements Requirement 10.069:	10.069	265	What system will be considered the "source of truth" for user accounts?	The requirement cited doesn't speak to "user accounts".
198	APPENDIX N – C/CMS Detailed Requirements Requirement 10.069:	10.069	265	Are there any preferred methods for security (related to IDAM and SSO)?	The HHS 2020 Systems Integrator (SI) contractor is responsible for IDAM/SSO implementation. They are using Oracle Identity Manager.
199	APPENDIX N – C/CMS Detailed Requirements Requirement 11.001:	11.001	269	Can you share information around the HHS 2020 framework processes and standards? Is there documentation for the Federal and State regulatory and policy requirements?	The procurement library should have all the information Offerors may need on framework.
200	APPENDIX N – C/CMS Detailed Requirements Requirement 12.006:	12.006	273	Can you share information around what the expected data and resource volumes will be?	This information is not known at this time. The State is looking for a robust solution that can meet the needs of the HHS 2020 Enterprise.
201	APPENDIX N – C/CMS Detailed Requirements Requirement 12.016:	12.016	274	Can you share information for the HHS 2020 security standards?	HHS 2020 Security requirements are from • CMS Minimal Acceptable Risk Standards for Exchanges (MARS-E), Version 2.0 dated November 10, 2015; • Internal Revenue Service (IRS) Publication 1075; • Confidentiality of substance use disorder Patient Records (CFR) 42 Part 2.
202	APPENDIX N – C/CMS Detailed Requirements	12.041	276	Can you provide example of items that would require check-digit verification?	Amendment 2 deleted this requirement.

	Requirement 12.041:				
203	APPENDIX H – BMS DETAILED REQUIREMENTS Requirement 1.09:	1.09	110	Can you share the Data Governance policies on Member data?	The HHS 2020 Data Governance Council will be developing policies specific to member data at a later date. These policies aren't available at this time.
204	APPENDIX H – BMS DETAILED REQUIREMENTS	1.09	110	Is there documentation available that describe the methods available for integrating with the Master Data Management (MDM) service?	Not yet, but Master Data Management (MDM) services will include the ability to get a single data domain by its unique identifier, the ability to get a collection of results based on criteria provided, and the ability to set data elements (with permissions based on the module's status as a system of record for that data element).
205	APPENDIX H – BMS DETAILED REQUIREMENTS Requirement 3.49:	3.49		What HIPAA transaction sets are expected to be used as part of this implementation?	Please see the response to Question 341 (below).
206	Appendix H, Table 9	4.06	137	For Requirement 4.06, does the State intend for the code sets, rates and service limits to be maintained in a separate reference system, or will these be maintained within the FS contractor's Claim Processing system?	The Contractor is responsible for storing and maintaining the code set and rate data required to support claim adjudication in a separate reference system, which will be the system of record for all such data. The BMS Contractor will also be expected to work with the FS Contractor to review and verify configuration changes associated with benefit plan updates, although FS staff will be responsible for the configuration itself and the FS claim adjudication system will be the system of record for benefit plans and associated rules. Please see Amendment 2.
207	Appendix H, Table 9	4.07	137	For Requirement 4.07, does the State expect that changes to the reference information in the FS contractor's Claim Processing component will be done in an automated fashion (i.e. API or file upload?)	Yes.

208	Appendix G, Section 2.2.1 Member Management		80	Regarding the requirement that vendors "Provide and update a configurable, flexible periodicity table of EPSDT services to provide for on-going updates as policies change," does the State intend for vendors to use State-defined periodicity schedules for medical, dental, vision, hearing, and behavioral health screenings, or does the State intend that vendors submit proposed periodicity schedules?	The State intends for the Contractor to use the State-defined periodicity table. However, the vendor is encouraged to propose a periodicity schedule for the State's consideration.
209	Appendix H, Table 6		109	Is the Member Management system expected to apply EPSDT rules on the member data available to it or is there any third-party system that identifies the EPSDT population and sends it to the Member management system?	The Member Management system is expected to apply EPSDT rules on the member data that is made available. The Contractor is also expected to be proactive and identify members of the EPSDT population and apply the EPSDT rules.
210	Appendix G, Section 2.2.1 Member Management		79	Is eligibility and enrollment information provided in real-time from other systems, or are we expecting to receive the information in an interface file? Please confirm that eligibility and enrollment information from ASPEN is provided in real-time through the ESB.	The ultimate goal is to provide real-time, but preliminary phases may require batch process.
211	Appendix G, Section 2.2.1 Member Management		81	Can member demographic data (name, mailing address, email address, phone, driver license number, DOB, SSN) be accepted from any State source?

In case of a conflict (e.g., an update from ASPEN, or an update that should be communicated back to a State system), is the Member Management vendor expected to resolve a data conflict via phone call, email, letter etc.? | Yes. The data can be accepted from any State source that is part of the HHS2020 Enterprise.

Conflicts will be resolved within the Master Data component provided by SI. The BMS Contractor will not be expected to resolve any conflicts. |
| 212 | Appendix G, Section 2.2.1 Member Management | | 81 | If vendors are expected to receive data from external data sources, is the vendor expected to verify any PII/PHI information from the third-party data sources? | Yes. |

213	Appendix G, Section 2.2.1 Member Management		81	Is the Member Management vendor expected to broadcast the changes to the Member Demographic data, by one system, to all interfacing parties? If so, what frequency and format of the changes to be sent?	The BMS Contractor is expected to provide bi-directional member demographic data to the MDM. The MDM will then send the data to any systems that may need the data. The State intends for the exchange of data to be real time and in the format that will be identified by the State.
214	Appendix G, Section 2.2.1 Member Management		80	Is the Member Management vendor expected to make or receive phone calls related to EPSDT and/or other outreach and education services? If so, will the Member Management vendor use the C/CSC telephone structure or will it be required to provide its own? If no, is the Member Management vendor expected to generate the outbound dialer files or messages for the NM C/CSC or that vendor's telephony system?	Yes. The Contractor will be required to provide their own telephone structure for such outreach. No. They will not be using the CCSC phone structure for outbound campaigns.
215	Appendix G, Section 2.2.1 Member Management		80	Can the State confirm that we will have access to claims and encounter data to track receipt of EPSDT services, referrals, and follow-ups? Or is there any other data source State is considering for this information? Will the vendor be responsible for tracking services that are an outcome of the EPSDT screening services?	The State confirms the BMS Contractor will have access to such data either from the FS Contractor or the DS Contractor provided via the ESB. The BMS Contractor will be responsible for the tracking of EPSDT services.
216	Appendix H, Table 6		110	What is the system of record for member opt-in choices for SMS and Email?	While these attributes will likely reside and be available through the MDM services, the Consolidated Customer Service Center and the Unified Portal will be two systems that could modify authorized rep and member opt-in choices after initially being set. ASPEN, the eligibility system, will also contribute to the

					initial capture of member contact preferences through the initial application.
217	Appendix H, Table 6		110	Are we expected to push any notifications to State mobile app?	This has not yet been determined but will be considered during UP design. Vendors should be prepared for implementing this function.
218	Appendix H, Table 6		110	Are we expected to capture and store images of Member documents (such as birth certificates, social security cards, driver's license, etc.) as part of the Member Management system?	The SI Contractor is providing an Enterprise Content Management solution. The BMS Contractor is expected to integrate with the enterprise solution which will allow BMS users to be able to view member documentation that will be captured, indexed and stored within the ECM solution from the various enterprise systems/modules.
219	Appendix H, Table 6		110	Are we expected to keep document links in the member management system for any document stored in electronic content management system (ECMS) system outside the Member Management system?	Yes.
220	Appendix H, Table 6		109	Regarding Data Access Rules and Member preferences (Authorized Rep, opt-in from channels), what is the system of record for capturing the member data access preferences and what is the hierarchy for establishing data access rules?	While these attributes will likely reside and be available through the MDM services, the Consolidated Customer Service Center and the Unified Portal will be two systems that could modify authorized rep and member opt-in choices after initially being set. ASPEN, the eligibility system, will also contribute to the initial capture of member contact preferences through the initial application.
221	Appendix H, Table 10	6.34	148	In requirement 6.34 the State specifies that the contractor will work with the SI Contractor to convert "all applicable data" from the legacy system. What is the approximate size (e.g. terabytes, etc.) and how many years of data are you expecting to convert (e.g. last five years)? Is there any expectation of data cleansing as part of data conversion?	The operational size of the legacy system is approximately 500 GB, and it includes seven years of claims data (plus claims for services that can only logically be provided one in a period that is greater in duration than seven years, such as a hysterectomy, which can only be performed once in a lifetime). All client data is kept by the eligibility system, which will continue to be available online after implementation of the MMIS replacement. The

						converted size is estimated at around 2 TB but is anticipated to available via the ESB. Data older than the seven years of claims will also be converted for historical purposes but will not be provided by default to the module. Data cleansing will be performed as part of the data conversion.
222	Appendix H, Table 10		147		How many State users will need to access the Member Management system to perform functions beyond viewing information? Can the State provide estimations of user counts by State role and by other vendors role, such as C/CSC?	There may be as many as 3,000 users on the C/CMS system (approximate and subject to change). Projected information about other vendors is not available.
223	Appendix H, Table 10		147		Can the State please confirm that the BMS vendor is required to use a single-sign on solution provided by the SI vendor? If so, please provide technical documentation on that solution.	Yes, the BMS vendor is required to use the single sign on solution provided by the SI vendor. The SI vendor will be using the Oracle Identity Access Management system, which is part of the Oracle Fusion Middleware suite.
224	RFP Section VI. A, Table 2		27		Will bidders have the opportunity to ask follow-up questions based on the State's response to questions?	No.
225	Section VIII. Evaluation		51-54		How will vendors be evaluated if they propose services and capabilities beyond the RFP, which may result in additional cost?	The State anticipates that an Offeror proposing such services would include information on the value and cost to the State for the enhanced services. Include this in the Budget Narrative.
226	16. Offeror Terms and Conditions		36		Item 16 allows Offerors to propose "specific, alternative language in writing and submit it with its proposal." The second paragraph also allows Offerors to submit "any additional terms and conditions that they expect to have included in a contract negotiated with the Agency." • Where in the proposal should Offerors place this language? Should Offerors place this language in Tab 13 Additional Items? Please confirm where the State is expecting to see this language.	Proposed revisions to the Sample Contract, including Terms and Conditions, are to be submitted as red-lined documents in Tab 15 (Additional Items) in Binder 1. They are not included in the page limit. Note that the page limit has been increased to 350 pages.

				Please confirm that this language is EXCLUDED from the page count of 300 pages.	
227	28. New Mexico Employees Health Coverage		38	The wording in Item 28 ("Offeror must agree to have in place," "Offeror must agree to maintain," "Offeror must agree to advise") implies that these agreements must be placed in the proposal. (1) Please confirm that Appendix F is the correct response to Item 28. (2) If this assumption is not correct, please confirm that the response language is EXCLUDED from the page count of 300 pages. Or—is the submission of a proposal sufficient to indicate agreement?	Yes, confirmed that completion of Appendix F will fulfill this response, and it is not included in the page count. Note that Amendment 2 increased the page limit for some responses.
228	31. Disclosure Regarding Responsibility		39	Item 31 states, "RFP proposal should include all disclosures." • Where in the proposal should Offerors place this language? Should Offerors place this language in Tab 13 Additional Items? Please confirm where the State is expecting to see this language. Please confirm that this language is EXCLUDED from the page count of 300 pages.	Confirmed that these are excluded from the page limit. These are to be placed in Tab 15 (Additional Items) as noted in Amendment 2.
229	D.3, Proposal Format		44	The Proposal Format instructions state, "The original RFP requirement text must be included in Offerors' proposal responses and cannot exceed the three hundred (300) page limit." Some of the individual requirements in Appendix H take up a half page. Even using 10 point font, including the entire text of each requirement in the 43 pages of Appendix H will take up a considerable portion of the 300 pages that are allowed for the entire proposal. Will the State increase the page limit to 350 pages?	To allow for the inclusion of the required text from the original RFP, we have increased the page limit for this response to 350 pages in Amendment 2.

230	D.3, Proposal Format		44	The Proposal Format instructions state, "The original RFP requirement text must be included in Offerors' proposal responses. . ." Does this requirement apply to the **mandatory State required forms** (RFP text for the forms is found on pages 49 and 50)? Including this text on a separate page for each required form would take up 2 pages per form (assuming double-sided copying), which would eat into the 300 pages allowed for the entire proposal without adding valuable content. Please confirm that the requirement to include FS RFP requirement text does NOT apply to the State required forms.	The original RFP text inclusion requirement does not apply to the mandatory required forms.
231		D.3, Proposal Format	44	The list of items that are excluded from the page count includes pricing. Please confirm that this pricing exclusion applies to everything in Binder 2 Cost Proposal: the Appendix B price sheets, budget narrative, estimated work schedule, and assumptions.	Confirmed, the page count does not include Cost Proposal materials in Binder 2.
232		VII.B.4, Performance Bond Capacity Statement	49	To satisfy the Performance Bond Capacity Statement, Offerors must include "a letter or statement of concurrence" with the proposal. Does this letter or statement of concurrence count as a "mandatory State required form" and therefore is excluded from the page count of 300 pages?	Yes, it is to be submitted in Binder 1, and it is excluded from the page count, which has been increased to 350 pages in Amendment 2.
233		Appendix H, Table 10, ID number 6.21 samples of training materials	147	ID number 6.21 on page 147 requires samples of training materials. Please confirm that: • Offerors may place these training material samples in an Appendix. These training samples will NOT count against the page limit of 300 pages.	Yes. The training materials are excluded from the page count, and they are to be placed in Tab 15 (Additional Items) in Binder 1.

234		Appendix H, Table 10, ID number 8.04 Certification artifacts/evidence samples	150	ID number 8.04 on page 150 requires samples of Certification artifacts/evidence. Please confirm that: • Offerors may place these Certification artifacts/evidence samples in an Appendix. These Certification artifacts/evidence samples will NOT count against the page limit of 300 pages.	Yes. The Certification materials are excluded from the page count, and they are to be placed in Tab 15 (Additional Items) in Binder 1.
235		Appendix B	51	Will the State confirm that: ALL services provided under the scope of work by the vendor are subject to the NMGRT, and that the GRT rate will be determined based on the specific location of the Vendor's New Mexico office, even if some portion of the Vendors' services are provided in a location outside of NM.	We suggest Offerors refer to NM statutes and the NM Tax and Revenue Department for questions on taxes.
236		VI.A.6, Sequence of Events	27	To ensure that vendors provide the most comprehensive proposal response, and in order to give vendors time to adjust and accurately incorporate the State's answers to questions, would the State please consider extending the due date of the proposal by 30 days?	See Amendment 1 for the revised schedule and new proposal submission date.
237		D.3, Proposal Format	44	The requirement to include "the original RFP requirement text" with our proposal and write individual responses to each of these requirements is clashing with the page limit of 300 pages for the entire proposal. In preparing our response documents, we found that the total page count for the 7 modules in Appendix H (Member, Provider, etc.) comes to 43 pages: these are just the requirements typed in 10 point font with no answers. That does not allow sufficient room for the kind of detailed, value and outcomes-focused responses that the State is looking for. Will the State increase or eliminate the page limit?	To allow for the inclusion of the required text from the original RFP, we have increased the Requirements Response page limit to 350 pages in Amendment 2.

238		MMISR Approach	14	Is the State's intent that the BMS vendor shall not scope the utilization of its native UI components against the NM user community, but rather a limited user community?	Yes.
				The primary interface for all Stakeholders will be the UPI. The UPI will ingest web services via the ESB, and the Financial services vendor shall make all necessary data available to the SI vendor.	
239		Appendix I, Article 3 Compensation, E Performance Bond	161	There is a reference that performance bond will be mutually agreed upon and also that "The required Performance Bond shall be conditioned upon and for the full performance, Acceptance and actual fulfillment of each and every Deliverable, term, condition, provision, and obligation of the Contractor arising under this Agreement"	The entire contract value, DDI and M&O.
				Please clarify if the intent is that the bond will be for the value of the Agreement to include DDI and M&O?	
				If not, please clarify expected % of Agreement for DDI and M&O for determining bond value and costs.	
240		D.2.A	43	Please confirm the reference to "unsecured Word" means the documents are not password-protected.	Yes, confirmed.
241		VII.B.8	50	To satisfy the Eligibility Statement, Offerors must include "a signed statement" with the proposal.	Ye. It is excluded from the page count.
				Does this signed statement count as a "mandatory State required form" and therefore is excluded from the page count of 300 pages?	
242		VII.B.7	49-50	To satisfy the Pay Equity Statement, Offerors must include "a signed statement of occurrence" with the proposal.	Yes. It is excluded from the page count.
				Does this signed statement of concurrence count as a "mandatory State required form" and therefore is excluded from the page count of 300 pages?	

243		D.2	42-43	Please confirm that the State is expecting the following number of electronic versions of the Technical and Cost proposals: • Technical Proposal—the requirement is for 12 CDs Cost Proposal—the requirement is for 1 CD	See Amendment 2 for revised Format and Organization requirements, including electronic versions.
244		VIII.A VII	51 46	"Organizational Experience (Narrative)" is worth 40 points but does not clearly tie to a proposal response requirement as defined in the RFP. The closest tie appears to be the requirement in Tab 11, bullet 3, where offerors are required to describe two BPO projects. Please confirm that the response to bullet 3 is what the State is expecting to see when evaluating for the 40 points allowed for Organizational Experience. If this is not what the 40 points are for, please provide guidance as to where in the proposal Offerors should be responding.	Amendment 2 has revised language to clarify the Experience & Personnel responses.
245		3.1.12	44	The explanation for Tab 12, Response to Specifications for Appendix H (for BMS) implies that the response to "Organizational Experience" goes in Tab 12. However, it appears that the Organizational Experience response now belongs in Tab 11 (where offerors are required to describe two BPO projects). Should this reference to "Organizational Experience" be deleted from the description of Tab 12?	Experience and Personnel responses, including Organizational Experience are to be submitted in Tab 13 per the revisions in Amendment 2.
246		II.A.3 Quality Assurance	15	Page 15 of 287 covers "Program Integrity support" within 3. Quality Assurance (QA) – "HSD is contracting with a BPO Contractor to provide the following Enterprise components of the QA Business Services using a CMS-compliant platform and processes: A. Program Integrity (PI) support, including Third-Party	Confirmed.

				Liability (TPL), Fraud and Abuse Detection System (FADS), services audit coordination and compliance" Will the state confirm that the PI system will be provided by the QA vendor?	
247	Pre-Proposal Conference		N/A	It was discussed that approximately 90% of the Medicaid recipients are supported by MCO's, approximately 10% are FFS, plus there are the other programs. Can the State provide more guidance on what services are expected to be provided through this contract for the FFS vs. the MCO's themselves?	Refer to Statement of Work, Appendix G.
248	Table 10, following ID 9.04		151 of 287	Below Table 10 – General Requirements in Appendix H, there are three additional required responses (for Staffing model, expectations for support from HSD, and how the business model enables cost-effective BMS operations). However, please clarify if there are any technical points assigned to these items for evaluation purposes.	Those responses will be evaluated and scored along with the others in the Requirements Response and are include in that score.
249	D.3.1.3, Proposal Content and Organization		44	Tab 3 is the "Two (2) Page Summary of Offeror's Approach." The complex nature of the approaches developed by Offerors—technical solution, understanding of the State's vision for BMS, teaming partners—offerors will need more than 2 pages to adequately summarize their responses. Will the State increase the page limit for Tab 3 to four (4) pages?	Yes. The page limit for the "Summary of Offeror's Approach" (Tab 3 in Binder 1) has been increased to four (4) pages in Amendment 2.
250	D.3.1.11, Proposal Content and Organization		44	Tab 11 is the 4-5 page summary of the Offeror's Response to Specifications for Appendix H (BMS). Within these 4-5 pages, Offerors are required to respond to five complex topics (as described on RFP page 46).	Yes. The page limit for the Statement of Work Response have been increased to 10 pages in Amendment 2.

					Each of these topics could generate several pages of response. Will the State increase the page limit for Tab 11 to 8 pages?	
251	1.12			110	Please explain the size of the surveys; will they be large batch surveys to groups of participants, or whether these will be individual questions to specific participants over time?	The surveys could be batch or individual surveys depending on the business need of the survey.
252	1.14			110	Would you please list the languages required to be supported?	The primary languages are English and Spanish. The BMS Contractor must have sufficient bilingual staff to support Spanish-speaking members. The use of a translation service (including Native American languages) is acceptable for any other member interaction request requiring a translator.
253	1.15			110	With regards to service materials mentioned: is this expected to include physically printed materials?	Yes. This could include physically printed material.
254	2.2.2			81	What is the expectation in the tracking of outreach for un-enrolled members and non-participants who convert to enrollment?	The State expects the BMS contractor to submit a monthly status report identifying outreach activity and listing providers who have enrolled in response to previous outreach efforts
255	2.2.2			81	Contractor's Provider Management component must provide configurable business rules to meet all the business needs outlined in this Section 2.2.2. Will the state provide the existing rules to be used by the replacement MMISR system?	The Provider Subsystem documentation for the legacy MMIS is in the Procurement Library under "Xerox Information." The current Conduent Provider Enrollment Manual has been added to the Procurement Library under "Procedure Manuals."
256	2.2.2			83	"The State's vision of the transformed Medicaid Enterprise is largely paperless. From a practical standpoint, hard copy notices must sometimes be produced, and hard copy correspondence and enrollment applications will still be received." Will the State provide the printing and mailing of the printed materials to citizens?	Yes.

257	2.2.2		83	"HSD has established a centralized operation to support the receipt, handling, and scanning of documents and has contracted with print/mail vendors to distribute outgoing correspondence." Will the State assume the receipt, handling, and scanning of all inbound mailed correspondence related to all components of the BMS proposal?	Yes.
258	2.2.2		83	"The SI Contractor provides standardized software that is used across the Enterprise to support these activities. Thus, the Contractor must implement procedures to process electronic data sent via the SI rather than paper documents and will route outgoing correspondence electronically via the SI to HSD's print/mail vendors for distribution." Will the State provide printing and mailing of all physical printed materials in support of the BMS contract?	Yes.
259	2.2.2		83	"The Provider Management service must include comprehensive training using a combination of web-based and instructor-led training." Will the State provide facilities and training rooms to support all of the training requirements listed in the BMS request for proposal?	Training rooms will be made available for training of State staff in Santa Fe. The BMS contractor is responsible for arranging for facilities and training rooms for stand-up provider training.
260	2.2.2		83	"The Contractor must develop and deliver these trainings pursuant to the Contractor's proposed Provider Management Training Plan, which must be submitted to and approved by the State." Will the State provide the number of participants to be trained in support of the BMS proposal?	Data on the number of active providers has been included in the Procurement Library (Addendum 9 – HHS 2020 MMIS Activity Data). Offerors should use their experience to estimate the number of these providers who will avail themselves of training offerings.
261	5.11		144	"Offeror shall describe how its proposed services comply with the SI's processes, standards and Shared Services, and how Offeror will coordinate integration with the SI Contractor."	The Concept of Operations document, which describes planned Shared Services, has been added to the Procurement Library. The SI System Design Document has also been added

				Will the State please provide the SI processes, standards, and description of Shared Services that is required to be integrated into?	to the Procurement Library. Finally, the SI RFP has been restored to the Closed Requests for Proposals site.
262	6.06		146	"Offeror shall describe how its proposed services handle the anticipated data and resource volumes for the BMS services." Will the State please provide a detailed volume of participants by each waiver program, along with historical or expected increases year over year? If these statistics exist in the Bidders Library, please identify the specific document that contains the statistics.	Historical and projected trend information is not available. Current waiver enrollment is as follows: Developmental Disabilities 3,185 Mi Via 1,682 Medically Fragile 172 PACE 403 Brain Injury 68
263	Appendix B		62	Will the State confirm that Vendors are allowed to define and propose a DDI Phase for the contract and that the State will modify the pricing sheets Appendix B BMS Cost Response Form #1 to differentiate fixed price costs for the DDI in Yrs 1 - X and that O&M costs can be listed separately in Yrs 1 - X?	The Cost Response Forms will not be revised to differentiate a DDI phase. Offerors can describe their proposed phasing and pricing in the budget narrative and detailed budget that are part of the cost response
264	General			Will the State confirm or clarify that: 1) systems necessary to fulfill service in BMS may be proposed and are independent of or not redundant with the C/CMS systems and 2) that any BMS systems may connect directly to the C/CMS and/or the Enterprise data store to share, leverage or use data and information necessary for either or both systems and services to function effectively?	1. Yes. 2. No, the BMS and C/CMS contractors will connect via the ESB.
265	General			Will the State confirm that all BMS services that require the management of Providers, Members, UM/UR and/or Benefits, may interact completely and in a bilateral manner with all stakeholders directly and that	While this has yet to be fully designed, the State's intent is that all incoming inquiries be received and routed through the UPI. The CCSC will respond to and resolve Tier 1 & 2 inquiries.

					required work flows do not have to run through the Consolidated Customer Service Center?	Tier 3 inquiries will be automatically or manually transferred to the appropriate State staff or BPO. For the purpose of the question, the tier levels are provided: • Tier 1 – CCSC CSR front line staff; • Tier 2 – CCSC supervisor or management staff; and • Tier 3 – Non-CCSC Staff (e.g., State, other HSD's BPO module's Staff). Tier 3 is the final entity for contact resolution.
266	General				In addition, will the State confirm that the Consolidated Customer Service Center will be involved or used to support the process of services (trained, leveraged or used as another input channel) as an additional option or "door" vs the vendor being the primary means to deliver services.	Yes. Both the CCSC and UP will be used to access and support vendor services.
267	General				Will the State confirm that all BMS services that require the management of Providers, Members, UM/UR and/or Benefits may interact completely and in a bilateral manner with all stakeholders directly and that required work flows do not have to run through the UPI?	See response #265.
268	General				Will the State provide the volume of UM/UR events or transactions that are currently processed per year, by department or program?	See response #370.
269	General				Will the State provide the estimated growth rate in these areas volume of UM/UR events or transactions that are currently processes per year, by department or program	The State is unable to provide a forecast of future growth.

270	General			Will the State confirm that Provider management will include providers in the non-medical programs associated with LTC, BH, CYFD, and Social Services?	Confirmed.
271	General			Will the State confirm that Member management will include all people involved in 1) the Medical Fee For Service (FFS) and Managed Care Organizations (MCO) programs and 2) the non-medical programs associated with DOH, LTC, BH, CYFD, and Social Services?	Member Management will include member data from those identified as well as other programs and services that may be identified in the future.
272	General			Will the State confirm that UM/UR will include Prior Authorization for service in FFS, PBM and MCO medical programs?	The BMS Contractor is responsible for Prior Authorization for FFS services. The FS Contractor is responsible for PBM and each MCO authorizes services included in its benefit plan for its members.
273	General			Will the State confirm that services to be offered are "Ready to go within 60 days" of contract award may be interpreted as DDI efforts vs. full services?	Confirmed.
274	2.20		114	The RFP States, "Offeror shall describe how its proposed services allow providers to securely submit requests via multiple media for update, recertification, termination or cancellation of their provider agreement, including contacting the CCSC." What does "including contacting the CCSC" mean? Does this mean routing these calls directly to the BMS vendor for handling?	Provider updates may not be initiated via phone call. This requirement has been revised in Amendment 2.
275	2.33		116	The RFP States, "Offeror shall describe how its proposed services facilitate electronic submission of provider enrollment applications, **Medicaid claims and non-Medicaid payment request forms to providers for non-Medical providers** to those in need of assistance, such as Native American providers, providers of small size or in remote areas, and those without a history of connectivity."	Intake of Medicaid and non-Medicaid claims or payment request forms are the responsibility of the Financial Services vendor. The BMS vendor has the responsibility to facilitate electronic submissions of provider enrollment applications and claims for those providers identified in this section 2.33. These responsibilities include training and technical assistance.

				Please confirm that "submission of Medicaid claims and non-Medicaid payment request forms" are in the Financial Services scope of work.	
276	2.41		117	The RFP States, "Offeror shall describe how its proposed services identify critical enrollment providers and make them a priority by performing provider eligibility determination within twenty-four (24) hours of application. Offeror shall acknowledge that the State will define critical enrollment providers, such as Tribal 638 and Health Home providers." Please provide average monthly volumes on number of critical enrollment providers.	The State does not define "critical enrollment providers" based on broad categories and virtually never requires that its contractor make an enrollment determination within 24 hours. Any such request would be made on an exception basis due to an emergency situation involving a particular provider.
277	2.47		118	The RFP States, "Offeror shall describe how its proposed services initiate, capture and track the fingerprint based criminal background check results for State and Federally identified "high risk" providers and the direct and indirect ownership interests of the provider." Does the State currently utilize a centralized approach/solution for collection of fingerprint-based criminal background checks that could be leveraged?	HSD utilizes Gemalto to initiate fingerprint-based criminal background checks. If permitted by the federal government, HSD will delegate its Gemalto access to the BMS Contractor as well as the responsibility for verifying background check results; otherwise, HSD will continue to handle this activity. Regardless, the BMS vendor's solution must be able to capture the status and result of such background checks. Note that the volume of this activity is extremely low since the few providers who require fingerprint-based criminal background checks have generally passed such a check via Medicare or another State Medicaid Agency.
278	2.54		119	The RFP States, "Offeror shall describe how its proposed services capture, validate, reconcile and monitor the unduplicated members assigned to a provider and determine any applicable administrative fees." What fees is this referring to?	Disregard the reference to fees. Requirement 2.54 was revised in Amendment 2.
279	2.80		122	The RFP states, "Offeror shall describe how its proposed services provide for downloading official	Confirmed. The BMS Contractor is responsible for developing such publications. The UP will

				publications such as policy manuals and notices from a single-source State repository and for maintaining the most recent or updated copies of such publications." Please confirm that the BMS vendor supplies the content of these materials, and UPI vendor manages the repository.	offer the capability for publications to be uploaded by the BMS Contractor to a repository, where they may be accessed by UP users. The BMS Contractor is not responsible for maintaining the repository itself.
280	N/A			The document titled "MMIS Activity Data" in the Data library include provider maintenance. Will the State provide further breakdown of this information by the type of maintenance performed (e.g. demographic changes, change of ownership, additional service locations)?	The provider maintenance data is inclusive of demographic and other changes that do not require a new provider application, including additional services locations for which the provider is using the same tax ID, NPI, provider type and specialty. Change of ownership or a new service location with a different tax ID, NPI, provider type or specialty would require a new application and would be included in those counts.
281	II. MMISR Approach		13	There are references to the modules functioning as black-box, so that the inner workings of the module are not specified by the state. But there are also references to all modules sharing tools procured by the SI, including business rules and workflow. Are those enterprise tools required? For example: If a contractor has built their module as a product, with pre-constructed configurable BRE and workflows that use COTS tools inside the module, would they be permitted to continue to use those tools? Or would they be expected to remove and replace with the SI-selected tools?	Any tools that are part of the COTS tools exclusively within the vendor offering are permitted. The SI provided tools will be exercised for anything external to the vendor offering.
282	120		120	The RFP States, "Offeror shall describe how its proposed services enable NM Title IV-D Program providers to electronically provide all required information, receive and respond to income withholding orders, receive and respond to National Medical Support Notices, transmit payments to the program, submit New Hire Reports and meet all other relevant Title IV-D requirements, including being a part	The New Mexico Online Business Services Portal is a one stop shop for employers in New Mexico. It is not fully developed but it is meant to be the one place that employers go to for all business with the State of New Mexico. CSED issues withholding orders, medical support notices, employment verification

					of the NM DoIT's Online Business Services Portal (OBSP)." Will the State please provide more details on the scope of this requirement? Specifically – • Withholding Orders and Medical Support Notices - what type of information would be collected and maintained in the Provider's record? • Transmit payments – What payments are being referred to here and what payment information is being transmitted? If this is child support payments for medical care, please confirm this is financial information that would be handled in the FS contract and not BMS. • New Hire reports – What are these and how are they applicable to a provider's record? What does "being a part of the NM DoIT's Online Business Services Portal (OBSP)" entail?	letters and other communication though paper now. Any information as required by Federal and States policy need to be collected and maintained for employers. CSED receives $140 Million in child support payments annually. CSED then disburses those payments to custodial parents who are owed support. The distribution and disbursement of child support payment, rules as required by the Federal regulations are an integral part of all child support case management. All Employers in New Mexico are required to report their newly hired employees and CSED is responsible for overseeing this process, which is a currently a collaboration between CSED, a vendor and the Dept. of Workforce Solutions.
283	119			119	The RFP States, "Offeror shall describe how its proposed services monitor and track Presumptive Eligibility Determiner (PED) training and certification, including required comprehension test score requirements, and monitor and track PED performance." The state expects the solution to track providers' completion of training related to PED (Presumptive Eligibility Determiner). Please clarify what the PED training entails. Is there an expectation that the Provider Management module/solution will support the PED Process itself, by creating and placing PED function via a provider web portal?	Most PED training is conducted "live" by HSD staff via the Blackboard Learning Management System. Potential PEDs register in advance and participate in the training remotely. Training takes one-and-a-half days. At the conclusion of the training, participants are tested and must receive 90 percent or better to be certified. PED training will continue to be an HSD responsibility. PED enrollment is maintained in the MMIS by the Provider Management function using a unique provider type, but training will continue to be supported by Blackboard.
284	117			117	What kind of providers are meant by Non-Medicaid Providers?	A non-Medicaid provider is a person or entity that provides a good or service to a participant in an HHS 2020 benefit program not funded by the Medicaid program. Examples include

					foster parents, treatment foster care agencies, Domestic Violence Providers, Shelter and Supportive Housing Providers, Activity Therapy, some Infant Mental Health providers who are not able to bill Medicaid, Attachment Healing, services for child survivors of sex trafficking, and Youth Support Services.
				Does this include any vendor the State may wish to pay?	At start-up, only goods or services that are delivered by an enrolled provider to an eligible participant in one of the HHS 2020 benefit programs are included. However, the State would like the flexibility to expand MMISR to other scenarios eventually.
				Is it limited to vendors for certain programs, and if so, what programs are included?	At start-up, it is limited to benefit programs administered by HSD, DOH, ALTSD or CYFD.
				Are these providers expected to be screened in the same manner Medicaid providers are screened, at enrollment and monthly?	Screening of non-Medicaid providers will be done as defined by the agency that administers the benefit program.
285				The BMS staffing and Key Personnel requirements do not specify the necessary credentials related to certification of managed care rates. Please confirm that the successful Offeror must employ (either directly or through subcontract) credentialed actuaries who satisfy the qualification standards of the American Academy of Actuaries to certify Medicaid managed care capitation rates.	Confirmed.
286				The current actuarial vendor has included 3-5 credentialed actuaries to support rate setting. Please identify if there is a minimum preferred number of actuaries to support the managed care rate develop for each line of business.	No.

287				The BMS Statement of Work for 2.2.4 related to Benefit Plan Management and the specific requirements included in Table 9 (items 4.35 – 4.47) do not clearly define the scope to be included in the requested fixed fee cost proposal. It is common for the frequency or volume of work associated with these tasks to vary dramatically from year-to-year. For reference, the hours associated with similar actuarial and policy services over the past three years have ranged from approximately 18,000 up to over 24,000. Given this variation, would cost proposals based on hourly contracted rates for this portion of the scope be more appropriate? Alternatively, we strongly recommend specifically defining the expected deliverables (including frequency and volume of analyses) to be included by year or anticipated hours by pricing component in order to support appropriate fixed fee proposals.	The State does not agree that the RFP fails to clearly define scope. The State is purchasing service availability. The State does not intend to contract at hourly rates. Deliverables can be negotiated during contract negotiations.
288				As there may be expected variation in the proposed deliverables included in the fixed fee cost proposal and described in the Offeror's accompanying budget narrative, please identify how different interpretations between Offerors in the anticipated deliverable frequency or volume to support variable work related to actuarial and policy consulting services included within section 2.2.4 for Benefit Plan Management will be addressed when determining the "lowest responsive offer" cost for this sub-factor. Is it HSD's direction that cost proposals should reflect the minimum necessary deliverable frequency and that additional work will be authorized through separate change orders?	Please see the Response Specifications section (VII.) and Evaluation section (IX) in the RFP, as revised in Amendment 2. Cost proposals should reflect all the required effort to achieve the requirements found in the Detailed Requirements, Appendix H.
289				Please clarify how the defined "Hourly Rates" included in Section IV Definition of Terminology are considered within the Fixed Fee costs proposed under Appendix B?	Amendment 2 removed the "Hourly Rates" definition from Section IV, as it is not needed for this contract.
290			88	On page 88 of the RFP, the State is requiring the Contractor, in collaboration with the State, to measure	The State anticipates quarterly, semi-annual, and annual measurements and assessments.

					and assess MCO performance in order to make recommendations on benefits plans and rates. How frequently will the State expect such measurement and assessment and is there an evaluation criteria available to review in order to understand the scope of this work?	
291				88	On page 88 of the RFP, the State is requiring the Contractor to monitor and report on budget neutrality as required by federal guidelines and to evaluate the enrollment and financial performance of the MCOs and their provider networks. Is the State's expectation that the Contractor will evaluate the financial performance of the MCOs' provider networks? If so, what type of financial review or audit is expected and how frequently?	The Contractor will be expected to evaluate the MCOs' financial performance as required by CMS. This review typically is done semi-annually.
292				89	On page 89 of the RFP, the Contractor will develop innovative reimbursement strategies and program designs for consideration by the State and will conduct analyses to project the potential budgetary, quality of care and other effects of such initiatives. At the State's direction, the Contractor will also provide analysis of initiatives proposed by the State or its other Contractors. Through the use of retrospective analysis of specific program areas, the Contractor will identify opportunities for improvement in program design and reimbursement. How many such analyses by year does the State expect?	The State's expectations are not based on quantity but rather business need and the impact of potential strategies and program initiatives. The State also expects the BMS vendor to respond to changes in State and federal program policy.
293					Related to the member management requirements related to outreach and communication to MCO members, how will the State delineate MCO responsibility versus BMS Contractor responsibility for these requirements?	The State does not require the BMS contractor to be a substitute for the MCO. The delineation of responsibilities will occur as result of discussions with the contactor, the State and the MCOs. The State seeks a BMS contractor

						whose member management services compliment or augment those of the MCOs.
294	4.46		142		On page 142 of the RFP (item 4.46), what is the State's expectation of frequency of managed care contract updates, policy updates and letters of direction? Policy updates are broad and may include regulation updates, provider supplements, managed care manual updates, legislation, CMS guidance, etc. How does the State define policy updates for purposes of this requirement? On average, how many letters of direction are issued annually?	MCO Contracts are updated generally two times per year. The frequency and number of policy updates can vary each year. The State defines a policy update as a change to the benefit program that materially affects coverage, payment, member eligibility or provider enrollment. Approximately 15 to 20 LODs annually.
295	Appendix B				As described in Appendix B, the total price for each component is proposed as a fixed fee. Please clarify whether the payment will be made based on each underlying deliverable, upon deliverable completion or rather if costs should reflect proposed hourly rates to be paid as work is completed, not to exceed the total proposed fixed fee.	To be negotiated.
296					To what extent is the State willing to negotiate the terms and conditions of the contract with the apparent successful Offeror(s)?	As noted in the RFP, Offerors may propose changes to terms and conditions and the contract, which may be negotiated with the State.
297					Will the State consider incorporating a mutually acceptable Limitation of Liability provision into the contract as it has in place in other current contracts?	As noted in the RFP, Offerors may propose changes to terms and conditions and the contract.
298					The Business Associate Agreement (BAA) requires contractors and subcontractors to agree to return or destroy all PHI in their possession. Will the State consider adding language to the BAA Article 5b. substantially similar to the following: *"Notwithstanding these or any other data retention, destruction or return provisions elsewhere in this Agreement, Business Associate may, in accordance with*	As noted in the RFP, Offerors may propose changes to terms and conditions and the contract, including the BAA.

					legal, disaster recovery and records retention requirements, store copies of Department's data in an archival format (e.g. tape backups), which may not be returned or destroyed upon request of Department. Such archival copies are subject to the obligations as set forth in this Agreement."?	
299					AWOP/UPLs for PACE programs are not required by federal regulation to be actuarially sound. Please clarify the intended reference to actuarially sound per member per month rates for the PACE program included on page 89 of the RFP.	The State has used actuarially sound rates for the PACE program for several years and intends to continue doing so in the foreseeable future.
300					The State currently uses Medicaid Rx to risk adjust managed care capitation rates by MCO. Risk adjustment is not referenced in the scope of work. Does the State intend to continue to risk adjust capitation payments?	Yes. Amendment 2 added a definition of "Capitation Rates" to mean "Risk Adjusted Capitation Rates", which should be used for all instances of the phrase "capitation rates" throughout this RFP.
301					Does the Benefit Plan Management scope of work include consulting services related to the ongoing maintenance and development of MCO financial reporting tools and templates in addition to the evaluation of financial performance?	Yes.
302				89	On page 89 of the RFP and Table 9, "Plan Benefit Management" Category, please clarify the references to "waiver requests and other program changes" and "waiver renewal amendments." Will the contractor be expected to support the next renewal of the 1115 waiver beyond activities necessary for budget neutrality? For example: a. Program policy options, program design, and development of concept papers? b. Stakeholder engagement activities, including Native American/American Indian consultation, meeting preparation and facilitation, responding to public input, and similar activities conducted during the past 1115 renewal?	Yes.

					c. Development of waiver special terms and conditions? d. Documentation for CMS 1115 waiver transparency requirements? Responding to CMS negotiations?	
303				89	On page 89 of the RFP and Table 9, "Plan Benefit Management" Category, please clarify the references to "waiver requests and other program changes" and "waiver renewal amendments." In particular, will the contractor be expected to provide assistance with <u>future amendments</u> to the 1115 (beyond budget neutrality) and if so, does the state have an estimate for the expected number of amendments? For example: a. Program policy options, program design, and development of concept papers? b. Stakeholder engagement activities, including Native American/American Indian consultation, meeting preparation and facilitation, responding to public input, and similar activities conducted during the past 1115 renewal? c. Development of waiver special terms and conditions? Responding to CMS negotiations?	Yes.
304				89	On page 89 of the RFP, will the Contractor be expected to provide assistance with the development of any new 1915(c) waiver authorities and/or amendments to existing 1915(c) waivers, outside of support for rates and cost neutrality? For example, drafting of the waiver application, helping to provide public notice of waiver changes, and conducting stakeholder engagement activities. If so, does the state have an estimate for expected number and type of 1915(c) waiver actions?	Yes.
305				88	On page 88 of the RFP, "After developing "what if" analyses of potential program and rate changes, the	The Contractor's role with respect to rollout will vary depending on the scenarios or program changes that the State elects to

					Contractor must make recommendations to the State and coordinate the rollout of approved changes." Please provide additional clarification about what is meant by "coordinate the rollout of approved changes." Specifically, what is the Contractor's role with respect to the various stakeholders (state, providers, members, contractors) involved in a change?	pursue. The necessity of notification of changes to stakeholders will be determined by the State. In all circumstances this will at a minimum include Enterprise agencies.
306					In Table 9, "Plan Benefit Management" Category, we do not see a requirement for vendor procurement support. Will the contractor be expected to provide assistance with MCO procurements and/or other vendor procurements? If so, please provide an estimate of the number and types of procurements the vendor can expect and detail on the type of assistance that would be required. For example: • RFP development • Evaluation criteria development • Contract language development • CMS documentation for compliance • Production of data books and financial data	The State has no scheduled MCO procurements at this time. The State recognizes that an MCO procurement is a major undertaking that may require assistance and consultation from the BMS contractor. No numbers can be provided at this time.
307	4.44			142	On page 142 of the RFP (item 4.44), please clarify the scope of the FFS provider rate development. Is the requirement to review all FFS provider rates annually to assess the need for updates and develop updated rates? If not, what specific rates and how frequent would the FFS rate development work be?	The requirement in the RFP asks Offerors to describe how their proposed services develop and analyze proposed adjustments to FFS provider reimbursement rates.
308	4.02				How will the Agency share financial data with the BMS vendor in order for the BMS to be responsible to "project the potential budgetary" impact of reimbursement strategies?	All data will be made available to module vendors through the ESB.
309	4.10				Does the Agency have an interest in the projected impact of services as billing code, pricing, and payment methodology change or is this limited to historical analysis?	Yes to projected impacts.

310	D.2.a		42-43	Per the RFP, vendors must submit, "one (1) original and one (1) identical hard copy of their Technical proposal and required additional forms and material and twelve (12) electronic versions. Acceptable formats for the electronic version of the proposal are Microsoft Word, Excel and PDF...In addition, the entire proposal including all materials in Binder 1 (not Binder 2) shall be submitted on a single CD. Contents of Binder 2 must be submitted on a separate CD. Proposals submitted on CD must include THREE versions: (1) a version in secure PDF; (2) a version in unsecured Microsoft WORD and/or Excel to enable the Department to organize comparative review of submitted documents; and (3) a redacted PDF for release to public under Inspection of Public Records Act requests. Electronic versions of the proposal must not exceed 10 MB per file, not for the entire proposal submission. Security policies do not allow the State to receive electronic copies via a USB drive." Please confirm the full submission package should be: Binder 1: - One (1) Original: hardcopy, confidential information marked and easily segregated - One (1) Copy: hardcopy, confidential information marked and easily segregated - One (1) CD with 3 copies: a secured PDF, an unsecured Word or Excel, and a redacted PDF. - Twelve (12) CDs with a 1 copy on each in either PDF, Word, or Excel Binder 2: - One (1) Original: hardcopy, confidential information marked and easily segregated - One (1) Copy: hardcopy, confidential information marked and easily segregated	See Amendment 2 for revised Format and Organization requirements, including the electronic submission.

				- One (1) CD with 3 copies: a secured PDF, an unsecured Word or Excel, and a redacted PDF	
311	D.1, Binder 1		44	Per the Proposal Content and Organization, Tab 10 is a "Signed Eligibility Statement". Please clarify what is required by this statement.	The Eligibility Statement on page 44 of the RFP requires Offerors to submit a signed statement using the language contained in the Eligibility Statement on page 50 in paragraph 8. Note that this section has been revised in Amendment 2. The Signed Eligibility Statement is to be placed in Tab 9 in Binder 1.
312	31		39	Please identify where vendors should include disclosures regarding responsibility.	These disclosures should be place in Binder 1, Tab 15 (Additional Items), per Amendment 2.
313	2.2.2		228-229	Please provide the average monthly and annual unduplicated counts of members for each program listed in the RFP for the following: ■ Home and Community Based Services (HCBS) 1915(c) Medicaid Waiver programs ■ Child, Youth, and Families Department (CYFD) ■ Aging and Long-Term Services Department (ALTSD) ■ Behavioral Health Services Division (BHSD) ■ Medical Assistance Division (MAD) ■ Child Support Enforcement Division (CSED)	Please see response # 262.
314	2.2.2		229	Please provide the average monthly and annual unduplicated counts of members for each of the programs **NOT** listed and named in the RFP for each of the following: ■ Child, Youth, and Families Department (CYFD) ■ Aging and Long-Term Services Department (ALTSD) ■ Behavioral Health Services Division (BHSD) ■ Child Support Enforcement Division (CSED)	This information is not available at this time.
315	2.2.2		228	Please confirm that the responders should not price for extension to future programs in the response to this RFP and that any such additions will be addressed in a change request.	Confirmed.

316	III (pg.19, sixth bullet); Appendix N, Table 14, ID	11.010	19 & 271	Please clarify that the requirement for Contractors to "Provide updates and related testing of installations at no cost to the state" refers only to product updates, and that it does not include any state-specific enhancements which may be desired/required by the State. Also, please confirm that such product updates refer specifically to the software and solution documentation and does not preclude reasonable charges associated with testing, training, state-specific user manual updates, etc.	The State does not confirm. Req 11.010 specifies that the Enterprise will incur no additional costs for changes, enhancements and updates.
317	VI.A Sequence of Events		27	Due to the complexity and pioneering approach taken by the State with this RFP, vendors may have additional questions after the first round. Would the State consider adding a second round of questions, scheduled within the current procurement schedule (i.e. submitted by October 15 and answered by October 31)?	No.
318	VI.A Sequence of Events		27	The current Sequence of Events has finalists submitting Best and Final Offers (BAFO) prior to Oral Presentations. Would the State consider reversing this sequence to allow finalists the opportunity to present their solutions, then develop their BAFO considering any insights and additional understanding of the State's needs gleaned at Orals? This could offer the State a better informed and more realistic BAFO.	No.
319	Appendix M, Section 2.2.1.A, 24th bullet; Appendix N, Table 14, ID	10.068 & 10.070	226 & 264-265	This bullet states that the C/CMS must include "Integration with MCO Care/Case Management Platforms, as well as the State's Health Information Exchange." Please confirm integration will be through the ESB. If not, please provide detailed information about the systems requiring integration	Confirmed.
320	Appendix M, Section 2.2.1.A, 25th bullet		226	Is this contract tracking separate and apart from that done by the CCSC vendor? Will the CCSC vendor be using the C/CMS solution to track contacts related to the programs served by the C/CMS? If not, will the	The CCSC will not be using the C/CMS solution to track contacts, but it is the intent that all HHS 2020 and MMISR solution modules share

				C/CMS vendor be required to integrate information from the CCSC vendor into the C/CMS solution?	data, through the ESB, when needed and necessary to conduct business.
321	Appendix M, Section2.2.2, ALTSD		229	This section states that "ALTSD intends for the C/CMS to **provide services in administration of programs** - - - (emphasis added)", Please confirm that the services required in support of the administration of these programs refer to the technology solution and not direct case management and/or administration support by Contractor's staff. If, in fact, it is the latter, please provide a detailed description on the specific requirements for this support, such as roles, responsibilities and specific duties and any available data regarding this support, such as number of clients served, etc.	Confirmed. The Services required in support of the administration of these programs do refer to the technology solution and not the direct case management and/or administration support by contractor's staff.
322	Appendix M, Section 2.2.2, BHSD		230	This section states that "BHSD" intends for the C/CMS to provide Care/Case Management services and Administrative Services Organization (ASO) services in **collaboration with the State** - - -(emphasis added)", Please confirm that the services required in support of the administration of these programs refer to the technology solution and not direct case management and/or administration support by Contractor's staff. If, in fact, it is the latter, please provide a detailed description of the specific requirements for this support, such as roles, responsibilities and specific duties and any available data regarding this support, such as number of clients served, etc.	Confirmed.
323	Appendix M, Section 2.2.2, CSED		230	This section states that "CSED intends for the C/CMS to meet federal and state requirements and to **provide services in administration of process areas** - - - (emphasis added), Please confirm that the services required in support of the administration of these process areas refer to the technology solution and not direct case management and/or administration support by Contractor's staff. If, in fact, it is the latter, please provide a detailed description of the specific requirements for this support, such as roles,	Confirmed. The Services required in support of the administration of these programs do refer to the technology solution and not the direct case management and/or administration support by contractor's staff.

				responsibilities and specific duties and any available data regarding this support, such as number of clients served, etc.	
324	Appendix M, Section 2.2.3.1		231	Please define "continually". Will the C/CSM be obtaining this information from the SI or directly from the other systems/data sources? Are you referring to regularly scheduled batch updates (i.e. nightly) or are you requiring real time updates? If the information is not coming from the SI, please provide specific details regarding the number of other systems, the schema of the data, etc.	The C/CMS will be obtaining this information from the SI platform. The SI platform has the capability to provide information in a real-time (upon request), or batch manner. The C/CMS may, for example, use the SI's Master Data Management system to validate demographic information prior to performing business logic, or it may decide to periodically pull information from the MDM system to ensure a copy stays fresh.
325	Appendix N, Table 14, ID (4th bullet)	10.006, 10.007, 10.008	252 - 253	Is it the State's intention to have Enterprise staff independently configure business rules within the solution? If the answer is "yes", how will the State ensure that all required testing is successfully completed, including regression testing and solution-wide testing, to ensure the new configuration does not have an adverse impact on the solution and its performance?	No. The State defines the business rules and the vendor is responsible for configuration.
326	Appendix N, Table 14, ID	10.034	256	This requirement asks how the proposed C/CMS solution **provides** (emphasis added) case management for the programs listed. Is the State asking how the solution provides a technical solution that facilitates and empowers effective case management of these programs or how the solution vendor actually provides case management of these program services?	The solution provides a technical solution that facilitates and empowers effective case management.
327	Appendix N, Table 14, ID 10.034	10.034	256	This requirement asks how the proposed C/CMS solution **provides** (emphasis added) the listed services for ALTSD's ADRC and the Aging Network Division. Is the State asking how the solution provides a technical solution that facilitates and empowers these services or how the solution vendor actually provides case management services for these program services? Most of the items listed appear to be solution	The solution provides a technical solution that facilitates and empowers these services.

				functionality; however, some could imply the actual provision of services (i.e. Prescreening program intake).	
328	Appendix N, Table 14, ID	10.081	266	This requirement asks how the proposed C/CMS solution **provides** (emphasis added) case management of the listed SCED functions. Is the State asking how the solution provides a technical solution that facilitates and empowers effective case management of these functions or how the solution vendor actually provides case management of these program services?	The solution provides a technical solution that facilitates and empowers effective case management.
329	Appendix N, Table 14, ID	12.08	273	Please define and clarify what is meant by false-positive results.	C/CMS Requirement 12.08 has been deleted in Amendment 2.
330	2.2.2		229-230	Please provide an implementation timeline for each of the programs outlined within each of the sections. In what order should the programs be implemented? For example, should each DOH program implemented simultaneously, should DOH programs and CYFD programs be implemented during the same time frame, should BHSD programs be implemented sometime in the future and if so when? Should ALTSD and CSED programs be implemented concurrently? Should MAD programs be implemented first? Etc., etc.	We do not have a priority timeline at this time. All HSD programs, including all Medicaid functions, will be the first to be implemented. The other participating Enterprise programs will follow.
331	2.2.2 &	10.081	230 & 266	The RFP contains two locations where they describe services related to child support: (Page 230) Child Support Enforcement Division (CSED): CSED intends for the C/CMS to meet federal and state requirements and to provide services in administration of process areas including, but not limited to: • Case Initiation; • Case Monitoring and Management; • Establishment; • Enforcement; • Customer Service; and • Financial Management.	CSED intends to use the C/CMS for all case management so the description on page 230 is correct. For financial management this includes all payment distribution and disbursement rules/accounting for child support payments. CSED has a complete business requirements document available as well as the federal certification requirements. For Locate, this involves interfacing through the data services and warehouse and MCI, to trigger automated workflows for establishment

				(Appendix X, Requirement 10.081 – page 266) Offeror shall describe how its proposed Solution provides case management of CSED functions, including at a minimum: • Initiation; • Establishment; • Enforcement; and • Locate. Please identify which of these descriptions of services is correct. If parts of each are correct, please provide a singular definition of services related to child support. Additionally, if financial management and/or "locate" is included, please define and clarify expectations from vendors for these services.	and enforcement actions as well as alerts for staff and record updates and notices.
332	General			Does the state anticipate integration with medical systems (EHRs/EMRs) for physiological data?	Yes, but the timetable is uncertain at this time and will vary by program.
333	General			What is the expected usage volume in terms of number of members, number of care team members, peak and average concurrent users?	Please see responses # 15, 23, 138, and 180.
334	Appendix N, Requirement	10.004	252	Will the enterprise criteria identify a unique case type for each member? Or can a member belong to multiple case types?	A Member can be assigned to multiple case types depending on the programs and services identified.
335	Appendix N, Requirement	10.033	255	Which formulary would be used? Does the state have license to extend the usage for this solution?	Req 10.033 does not require a formulary. If an Offeror feels it is necessary please add to proposal.
336				The RFP emphasizes a phased implementation for the C/CMS and includes many different case types and initiatives beyond HSD. Does the State have a schedule for when they expect specific case types to be in production? If there is no timeline, is there an order of priority for the different case types and sister agency initiatives?	We have no specific schedule or timeline for priorities. All HSD programs, including MAD, will be the first to be implemented. The other participating Enterprise programs will follow.

337				Since the stated intention is for the Unified Public Interface to serve members and providers accessing HHS2020 data and resources, is it safe to assume that the primary users of the C/CMS are State staff managing the various case types? If not, please specify the additional user types.	State Staff and any additional systems or personnel outside the State staff that is identified.
338				The C/CMS requirements include numerous references to eligibility determination and management, but other HHS2020 documentation states the ASPEN system is responsible for eligibility determination. Can you please confirm that the C/CMS is indeed responsible for eligibility management and if so, how this functionality will differ from that of ASPEN?	See response #30.
339				Much of the described functionality is dependent on interoperability with other HHS2020 modules via the System Integrator. Is there an SI roadmap and/or project timeline that we can use to better inform our project plan proposal for the C/CMS module?	The timeframe is dependent on successful and timely completion of other related procurements. We anticipate the following milestones: • Late Q2 2020 – Early Q3 2020: Integrate DS and QA into SI platform • Late Q3 2020 – Early Q4 2020: Integrate Financial Services and BMS into SI platform • November 2021: Internal portal integrated with BMS
340	HHS 2020 Overview Slide 9-10-19.pdf			Where does EDI transaction validation, translation, routing, reporting and visibility exist in the environment depicted in the overview slide?	BMS and FS modules are where EDI transaction processing will occur.
341	2.2.3 Utilization Management (UM) and Utilization Review (UR)			What EDI transactions are in scope for the BMS module (eg HIPAA X12, NCPDP)?	X12 270/271 – Eligibility Inquiry and Response X12 278 – Service Review (Authorization Request)

342	2.2.3 Utilization Management (UM) and Utilization Review (UR)			Can the department provide the specific functionality required as referenced in the bullet on page 85 "Provide their own EDI capability…" (eg, validation, acks, translation, routing, visibility, etc)	Refer to p. 133 UM/UR 3.49 under Requirements. BMS is responsible for HIPAA transaction 278.
343	2.2.3 Utilization Management (UM) and Utilization Review (UR)			Considering the recent approval of the Phase V CAQH CORE Operating Rule, does the department require "out of the box" Phase V compliance?	The State requires "out of the box" Phase V compliance.
344	1. Care/Case Management Services and Approach			Considering the recent proposed CMS rule for member interoperability, how does the state plan on addressing FHIR, USCDI, Blue Button, TEFCA, and Consent requirements as part of the Case/Care Management module?	The canonical data model used to communicate changes between modules is planned to implement the FHIR standard.
345				Per the pre-proposal conference there was dialog associated with how the C/CMS may be leveraged beyond HSD but also inter-agency. Please share use cases or examples of how other agencies would leverage the system?	Refer to Appendix M Section 2.2
346				Per the pre-proposal conference there was dialog associated with how the C/CMS may assist with the transition from MCO to FFS or vice versa. Please provide examples of how the system would be leveraged accordingly.	There may be circumstances when a member moves from managed care to FFS or vice versa and the Contractor will be responsible for tracking the transition and sharing information as required.
347				Offeror shall describe how its proposed Solution collects, updates and administers contract information, including at a minimum: • Identification of contract type; • geographic locations; • demographic information; • covered services; • rates; • contract start and end dates;	The requirements around Contract Management will not be removed. The C/CMS may be used to track various State contracts. The items listed define a minimum list of data elements that will be considered when establishing a contract management case type.

				• contract period/year; • organization type; • enrollment data; • member month; • adverse actions, impact and related plan; • performance standards and monitoring; and • re-insurance threshold. - Typically these would all be solutions associated within the Provider Modules. As a C/CMS system is very member focused. Considering these referenced requirements transition the system focus/align with provider contract monitoring, we request these requirements be removed or updated accordingly.	
348	Appendix H instructions		pg. 107	The instructions state that "Offerors also must provide additional information for each applicable requirement" referring to Product Type, Currently Deployed and Security Tested, but unlike in the Instructions for Appendix N, Page 250, is not more specific. May we assume that any requirement that is not "functional" i.e. does not describe the actual system components, is not applicable for the additional information? An example of this is Requirement 5.17, Page 145: "Offeror shall acknowledge its responsibility to adhere to and comply with the requirements contained herein and in the Statement of Work (APPENDIX G)."	That is correct. Additional information is not needed for non-functional requirements.
349	BMS Detailed Requirement 2.16,		pg. 114	Requirement reads, "Offeror shall describe how its proposed services provide the ability for the application to be routed to other agencies for review and approval and notify Human Service Department (HSD) of newly-approved applications." Should we presume that this will be both for current legacy systems and for systems as they are replaced?	Yes, the SI will have primary responsibility for data flows between systems, but the Provider Management solution must be able to post applications onto the Enterprise Service Bus using the canonical data model and work with the SI to determine appropriate routing for those applications.

				Further, should we assume that the SI has primary responsibility for data flows between systems?	
350	BMS Detailed	Requirement 6.02,	pg.145	Please clarify the "BMS Information" referenced in this requirement, "Offeror shall describe how its proposed services provide Stakeholders with access to BMS information."	"BMS information" is the data maintained by the contractor as part of its responsibilities under this contract, including member, provider, UM/UR and benefit plan information." (Note that the correct RFP reference is 6.04.)
351	BMS Detailed,	Requirement 6.27	pg. 147	Requirement reads, "Offeror shall describe how its proposed services deliver automated alerts and notifications and minimize manual interventions or actions." Please clarify if this is with respect to System Operations or functionality (i.e. workflow).	Offerors should address both system operations and business operations (workflow) in their responses.
352	BMS Detailed,	Requirement 2.33	pg. 116	Requirement reads Offeror shall describe how its proposed services facilitate electronic submission of provider enrollment applications, Medicaid claims and non-Medicaid payment request forms…" Please clarify the Offeror's responsibilities for receiving and/or processing claims.	The BMS contractor will not receive or process claims. As stated in Appendix G, however, "The BMS Contractor will be expected to address tools for connectivity to foster electronic submission of claims and payment request forms for medical and non-medical providers. The BMS Contractor is encouraged to make billing software available to providers in need of such assistance, and to provide "hands-on" assistance (such as software installation) to those most in need, such as Native American providers, providers of small size or in remote areas, and those who may have connectivity issues" (Section 2.2.2).
353	RFP, Appendix K,		pg. 217	SLA #34 - The BMS Contractor shall not exceed one percent of daily unresolved calls past one week, to be computed on a weekly basis and, at a minimum, reported monthly. Please clarify if SLA 34 applies to both the call center and the help desk?	Yes, SLA #34 applies to both the call center and the help desk.

354	RFP, Table 10 - General Requirements, Support and Maintenance,	7.02	pg.149	What does level 1 and level 2 support include? Please define what a level 3 call is so we can properly staff and clearly know what we are responsible for.	The CCSC RFP describes the tiers as follows: • Tier 0 – Request processed by automation (e.g., IVR) until it is resolved or transferred to higher tier; • Tier 1 – CCSC CSR front line staff; • Tier 2 – CCSC supervisor or management staff; and • Tier 3 – Non-CCSC Staff (e.g., State, other HSD's BPO module's Staff). Tier 3 is the final entity for contact resolution. A Tier 3 call is one that requires specialized expertise not available at the CCSC.
355	RFP, Table 10 - General Requirements, Support and Maintenance,	7.01	pg. 149	Please clarify the expected callers who will be calling into the contractor's help desk? (Providers, State users)	A substantial majority of calls will be from providers.
356	RFP, Table 10 - General Requirements, Support and Maintenance 7.01,	7.01	pg. 149	Please clarify the anticipated number of callers who will be calling into the contractor's help desk on a monthly basis?	This information is not available due to the change in the MMISR call center model from current operations. Please see the files posted in the "General" category in Procurement Library for historical call center metrics.
357	RFP, Table 10 - General Requirements, Service Expectations	6.36	pg.148	RFP states, "Offeror shall describe how its proposed Solution will transfer to the State, or its designee, all licenses and software, within one hundred twenty (120) days of receipt of transfer request from the State." Appendix H of the RFP permits Offerors to propose SaaS and/or PaaS based solutions. For either type of solution, the Offeror/Contractor does not transfer	This requirement has been deleted in Amendment 2. No software licenses will be transferred to the State given the service approach for this module.

				software licenses. In addition, the RFP encourages the use of commercial, off the shelf (COTS) software products such that even if an Offeror/Contractor does not transfer a SaaS or PaaS software component to the State, the State is still able to secure a right to continue to use such COTS software components either through a successor contractor or from the COTS manufacturer directly. Other software components of an overall Solution may only be used by the Contractor as a tool to deliver a service based outcome. Transferring a license for those software components to the State is both unnecessary and inconsistent with the "black box" view of the State expressed in Section I(C) regarding the "inner workings of a Contractor's technology". In light of the foregoing, would the Agency please clarify/amend the RFP such that Service Expectation 6.36 would not apply to any software component of an Offeror's Solution that is (a) a SaaS or PaaS software component or b) a software component that is used solely by the Contractor and not by the State?	
358	RFP, Appendix G,		pg. 73	Appendix G – Please confirm the State is only requiring a 4-5 page response to Appendix G and not a response to each of the requirements listed in Appendix G.	Yes, confirming a single response to Appendix G with a 10 page limit for the Statement of Work Response. See Amendment 2.
359	RFP, Section 2.2.2,		pg. 83	What is the historical volume of calls handled by the Tier 3 call center on a yearly basis over the last 3 years? What is the average call length?	Currently there is no distinction among call tiers. Please see the files posted in the "General" category in Procurement Library for historical call center metrics.
360	RFP, Section 2.2.2,		pg. 83	What is the name of this standardized software provided by the SI that is used across the Enterprise? Is it available on the commercial market and is a COTS product?	The software provided by the SI for Electronic Document Management is Hyland Onbase. The software provided by the SI for Customer Communication Management is Hyland Content Composer. Both are COTS products, but the SI will ensure that these two products are service-enabled via the Enterprise Service Bus.

361	RFP, Section 2.2.2,		pg. 84	What has been the volume of "hands-on" assistance sessions yearly over the last 3 years? What has been the average length of time for a session?	Over the past three years, the number of "hands-on" assistance sessions averaged 167 per year, including visits to provider offices, provider visits to the fiscal agent's Albuquerque office, and web/phone sessions. One-third of these sessions are conducted by web/phone. Technical assistance to existing providers lasts from 60 to 90 minutes. Technical assistance to new providers lasts from 90 to 120 minutes, with post-training follow-up by email or phone.
362	RFP, Section 2.2.3,		pg. 84	Over the past three years and on a yearly basis, what is the standard wait time for the UM/UR process?	Ten business days.
363	RFP, Section 2.2.3,		pg. 85	How many appeals and Fair Hearing processes have occurred each year over the last 3 years?	Over the past 3 years the TPA has processed 92 Fair Hearing Requests: 2016 - 57 2017 - 18 2018 - 17 Reconsideration requests have increased each year. 2016 - 16 2017 - 23 2018 - 44 For the DD Waiver, the DOH-DDSD prepares for and attends the Fair Hearings.
364	RFP, Section 10.1,		pg. 101	Regarding Targeted provider outreach, including to Tribes, Pueblos and the Indian Health Service and, Targeted outreach to Behavioral Health or other special providers… Please provide location of these providers and number of providers?	Information on Indian Health Service and Tribal 638 providers has been added to the Procurement Library under "General." Please see Albuquerque Area IHS 638 Facility List and Navajo Area IHS 638 Facility List. Behavioral Health and other providers which the State may designate for targets outreach are located statewide and their number will vary depending upon the outreach needed.

365	RFP, Requirement 6.22,	6.22	pg.147	Please further clarify the types of agency users to be trained, e.g., roles, description of roles, numbers of individuals in each role, etc.? For Example: Provider and UM/UR.	The State anticipates the following numbers (approximate and subject to change) of Medicaid program and business analyst staff will require training initially: Provider Management: 60 Member Management: 70 UM/UR:40 Benefit Plan Management: 60 As additional Enterprise agencies migrate to MMISR, additional staff will require training.
366	RFP, Requirement	6.22	pg.147	How many people need to be trained in each of the required work streams for ongoing training during maintenance over the life of the contract and at what frequency?	Please see the response to Question 365 above. It is anticipated that periodic refresher training and training for replacement staff would be needed. Training needs for other agencies will be determined when additional programs are incorporated into the MMISR solution.
367	Article 38 Performance, Section B,		pg. 185	The RFP states, "Contractor agrees that, if Federal Tax Information (FTI) is introduced into Contractor's information systems, work documents, and/or other media by written agreement, any FTI as described in 26 U.S.C. § 6103, limited to FTI received from, or created on behalf of HSD by Contractor; Protected Health Information (PHI) as defined in 45 C.F.R. § 160.103, limited to PHI received from or created on behalf of HSD by Contractor; or Personally Identifiable Information (PII) as defined by the National Institute of Standards of Technology, limited to PII received from or created on behalf of HSD by Contractor pursuant to the Services; all together referred to hereafter in Article 39 as Confidential Information, made available to Contractor shall be used only for the purpose of carrying out the provisions of this contract." Will the information system contain FTI?	Yes.

368	Section 6.2 Provide BMS Components,		pg. 94	It is noted that "During this phased approach, some legacy activities will continue to be conducted by the incumbent MMIS fiscal agent. Coordination will need to occur with the modules as well as legacy vendors during the phased release." Is there any expectation that integration to the legacy vendor and/or incumbent MMIS fiscal agent or the legacy/incumbent systems will be required, and if so, to what extent?	No direct integration between the BMS contractor's systems and the legacy MMIS will be required. In the event that a BMS module is brought up while the incumbent fiscal agent is still operating the legacy MMIS, data will be exchanged between the systems via the SI's ESB in the format defined by the canonical data model.
369	RFP. Requirement Section 10.2 –		pg. 101	Can the State clarify translation requirements for training (instructor-led, online, and supporting reference materials)?	Amendment 2 revised this requirement as follows: "The Contractor must provide Americans with Disabilities Act (ADA) 508 compliant content and materials in agreed-upon formats (e.g., online, printed) with State approval for each training tailored to the BMS configuration, contents and use."
370	Table 8 – UM/UR Requirements,		pg. 126	What type of authorization requests are submitted? What is the annual volume by request type?	(Approx. volume) Behavioral Health 1396 Dental 3083 DME 1538 HCB Waivers 13348 Home Health 151 Out of State 258 Rehab Services 86 (in/out) Transplant 19 *EMSUI 2214 ICF-IID 282 PACE – level of care 512 Med/Surg 152 NF - level of care 85 Therapies 2092 Acute to Acute hospital 150

					*Emergency Medical Services for Undocumented Individuals
371	UM/UR,	3.04	pg. 126	Could the State provide a use case for the requirement, "link multiple referrals"? Is the intent to show all referrals for a specific member or provider, or is there another intent?	The intent is to show all referrals for a member or provider.
372	UM/UR,	3.05	pg. 126	The RFP states "Offeror shall describe how its proposed services identify the service Provider at the detail service line level." Could the State provide a use case for this requirement? Is there a requirement for a PA request to allow multiple providers on one authorization for the same service, for different services or is there other intent?	The Traditional Develop Disabilities Waiver has a Prior Authorization (budget) that includes multiple providers for different services on the same PA.
373	UM/UR,	3.38	pg. 131	The RFP states "…even when co-morbidities are not listed." Can the State provide a use case or clarify the intent of this requirement?	A member's primary or other co-morbidities will be apparent from the claims history available to the BMS contractor and should be considered when reviewing an authorization request, even if the requesting provider did not include this information in the request itself.
374	UM/UR	3.50	pg. 133	The RFP states "Offeror shall describe how its proposed services provide the ability to assign authorizations at the agency or program level and manage capacity." How is agency/program capacity currently captured, and how will the Offeror access this information?	The TPA contract manager participates in program and departmental level meetings regarding program capacity and projected allocations per program. The TPA contract manager meets bi-weekly with the TPA and provides updates on upcoming changes to the programs.
375	Section 12.2,		pg. 104	Regarding, "This Plan must address all CMS, DoIT, HSD and other applicable State requirements", can the State detail the specific regulations or requirements they are referencing?	The State's expectation is that offerors will be familiar with CMS requirements, including certification requirements and the MITA framework. HSD requirements are contained in the RFP, Procurement Library and answers to these questions. HSD is responsible for addressing DoIT requirements; DoIT has

					approved the RFP and their approval of the contract will also be required.
376	Section 12.1,		pg.103	Regarding, "The Contractor must develop, document, coordinate and implement a comprehensive Business Continuity Plan that complies with State and Federal standards, integrates with the SI Contractor's consolidated Business Continuity and Recovery plan…" Please define the level of integration required by the State.	The BMS Contractor's Business Continuity/Disaster Recovery Plan will be integrated into the Master BC/DR Plan developed by the SI contractor. The BMS contractor will also need to integrate disaster recovery and business continuity testing activities and connectivity to other disaster recovery environments of other module vendors.
377	SLA Item 37		pg.217	What is the current volume of telephone authorizations for which the State is proposing the 95% within 120 seconds answer time SLA?	Authorizations are typically not issued by telephone. The Telephone Report received from the current contractor reports how many calls are received. For CY 2018, 12,781 calls were received. Of the 12,781 calls/faxes received, 6,450 calls were requesting the status of an existing authorization. Note that these calls are for all tiers, whereas the BMS Contractor is responsible for Tier 3 calls.
378	Appendix B,		pg. 62	Appendix B states "Provide an all-inclusive price for all components and activities related to Benefit Management Services, including project management." We suggest modification of the required pricing structure to include separation for implementation in order to support guidelines for 90/10 reimbursement.	We will not change the pricing structure for this RFP. The State adheres to the CMS guidance on 90/10 claiming which includes enhanced matching for such items as configuration of COTS and SaaS.
379	Requirement,	6.08	pg. 146	This requirement states, "Offeror shall describe how its proposed services reduce false-positive results based on previous results."	Amendment 2 removed Requirement 6.08.

				In order to provide a responsive solution to this requirement at the lowest cost possible, please clarify what is meant by a false positive result in the context of Requirement 6.08.	
380	Section: 1. Proposal Content and Organization	Letter of Transmittal (Appendix C)	44 & 45	Would the State please confirm if the Letter of Transmittal (Appendix C) goes in Binder 1 or Binder 2 Cost? Or both?	Binder 1, Tab 2.
381	Section: 1 Proposal Content and Organization	2.Two (2) Page Summary of Offeror's Approach	44	Would the State provide the evaluation points for this or is it pass/fail?	Pass/Fail (no points).
382	Section: 3. Proposal Format	Page Count	44	Would the State please confirm that the Experience & Personnel to include Organizational Experience (narrative) and Staffing Model are not included in the 300 page limit?	Yes, confirmed. Note that the page limit for this section has been increased to 350 pages per Amendment 2.
383	Section: VII. Response Specifications	VII. Response Specifications APPENDIX G 4-5 page summary	45-46	Would the State please confirm that the only proposal response required for Appendix G are the items specified in VII. Response Specifications.	See the revised VII. Response Specifications in Amendment 2.
384	Section: Proposal Format	Proposal Format	43-44	Would the State please confirm all other sections of the proposal response are excluded from the 300 page limit which is only for APPENDIX H.	Yes, confirmed. Note that the page limit for this section has been increased to 350 pages per Amendment 2.
385	Section: Proposal Format	Proposal Format	43	Would the State confirm if Arial Narrow 10 point is acceptable for graphics?	Yes, that is acceptable for graphics.
386	Section: Proposal Format	Proposal Format	44	"The Offeror is expected to include in the 300-page limit, a summary work plan with milestones and a summary implementation schedule." Would the State please specify what section these summary plans should be included?	See Amendment 2 for revisions to this section. A detailed Work Plan should be included with the Requirements Response (to Appendix H for BMS or Appendix N for C/CMS) and placed in tab 15 (Additional Items) and is not included in the page limit. Note that the page limit for this section has been increased to 350 pages.

387	Section: Paragraph:	A. The MMISR Modules and Services Procurements	14	Can the State specify what are the shortlisted products as part of the SI contract for - ESB - MDM - EDM - Business Rules Engine - BPM - ODS - IDM/SSO - Security Tools - EDW This will help us to refine and define our BMS integration approach with SI and other module vendors.	ESB: Oracle Fusion Middleware Oracle Service Bus MDM: Built on top of MarkLogic Smart Mastering EDM: Hyland Onbase Business Rules Engine: Oracle Business Rules (part of Oracle Fusion Middleware) BPM: Oracle Business Process Management (part of Oracle Fusion Middleware) ODS: Built on top of MarkLogic database IDM/SSO: Oracle Identity and Access Management Security Tools: Oracle Identity and Access Management, Splunk, NSX EDW: IBM Watson Health data warehouse
388	Section: Paragraph:	6. Unified Public Interface (UPI)	17	What assumptions should the BMS vendors take since the entry point for BMS services would be though UPI?	Regarding the UPI, the BMS contractor must make its web services available via the Unified Portal instead of deploying a portal of its own and respond to Tier 3 calls routed by the CCSC. Any assumptions are up to Offerors in developing their solutions
389	Section: Paragraph:	Table 1 - RFP Release Timeline	18	Can the State provide the notional implementation timeline for the MES modules? - This would help to align, logically fit the implementation timeline of the BMS solution with the rest of the modules particularly with SI module vendor - This will help to define the DDI vs Operations timeline for BMS and has a bearing on the cost - This will help to plan on CMS certification activities - This will help the bidders to structure the implementation cost proposal in a uniform manner and also help the State to assess the bidders in a uniform manner.	Please see the End-to-End Timeline (MMISR E2E), which is in the Procurement Library under the "General" category.

390	Section: Paragraph:	Provide their own EDI capability to the HHS 2020 Enterprise to provide for acceptance and transmission of all electronic HIPAA transactions (e.g., 278);	85	Should the bidders assume the core EDI capability would be available as a centralized shared service for the BMS vendors to leverage? If not the BMS vendor needs to stand up a EDI solution just for 278 transaction while the Financial Services module vendor has to standup their own for the rest of the EDI transactions such as 837, 270, 271 etc. This would be cumbersome to providers for EDI trading partner testing since they have to act with 2 or more different systems and module vendors.	The EDI capabilities for specific modules are expected to be provided as a solution with each module. There is no centralized shared service for EDI.
391	Section: Appendix B Paragraph:	Appendix B – BMS Cost Response Form #1	62	Total costs must include applicable New Mexico Gross Receipts Tax (NMGRT). **Total:** Would the State confirm what costs are to be taxed?	We suggest Offerors refer to NM statutes and the NM Tax and Revenue Department for questions on taxes.
392	Section: Paragraph:		80	Can the State clarify what kind of integration is needed with Customer Communication Management (CCM) and who performs CCM.	CCM is an Enterprise service maintained and operated by the SI using Hyland Content Composer. The BMS contractor will use the Enterprise CCM to create templates and generate hard copy and electronic notices. These communications will be stored by the Enterprise EDM using Hyland OnBase, which will also be maintained and operated by the SI.
393	Section: Paragraph:	2.89	124	Could the State specify how may site visits per year are needed to be accounted to cost the travel.	No, the State will not specify, as these are on an as-needed basis. See the response to Question 361 for historical information.
394	Table 9 - Benefit Plan Management Requirements	4.06 & 4.07	137	Would the State clarify which module or system will house the following reference information and act as system of record. 1. Procedure code Sets (HCPCS, CPT, CDT etc) 2. Revenue Code Sets 3. Diagnosis code Sets 4. Place of Service codes 5. Procedure, Provider Specialty Rate Files 6. Service Limit Definitions 7. NCCI File sets	The Contractor is responsible for storing and maintaining the code set and rate data required to support claim adjudication. The data developed by the Contractor and approved by the State must be stored in the Contractor's Benefit Plan Management Solution, which will be the system of record for all such data. The BMS Contractor will also be expected to work with the FS Contractor to review and verify configuration changes associated with benefit plan updates,

				Requirement 4.07 mentions that the reference information would be housed in the FS module. Is the expectation that the BMS operations team would go and update information in FS module and FS module is the system of record for all code sets. BMS system will not house any reference data including rate file and all information will be housed and maintained in FS module vendors system.	although FS staff will be responsible for the configuration itself and the FS claim adjudication system will be the system of record for benefit plans and associated rules. Please see Amendment 2.
395		4.10	138	Should the BMS vendors assume that the BMS operations team will have access to the FS module to assess the impact analysis and will get the required analytical support from FS module vendor to perform impact analysis assessments.	No, but data will be made available to the BMS Contractor for this function.
396		4.12	138	In which module (FS or BMS) is the reference for HCPCS and CPT code associations maintained? Based on requirement 4.07 its looks like FS module will maintain the file and associations.	See the response for 394 above.
397		4.20	139	Which module will be the reference system of record for Rate files? Is it the BMS or FS? Requirement 4.22 mentions the reference information will be maintained in FS module.	See the response for 394 above.
398		4.24	130	Should the vendors assume the FS module will have the rate files including Manage care rates and the BMS operations team will have access to update the rate file in FS module vendors system.	See the response for 394 above.
399		4.35, 4.40		Will the actuaries use the FS module vendors system to upload and update the rates? This will make since the FS module maintains all the rates.	See the response for 394 above.
400			182	Would the State please provide the definition for the "PSC" acronym that is used in the BAA?	PSC in this context means "Professional Services Contract".
401	Section: 2.2. Benefit Management Services Components	2.2.3 Utilization Management (UM) /Utilization Review (UR)	86	1. Can the Medical director participate via telephone or web conference for appeals and hearings?	1. Participation via telephone is generally acceptable but in rare circumstances testimony may be required in person.

				2. What were the total number of hearings and appeals for FY18?	2. Approximately 450 were handled by HSD in FY18, exclusive of the appeals and hearings handled by the MCOs.
402	Section: 2.2. Benefit Management Services Components	2.2.3 Utilization Management (UM) /Utilization Review (UR)	86	Please describe any interfaces between the UM solution and the Waiver expenditures to support expenditure management.	The interface will be via the ESB operated by the SI; data will be exchanged between the BMS Contractor's UM solution, the FS claim adjudication solution, and the C/CMS.
403	Section: Appendix H – BMS Detailed Requirements	UM/UR 3.20	128	Please provide historical and planned review volumes so we can determine appropriate staffing.	Please see the response to Question 370.
404	Appendix H – BMS Detailed Requirements	UM/UR 3.20	128	Please provide the types of reviews that are submitted and the volume of reviews per type.	Please see the response to Question 370.
405	Appendix H – BMS Detailed Requirements	UM/UR 3.20	128	Please provide the distribution of how reviews are submitted. What percentage are submitted online, phone, fax or other method.	In 2017, the State mandated that all Fee for Service providers rendering services requiring a prior authorization, all Developmental Disabilities Wavier Case Managers, Mi Via Consultants and Medically Fragile Case Managers, submit and retrieve correspondence from the TPA Provider Portal. The TPA is required to maintain fax lines for Mi Via Participants, Out of State requests, and Applied Behavior Analysis (ABA) review requests. As of FY 2019, 67% of providers utilize the Provider Portal.
406	Appendix H – BMS Detailed Requirements	UM/UR 3.27	129	Please clarify caseload weighting and describe the current weighting calculation and rationale?	None of the Enterprise agencies currently have a formalized caseload weighting methodology. This is in development by CYFD, however. The rationale will include type of case, level of care of the member, diagnoses, and other factors.
407	Section: VI Table 2	Table 2 – Sequence of Events	27	In order to ensure sufficient time to incorporate the anticipated changes to proposal development based on the State's answers to questions, would the State	See Amendment 1 for revised submission dates.

				consider extending the proposal due date by two weeks to November 20th?	
408	Section: Appendix B	BMS Cost Response Forms #1 and #2	61-62	Because the Federal match rate is different for DDI's and the state is not requiring all vendors to adhere to the same DDI schedule, it will be difficult to perform an apples-to-apples comparison between vendors unless the DDI costs are called out separately from the Operational costs. Would the State consider adding a DDI cost field for each of the Pricing Elements?	No, the State will not change the cost proposal form.
409	Section: 2.2.4	Benefit Plan Management	80	The RFP text states that for Benefit Plan Management services, the BMS vendor is to update data in the FS Solution. Can the state explain whether any Benefit Plan Management solutions are required to be provided by the BMS vendor, or are all systems to be updated provided by the FS vendor?	See the response for 394 above.
410	Section VII	Response Specifications for BMS	46	The RFP states that "the state is requiring the entire response to Appendix G to be a 4-5 page summary…" Following are several bullets explaining what must be included in the response. Can the State please confirm it is expecting vendors to address the 5 sub bullets on page 46 as well as responding to the remainder of the 14 different sub sections of requirements in Appendix G in that 4-5 page summary?	See Amendment 2 for revisions to the response section. The page limit for the Statement of Work Response has been increased to 10 pages.
411	Appendix H	Bullet F	152	Can the State please explain what is meant by "BMS being fully functional for the DDI period" as it relates to being operational within 60 days of award? Does that mean all solution products must be implemented and operating?	No, it means that the Contractor must be fully staffed and ready to start operations.
412	RFP	Various	Various	The RFP has not required a specific Implementation Period or go-live date for the various components. If vendors propose their own go-live dates, this could result in difficulty in comparing proposals as vendors that propose very late go-live dates, would inherently lower their costs as operational costs would not start until later in the 4-year base contract due to the go-live	No.

				date being later. Would the State consider putting a DDI target or not-to-exceed duration in the RFP?	
413	RFP	Various	Various	Is the State expecting all components to go live at the same time, be staggered, or leave that up to the vendor?	The State encourages the Offeror to answer this in their proposal.
414		RFP Section/Title — Section D. Response Format and Organization, 2. Number of Copies, Item a	42 - 43	The RFP states, "Binder 1: one (1) original and one (1) identical hard copy of their Technical proposal and required additional forms and material and *twelve (12) electronic versions.* Acceptable formats for the electronic version of the proposal are Microsoft Word, Excel and PDF." Would the State please clarify what is meant by 12 electronic versions (CDs, Email, etc.) since paragraph 2 of Item a. of the aforementioned section states, *"In addition, the entire proposal including all materials in Binder 1 (not Binder 2) shall be submitted on a single CD. Contents of Binder 2 must be submitted on a separate CD.* Proposals submitted on CD must include THREE versions: (1) a version in secure PDF; (2) a version in unsecured Microsoft WORD and/or Excel to enable the Department to organize comparative review of submitted documents; and (3) a redacted PDF for release to public under Inspection of Public Records Act requests. Electronic versions of the proposal **must not exceed 10 MB per file**, not for the entire proposal submission. Security policies do not allow the State to receive electronic copies via a USB drive."	See Amendment 2 for revised Format and Organization requirements, including the electronic submission.
415	Section: Binder 2	Cost Proposal Format VII Response Specifications	45-46	VII Response Specifications appears to require duplication in the Binder 2 Cost section. Would the State confirm section VII Response Specifications belongs in Binder 2.	Only the Cost Response is to be placed in Binder 2.
416	2.2.4		87	Who currently provides the services for the Benefit Plan Management requirements?	Conduent State Healthcare, LLC supports reference file updates. Mercer Health and

						Benefits, LLC provides actuarial and benefit plan consulting services.
417	2.2.4		87		Does the State anticipate that the BMS vendor will have access to the new Financial Services solution to perform analysis on reference file changes?	No, not the FS module/solution, only to the data required to perform the analysis.
418	2.2.4		87		Will the new Financial Services vendor give the BMS vendor access to their system to perform all the reference file updates or does the State anticipate that the entire reference system will be a completely separate solution?	See the responses to Questions 207 and 394 above.
419	2.2.4		87		Does the State expect the BMS vendor to take an advisory role on the development of new programs, including code sets and rules or for the Vendor to take a more active role in determining policy?	An advisory / consulting role. The State determines policy.
420	Appendix H (3.12)		127		What is the current volume of paper documents for UM/UR services?	See the response to Question 405.
421	Appendix H (3.14)		127		Please expand on this requirement. Offeror shall describe how its proposed services reconcile assigned authorization IDs with one or more providers.	The Offeror should describe a solution for this in its proposal.
422	Appendix H (3.15)		127		How is the vendor expected to respond to request submitted via toll free line as expected in requirement item 3.01?	For requests submitted via phone, the Contractor must have the capability to respond by phone, portal and mail within the established turnaround times.
423	Appendix H (3.19)		128		Please expand on this requirement. Offeror shall describe how its proposed services provide electronic authorization functionality to Providers with a no cost exception process for those providers who do not have electronic functionality.	The Contractor must provide an electronic platform, accessible by providers via the UP, for authorization requests and document exchange. The vendor must also provide at no cost an alternate method, such as fax, for submission authorization requests and document exchange to provider who do not have electronic functionality.
424	Appendix H (3.28)		129		What is the daily current volume of authorization requests?	Authorization volume varies daily. Various NMAC and program criteria/regulations

					regarding frequency of reviews, allocations, agency closures, etc. can directly impact the volume of authorization requests.
				Are suspended authorizations considered processed to completion?	Authorizations must be decisioned to be considered complete. In the current system, an authorization may be placed in a "pend" status if additional documentation is required. A Request for Information (RFI) process is used when more information is needed to complete the determination. When 3 RFIs have been issued and still no decision can be made, a Technical Denial may be issued. At that time, the Authorization will no longer be in a "pend" status and can be "decisioned" and the authorization process is considered complete.
425	Appendix H (3.37)		131	Please expand on this requirement. Offeror shall describe how its proposed services support the application of authorization and provider restrictions.	The BMS Contractor is responsible for authorizing fee-for-service procedures as required by State policy, including verifying that the provider type and specialty are appropriate for the service and specifying in the Contractor's UM/UR solution the specific provider who was authorized to perform the requested procedure.
426	Appendix H (3.38)		131	Please expand on this requirement. How is this possible if it's not listed? Offeror shall describe how its proposed services support authorization determination based on historic primary and other co-morbidities, even when co-morbidities are not listed.	Please see the response to Question 373.
427	Appendix H (3.46)		132	Please expand on this requirement. Specifically, why is "Standard Dental Claims" listed?	Requests for prior authorization of dental services are currently initiated by submission of an ADA claim form with supporting documentation and other material (such as radiographs and casts).
428	Appendix H (3.66)		136	What is the current volume of telephone authorization calls?	See the responses to Questions 377 and 405.

429	General			Do you have an incumbent vendor providing BMS services to the Agency? Where can I possibly request a copy of the proposal submitted by the incumbent vendor, in case it was previously awarded through a formal solicitation?	BMS services as outlined in this RFP are currently provided by numerous contractors as well as State staff. Please refer to the HSD website at https://www.hsd.state.nm.us/LookingForInformation/medical-assistance-division.aspx for HSD's current contracts. They can also be found on the State's "Sunshine Portal". Proposals are not posted online; they must be requested through an IPRA.
430	Appendix D – Reference Questionnaire Form		66-67	Would the State please confirm whether the due date for the reference questionnaire form is November 22, 2019, the proposal due date, or November 6, 2019?	Confirmed. Amendment 2 revised the submission deadline for References to November 22, 2019, 3:00 pm, the same as proposals.
	End of Responses				*End of Responses*