Health Canada
Non-Insured Health Benefits Program
Health Information and Claims Processing Services (HICPS)

Annex A

STATEMENT OF WORK

TABLE OF CONTENTS

Acronyms

AAC	Actual Acquisition Cost
ACD	Automatic Call Distributor
ACDQ	Association des chirurgiens dentistes du Québec
ACL	Access Control List
AHFS	American Hospital Formulary Service
APM	Administrative Procedures Manual
APSI	Atlantic Pharmaceutical Services Inc.
AQPP	Association Québécoise des Pharmaciens Propriétaires
ATC	Anatomical Therapeutic Chemical (ATC) Classification System
BC/BCP	Business Continuity/Business Continuity Plan
BEQ	Benefit Exception Questionnaire
BI	Business Intelligence
CAD	Controlled Access Drug
CAO	Canadian Association of Optometrists
CCP	Client Confirmation Program
CDA	Canadian Dental Association
CDAnet	Canadian Dental Association Network
CDHA	Canadian Dental Hygienist Association
CDHAnet	Canadian Dental Hygienist Association Network
CICA	Canadian Institute of Chartered Accountants
CISD	Canadian Industrial Security Directorate
CLHIA	Canadian Life and Health Insurance Association
COB	Coordination of Benefits
CPhA	Canadian Pharmacists Association
CSR	Customer Service Representative
DAC	Denturists Association of Canada
DACnet	Denturists Association of Canada Network
DBL	Drug Benefit List
DC	Defined Cost
DCV	Daily Claim Verification
DDD	Defined Daily Dose
DEC	Drug Exception Centre
DIN	Drug Identification Number
DOB	Date of Birth
DNA	Deoxyribonucleic Acid

DNE	Do Not Enrol
DPC	Dental Predetermination Centre
DR/DRP	Disaster Recovery /Disaster Recovery Plan
DRR	Documentation and Reporting Repository
DUR	Drug Utilization Review
EDI	Electronic Data Interchange
EFT	Electronic Funds Transfer
EOB	Explanation of Benefits
ETR	Estimated Time to Repair
FN	First Nations
FN/I	First Nations and Inuit
FNHA	(British Columbia's) First Nations Health Authority
FNIHB	First Nations and Inuit Health Branch
FTP/SFPT	File Transfer Protocol/Secure File Transfer Protocol
GN	Government of Nunavut
GNWT	Government of the Northwest Territories
GOL	Government On-line
GPI	Generic Product Identifier
GSP	Government Security Policy https://www.tbs-sct.gc.ca/pol/doc-eng.aspx?id=16578
HC	Health Canada
HCNet	Health Canada internal network
HICPS	Health Information and Claims Processing Services
HTTPS	Hypertext Transport Protocol Service
IDS	Intrusion Detection System
INAC	Indigenous and Northern Affairs Canada
IRC	Inuvialuit Regional Corporation
IT	Information Technology
ITIL	Information Technology Infrastructure Library
IVR	Interactive Voice Response
LAN	Local Area Network
LCE	Lowest Cost Equivalent
MAC	Maximum Allowable Cost
MGI	Management of Government Information policy http://www.tbs-sct.gc.ca/pubs_pol/ciopubs/TB_GIH/mgih-grdg_e.asp
MHC	Mental Health Counselling
MITS	Management of IT Security policy

	http://www.tbs-sct.gc.ca/pubs_pol/gospubs/TBM_12A/23RECON_e.asp
MSE	Medical Supplies and Equipment
MSERC	Medical Supplies and Equipment Review Centre
NAPRA	National Association of Pharmacy Regulatory Authorities
NAT	Network Address Translation
NIC	Network Interface Card
NIHB	Non-Insured Health Benefits
NOS	Network Operating System
NTI	Nunavut Tunngavik Incorporated
OTC	Over–the-counter (drug)
OWASP	Open Web Application Security Project
PA	Prior Approval
PBX	Private Branch Exchange
PD	Predetermination
PDA	Prescription Drug Abuse
PDF	Portable Document Format
PIA	Privacy Impact Assessment
PIPEDA	Personal Information Protection and Electronic Documents Act
	https://www.priv.gc.ca/en/privacy-topics/privacy-laws-in-canada/the-personal-information-protection-and-electronic-documents-act-pipeda/
PMP	Prescription Monitoring Program
POS	Point of Sale
PRE	Problem Resolved Explanation
PRSUM	Provider Registration System User Manual
PV	Pre-verification
PWGSC	Public Works and Government Services Canada
QA	Quality Assurance
QC	Quality Control
RAS	Remote Access Service
Réseau ACDQ	Network used by Providers who are members of ACDQ
SA	Special Authorization
SCNet	Secure Channel Network
SOW	Statement of Work
SRCL	Security Requirements Check List
SSL	Secure Socket Layer
SUM	System User Manual
SVS	Status Verification System

UAT	User Acceptance Testing
TA	Task Authorization
TRA	Threat and Risk Assessment
VPNE	Virtual Private Network Enterprise
WAN	Wide Area Network
WWW	World Wide Web (alternatively referred to as “the Internet”)
YG	Yukon Government

Glossary of Terms

Active Providers: Active Providers are those that have submitted a claim within the last 24 months. (See also: “Providers” and “Inactive Providers”).

Adjusted Claim Line: A claim line that has been settled and paid at an amount differing from the original amount claimed to achieve compliance with NIHB policy.

Alerts: Electronic messages sent to Providers or Clients (via email, or other electronic means) who have subscribed to receive notifications regarding website updates. May also be used to send urgent/time sensitive messages (e.g. service disruption).

Auto-adjudication Query: An auto adjudication query allows HC Users to define complex rules (for example prerequisites) that are to be evaluated by the solution when an item or service is claimed and a specified result occurs (as defined by the Project Authority), with no HC intervention.

Automated Post-determinations and Post-approvals: An automated action initiated by the Contractor to pend specific paper-based claim submissions that require HC review and adjudication in order to complete processing.

Benefits: Refers to the financial supports to registered First Nations and recognized Inuit for items and services not already covered by other private or public plans and programs. Specifically, the term refers to the range of items and services covered under HC’s NIHB Program.

Broadcast message: Broadcast messages provide information directed to all or specific Providers and can be delivered electronically (by electronic data interchange, e-mail), fax or by mail.

Claim form: The claim request document sent electronically, by fax or by mail to the Contractor or to HC or, the real-time claim transaction sent electronically to the Contractor. A claim request form may contain one or more claim lines.

Claim line: Request for payment for one item or one service.

Claim Statement: Statement that explains the status of the claim and results of adjudication for each of the claim lines processed during the payment period; provides service provider information, Client and benefit information as well as explanatory codes for any claim line that has been adjudicated. The Claim Statement can also be used as the Explanation of Benefits (EOB) for coordination of benefits with third party insurance.

Client: Registered First Nation person or recognized Inuit eligible for benefits with the NIHB Program. FN clients are defined as a Registered FN with INAC according to the Indian Act. Inuit clients under NIHB are recognized Inuit with Nunavut Tunngavik Incorporated (NTI), Inuvialuit Regional Corporation (IRC) and Makivik Corporation (James Bay Inuit residing off the Catchment Area). For the purposes of this document, the term “Client” also includes authorized Client representatives including, but not necessarily limited to, a parent or legal guardian in the case of an underage child, or an individual with power of attorney. Client representatives can perform some actions on a Client’s behalf and have access to some information in accordance with HC policies and approval by the Project Authority.

Client Affiliation: When a client becomes eligible for NIHB benefits under a devolved organization, including but not limited to FNHA.

Client Identification Number: Also, “Client ID”, is a unique number assigned to NIHB Program benefit Clients.

Client Notepad: Displays a chronological history of Client notes made by users (Contractor and HC) from all benefit areas.

Concordance: The alignment of changes to definitions in data elements that provide harmony between current and historical reporting.

Confirmation Letter: A solution generated letter sent to the Provider or Client to inform the recipient of the results of NIHB's review for a requested benefit or appeal.

Contractor Payment Date: The date the Crown processes Electronic Funds Transfer (EFT) payments to the Contractor.

Controlled access drug (CAD): Are drugs that require professional intervention from the pharmacist at the point of sale and possibly referral to a practitioner. While a prescription is not required, the drugs are available only from the pharmacist and are retained within an area of the pharmacy where there is no public access and no opportunity for patient self-selection.

Coordination of benefits (COB): Refers to the practice of ensuring that coverage for healthcare claims do not exceed the maximum amount the NIHB Program would pay according to the NIHB Program's rules when a Client is eligible for coverage under two or more healthcare plans at the same time (private, and public). In the context of the NIHB Program, when Clients are covered by another public or private healthcare plan, claims must be submitted to these other plans first before the remaining balance of such claims can be submitted to the NIHB Program for payment.

Daily: The period of measure described as "Daily" must mean the period of each calendar day from 00:00 to 24:00 EST. Daily periods of measure mean measurements over consistent, continuous, twenty-four (24) hour periods in Eastern Time.

Delisted Provider: A Provider who is no longer an eligible service provider under the NIHB Program. A Provider who is otherwise in good standing may be delisted because: (a) they are ceasing their practice, taking a leave of absence or are otherwise voluntarily stopping their practice permanently or for an extended period of time; or (b) still practicing but choosing to no longer participate in the NIHB Program. Examples include but are not limited to: office relocation; retirement; a sabbatical; an educational, teaching or research leave; or illness. The delisted Provider may no longer be able to submit claims for services after the delisting date at all offices or service locations used by the Provider until such time that the Provider may be re-enrolled with the NIHB Program.

Dental health professional associations: Refers to national, provincial, and territorial dentist, hygienist, and denturist associations within Canada recognized under the NIHB Program and to any future dental professionals permitted to practice in the provinces and territories of Canada.

Dental Predetermination Centre (DPC): Refers to the NIHB Dental Predetermination Centre that handles all dental-related predetermination requests, client appeals, and client reimbursements.

Dossette: A pre-packaged supply of medications in solid oral dosage form produced by a pharmacy to facilitate medication management. NIHB accepts claims for Dossettes in jurisdictions where unique adjudication rules are in place to ensure program policy compliance.

Drug Benefit List (DBL): A listing of the items provided as benefits by the NIHB Program.

Drug Exception Centre (DEC): The NIHB Drug Exception Centre (DEC) is an inbound call centre for pharmacy providers. DEC handles all requests for medications that require prior approval (limited use, exception, frequency limits, no substitution, PMP etc.). Additionally, the DEC reviews and processes manual client reimbursements for pharmacy items and pharmacy appeal requests.

Drug Utilization Review (DUR): The purpose of this review process is to identify drug related problems or interactions. The results of the analysis are returned to the Provider at the point of service in the form of warning or rejection messages. The purpose of the messages is to provide important drug related information to the Provider, but this information should not replace the professional judgement of the pharmacist.

Edits: NIHB policy and adjudication rules. Both “rules” and “edits” are synonymous terms and can be used interchangeably.

Electronic Claim Line: Request for payment for one item or one procedure submitted through EDI or Internet submission.

End-dated: The final date on which (i) the Provider’s enrolment is valid; (ii) the benefit or benefit parameter is valid; or (iii) the Client is eligible for NIHB coverage. A Client can be end-dated and later be become re-eligible for NIHB coverage. While the Client is end-dated their historical record remains intact. Depending on the circumstances, a Provider that has been end-dated may also be eligible to re-enrol in the future.

Exceptions: Items not listed as benefits on NIHB Program Benefit Lists and that are not Exclusions under the NIHB Program. Exceptions require prior approval or predetermination and are considered on a case-by-case basis (see also “Exclusions” in this Glossary).

Exclusions: Items not covered by the NIHB Program. These are items or benefits not available through the exception or appeal process.

Explanation of Benefits (EOB): See definition of Claim Statement.

Final Claim Day: The last day the Contractor accepts claims for processing.

First Nations Health Authority (FNHA): In the province of British Columbia, the FNHA is the outcome of devolution. The FNHA has assumed all of HC’s NIHB Programs, services, and responsibilities formerly administered by the FNIHB’s former Pacific Region (See “FNIHB Regions” in this Glossary).

Fiscal year: Government fiscal year includes twelve months from April 1st to March 31st.

Form Letter: A standardized letter format that may be sent to one or more recipients and populated with information for each recipient’s letter.

FNIHB: The First Nations and Inuit Health Branch of HC supports the delivery of public health and health promotion services on-reserve and in Inuit communities. It also provides drug, dental and ancillary health services to First Nations and Inuit people regardless of residence. The Branch also provides primary care services on-reserve in remote and isolated areas, where there are no provincial services readily available.

FNIHB Regions / Regional Offices: There are 7 First Nations and Inuit Health Branch (FNIHB) regions/regional offices. The regional offices are (i) Atlantic (Newfoundland, New Brunswick, Nova Scotia, and Prince Edward Island); (ii) Quebec; (iii) Ontario; (iv) Manitoba; (v) Saskatchewan; (vi) Alberta; and (vii) the Northern Region (Northwest Territories, Nunavut and Yukon).

General Notepad: a chronological history of notes made by HC Users attached to a record for communication with the Provider and Client and displayed on the Confirmation letters.

Generic Product Identifier (GPI): A 14-character hierarchical classification system that identifies drugs from their primary therapeutic use down to the unique interchangeable product regardless of manufacturer or package size.

HC User: Health Canada user authorized by the Project Authority to use the HICPS solution with their official functions and level of HICPS access.

HC Transfer: An agreement between HC and a First Nations or Inuit organization that may provide for the transfer of responsibilities for the management and payment of claims for non-insured benefits. Clients covered under such agreements are not eligible for NIHB Program benefits. Transactions may flow through HICPS, however, in instances where the organization has entered into an agreement with HC to buy-back claims processing services.

HICPS: The Health Information and Claims Processing Services include all of the services and systems used to process NIHB claims; to support Providers and Clients with the processing and settlement of their claims; to support HC staff in their adjudication role(s) as it relates to prior approvals, special authorizations and predeterminations; and to ensure compliance with NIHB Program policies including claim verification, reporting and financial control practices.

HICPS Account: Canadian Financial Institution account used by the Contractor solely for the payment of all NIHB Program claims for drug, dental, medical supplies and equipment, mental health counselling, vision care and any other benefit claims handled under this Contract.

Implementation Date: The day immediately following the last day of the Pre-Implementation Phase (see SOW Article 1.5.1 *Pre-Implementation Phase*) must be the Implementation Date. The Operations Phase (see SOW Article 1.5.2 *Operations Phase*) must start on the Implementation Date.

INAC Registration Number: A unique number assigned to eligible First Nations person registered with INAC under the *Indian Act* in the Indian Register that may be used to verify client eligibility for NIHB Benefits.

Inactive Providers: Refer to Providers who are enrolled with the NIHB Program but have not submitted a claim within the last 24 months. (See “Active Providers”).

Ineligible provider: Refers to providers who are not enrolled with the NIHB Program in accordance with SOW Articles 3.3.1.4 *Providers not enrolled in NIHB* and 3.3.1.6 *End-dating of Delisted or Terminated Providers*.

Infant Number: Also referred to as an IN number, which is a temporary number assigned to First Nations and Inuit Clients under an age specified by the Project Authority that are not yet registered, these records are linked to an eligible Client ID.

Internal Notepad: a chronological history of notes made by HC Users attached to a record for internal HC use and display only.

ITIL Best Practice: Information Technology Infrastructure Library best practices that are a set of IT service management standards integrating service support with service delivery (the long term planning and improvement of IT service provision with the day-to-day operation and support of IT services).

Limited-Use Benefit: Item with established criteria which must be met in order for the NIHB Program to cover the claim.

Logical Segregation: Is the non-physical separation of data from the Contractor's other client data such that the data, data reporting or the extracting of Canada's data can be done effortlessly and without dependency upon the Contractor's other client data.

Lowest Cost Equivalent (LCE): The unit price of a medication NIHB will reimburse is based upon the price of the lowest cost interchangeable generic equivalent listed on each province's and territory's formulary. A higher unit price of the medication may be reimbursed if approved via the NIHB approval process.

Manual Claim Line: A non EDI provider claim entered by the Contractor, or an HC User.

Maximum Allowable Cost (MAC): The NIHB Program has a maximum allowable cost (MAC) pricing model for select medications. Pricing for these medications will be determined by NIHB**.**

Monthly: Monthly periods of measure mean measurements taken from the start of the first day to the end of the last day in each calendar month. The total number of days varies according to the month of the year.

MSE Benefit Category: The MSE benefits currently includes seven benefit categories – Audiology, General Medical Supplies and Equipment, Orthotics and Custom Footwear, Oxygen Supplies and Equipment, Pressure Garments and Pressure Orthotics, Prosthetics, and Respiratory Benefits.

MSE Review Centre (MSERC): The HC work unit that is an advisory service that provides MSE Recommendations for requests for MSE benefits.

MSE Recommendation: The advice from an MSE Review Centre Reviewer to the region regarding a prior approval requested item: the recommendation decision is in accordance with program criteria and medical judgement. The reviewer provides advice on the item, quantity, cost, frequency, prescriber credentials, and Provider credentials.

myKEY: Also referred to as PKI Key, PKI Certificate, Entrust Profile or ID-Based Certificate, is a system that provides an efficient, effective, common basis to share files securely using encrypted electronic communication. myKEY is supported by Shared Services Canada (SSC) and is most commonly used within government departments to access internal applications. With strong authentication as well as encryption, the myKEY system is also available to anyone who has a working relationship with the Government of Canada.

NHQ (National Headquarters): In HC's organizational structure, the term "NHQ" refers to the central NIHB administrative office(s).

No Substitutions are Allowed: NIHB will consider reimbursement for a higher-cost interchangeable product when a patient has experienced an adverse reaction with a lower-cost alternative.

Non-Insured Health Benefits (NIHB): The HC program that provides coverage to registered First Nations and recognized Inuit in Canada for a specified range of medically necessary items and services that are not covered by other plans and programs.

NIHB Unique Procedure Code: Refers to procedure used to track and report on dental procedures not defined by any Canadian Dental health professional associations.

Operations Phase: The Operations Phase encompasses the period that commences on the Implementation Date and ceases on the Final Claim Day (see SOW Article 1.5.2 *Operations Phase*).

Paid: Refers to a claim line that complied with NIHB Program rules and was paid.

Paid Reversed: Refers to a claim line that was paid but subsequently reversed; thus changed to a "paid reversed" category claim.

Payee: Refers to the person, business, institution, agency, or organization to whom payment was made.

Payment Date: The date the Contractor processes payments through Electronic Funds Transfer (EFT) payments or mailed cheques to Providers or Clients.

Pharmacy Benefit Status: The Pharmacy benefit currently includes seven status types – Open Benefits, Limited Use, Exception, Exclusion, Non-Benefit, Not-Determined, and Discontinued.

Post Approval: The administration and adjudication of benefits for a service that has already been rendered. This is a submission that may be considered for coverage under specific circumstances under the NIHB Program and must be supported with a rationale.

Predetermination (PD): Predetermination is a method for the administration and adjudication of dental benefits. Predetermination is seeking review prior to proceeding with treatment and enables both the dental provider and client to understand the coverage commitments.

Pre-Implementation Phase: This phase commences upon contract award and ends with the Implementation Date (See Sow Article 1.5.1 *Pre-Implementation Phase*).

Prescription Drug Abuse (PDA): NIHB implements dose limits on drugs of concern (for example, opioids, gabapentin, benzodiazepines, stimulants, etc.), as a client safety measure at the point of sale (pharmacy).

Prescription Monitoring Program (PMP): NIHB implements the Prescription Monitoring Program (PMP) which focuses on the safe and appropriate use of drugs of concern. An analysis is conducted on claims submitted to the program that allows NIHB staff to identify clients at highest potential risk (i.e.: double doctoring, multi-pharmacy) for misuse of benzodiazepines, opioids, stimulant drugs and/or gabapentin to prevent inappropriate use. PMP procedures include restricting payment for all drugs of concern until the client identifies a prescriber (or group practice) who agrees to be sole prescriber for these items. Clients are identified for PMP through a variety of methods including "risk score," accessing Opioid Addiction Treatment (OAT) Therapy, and "special" cases identified case by case.

Pre-verification (PV): Providers or Clients may call the Contractor's HICPS Call Centre to be informed whether a Client is eligible for program benefits and the procedures are eligible (e.g. Frequency Limited benefits) on the date they call.

Previous Contractor: The Previous Contractor is the Contractor that operated the HICPS Contract at the time of the release of the bid solicitation, of which this Statement of Work formed part (Contract #HT166-050763/001/XO).

Pricing Category: A set of pricing rules that apply to all items associated to the relevant category.

Pricing Schedule: A collection of pricing categories for a HC defined group of providers within a jurisdiction, unless otherwise defined in the SOW.

Primary Client identification number: A unique number assigned to NIHB Clients (aka Client ID).

Prior Approval (PA): A Program coverage confirmation issued by Health Canada to a Provider to ensure that the Provider is advised that the Client is eligible for specific items, drugs, services, procedures, benefits and frequency exceptions.

Privacy and Security Standards: All the privacy and security requirements of this Contract, as summarized in SOW Article 1.4.6 *Robust Privacy Measures*.

Professional Fee: The maximum fee HC will pay against the regulated fee.

PROTECTED B Information: PROTECTED B information applies to particularly sensitive information or assets whose compromise could reasonably be expected to cause serious injury to non-national interests. Unauthorized disclosure could result in substantial distress to individuals due to loss of privacy; significant loss of competitive advantage to a Canadian company; impeding the investigation of a serious crime; or impeding the development of major government policies. Examples include records that contain medical, psychiatric or psychological descriptions; compiled and identifiable as part of an investigation into a possible law violation; concerning the eligibility for social benefits or the determination of benefit levels (this would not include cheques or other such payment documents); appearing on a completed income tax form; describing an individual's finances, that is, income, assets, liabilities, net worth, bank balances, financial history or activities, or credit worthiness; containing personal recommendations or evaluations, character references or performance evaluations; concerning an individual's racial or ethnic origin, or religious or political beliefs, and associations or lifestyle; and containing blood or DNA samples.

Provider: A practitioner, business, professional, institution or agency licensed by the applicable professional authority or governing body to practice or provide eligible services in the province or territory in which a Client obtains a service. When capitalized, a "Provider" means a provider that is enrolled in the NIHB Program by the Contractor and remains in good standing with the Program.

Provider Claim Verification Program: The systematic and continual verification of paid claims against HC's NIHB Program billing requirements. Claims that do not meet these requirements are subject to recovery.

Provider Enrolment: The Project Authority requires that NIHB Providers who submit benefit claims for reimbursement be enrolled in the NIHB Program. To be considered, interested parties must be licensed by the applicable professional authority or governing body to practice or provide eligible services in the province or territory in which a Client obtains a service. As part of the enrolment process, the Contractor must ensure that all NIHB provider eligibility criteria are met and maintained.

Provider ID: A unique number assigned to NIHB enrolled Providers.

Provider Notepad: Displays a chronological history of Provider notes made by users (Contractor and HC) from all benefit areas

Quarterly: Starting on April 1 of each year, fiscal year quarterly periods extend from April 1 to June 30; July 1 to September 30; October 1 to December 31; and January 1 to March 31.

Recovery Account: A Canadian Financial Institution account used solely to deposit amounts recovered from enrolled Providers, interest accrued on HICPS related accounts and to affect transfers for stale-dated cheques.

Regional Office: See FNIHB Regions.

Rejected Claim Line: A claim line that has been settled without payment because of insufficient or invalid information or because of non-compliance with NIHB policy.

Request: The information submitted for an item or service, for a specific Client, by a Provider for approval. The request is differentiated from the “claim” in that the request is prior to the approval for the submitted item or service while it becomes a “claim” once approval for that item has been granted and service or benefit has been delivered.

Returned Claim: A paper claim returned to the Provider or HC due to non-compliance with NIHB policy for insufficient or invalid claim information and that is expected to be re-submitted by the Provider. It does not include real-time (electronic) claims that have been rejected for non-compliance with basic rules for sufficient or valid information on electronic claims.

Reversal: A process for repealing a claim line whose payment is no longer valid. The reversal cancels the original settled claim line and provides a record of the cancelled transaction. The paid amount and quantity on a reversed claim line is the negative of the paid amount on the original claim line. Any benefit frequency counts are also reversed.

Secure Channel Network: Provides secure, private and high-speed access to all Government of Canada online services.

Settled Claim: A claim line for which the final processing has been fully determined on the solution according to NIHB eligibility and pricing rules.

Software Vendor: A company that provides software and related software support. In the context of this Contract, the Project Authority primarily intends to mean vendors of claim submission software and related support to Providers.

Special Authorization: Special Authorization is a process that allows designated HC Users to customize benefits for a Client.

Stale-dated: Cheques that have not been cashed within 6 months of the issue date on the cheque.

Status Verification System (SVS): HC’s NIHB Client management system provides Client eligibility for NIHB Program benefits. SVS data on FN Clients are based on information provided by INAC. SVS data on Inuit Clients are based on information provided by the GNWT, the GN, and Inuit organizations including the IRC, the NTI, and, in Quebec, the Makivik Corporation.

Subsequent Contractor: The Contractor selected by Canada to deliver HICPS following the end of the Operations Phase of this contract.

Termination of Enrolment: Termination of a Provider's enrolment in the NIHB Program on the authority of HC for not following the NIHB Program policies or on other grounds. The Provider whose enrolment has been terminated loses billing privileges for all services rendered after the termination date at all offices or service locations used by the Provider. In addition, the Provider is barred from enrolling with the NIHB Program in the future unless agreed to by HC NIHB Program officials.

Third Parties: For the purposes of this document, "third parties" refer to insurers other than the NIHB Program, whether private or public (federal, provincial, or territorial)

User: Generic term (lower case) referencing any user that is authorized by the Project Authority to use the HICPS Solution. Each user has varying degrees of HICPS access and authority in accordance with their user profile. Such users may be either Contractor staff or HC staff unless otherwise specified (see "HC User"). This does not include Clients or Providers viewing their personal or claims information through a web-based account.

Verification Parameters: Parameters used to enforce NIHB policies and procedures during claim adjudication and approval. For example, parameters may include (a) rules to enforce age, frequency, prior approval and other eligibility limitations on certain benefit items; (b) rules for coordination with other health insurance plans; and (c) jurisdictional pricing parameters such as allowed markup percentages and tolerance percentages.

1.0 Overview

1.1 The Non-Insured Health Benefits Program

The NIHB Program of HC's FNIHB provides eligible registered First Nations and recognized Inuit with a range of medically-necessary health-related goods and services not provided through private insurance plans, provincial/territorial health and social programs or other publicly funded programs. These benefit categories are:

- Dental care;
- Eye and vision care;
- Medical supplies and equipment;
- Drugs and pharmacy products;
- Mental health counselling;
- Medical transportation to access medically necessary services not available in the community of residence (out-of-scope for this Contract).

1.2 The Health Information and Claims Processing Services

As with other public and private plans, the NIHB Program does not provide direct services to clients. It relies mainly on pharmacists, dentists and other health providers to deliver services to clients. Through the Health Information and Claims Processing Services (HICPS), the NIHB Program reimburses Providers or Clients for the cost of eligible services up to the NIHB maximum allowable. These services are essential to the NIHB Program's ability to fulfill its mandate to ensure access by First Nations and Inuit clients to needed health benefits.

HICPS includes:

- All services and solutions used to process and pay NIHB claims in accordance with NIHB Program client and benefit eligibility;
- Supporting Providers and Clients with the processing and settlement of claims;
- Ensuring compliance with NIHB Program policies including Provider Claim Verification;
- Reporting and financial control practices;
- Pricing policies.

Since 1990, Canada has retained the services of a private sector Contractor to administer the following core health information and claims processing services on its behalf:

- requests and claims processing, and settlement;
- Provider enrolment and communications;
- payment and financial operations;
- systems and services in support of the NIHB review centres;
- Provider Claim Verification Program and recoveries;
- data retention, collection, and reporting.

The services provided by HICPS are delivered from within a federal - provincial framework that requires significant coordination. The operational boundaries of this framework are delineated by rules reflected in the policies and adjudication rules set out for the HICPS solution. Many of these rules are defined through the following:

- the *Financial Administration Act*;
- the *Privacy Act*;
- the *Personal Information Protection and Electronic Documents Act*;

- the *Management of Government Information (MGI) Policy*;
- the *Management of Information Technology Security (MITS) Policy*;
- the *Government Security Policy* (GSP);
- the central government reporting responsibilities (such as reporting to Parliament);
- the NIHB Program policies;
- provincial and territorial healthcare policies.

1.3 HICPS Scope

In accordance with the requirements, terms, and conditions contained within this Statement of Work, the Contractor must deliver the services outlined below.

1.3.1 Provider and Client Support Services (SOW Articles 3.3.1, 3.3.2, 3.3.3)

These services encompass:

a) enrolling Providers in the NIHB Program;

b) providing Providers and Clients with the option of creating a secure web account whereby they can access, including their personal information, claims history, status of pending requests, and view Client eligibility for benefits;

c) developing and maintaining accessible online forms used by Providers, Clients, and where applicable Prescribers, including, but not limited to, claim forms, client reimbursement forms, Prior Approvals, special communication letters used for routine tasks, BEQ's;

d) communicating with Providers and Clients through various communication channels such as the HICPS Call Centre or HICPS Website.

1.3.2 Benefit Solution Services (SOW Articles 3.3.4, 3.3.5, 3.3.6, 3.3.7, 3.3.8, 3.3.9)

This service encompasses:

a) creating and maintaining NIHB benefits lists, their associated pricing, and frequency limits in accordance with NIHB policy;

b) supporting the HC Users in their work adjudicating Prior Approvals, Predeterminations, Client Reimbursements and Appeals;

c) supporting HC Users in easily accessing and maintaining all the information relevant to their decision making;

d) supporting HC Users with communicating the outcome of adjudication process with Providers and Clients.

1.3.3 Manual and Electronic Claims Processing (SOW Articles 3.3.10)

This encompasses the processing of NIHB Pharmacy, Dental, MSE, Vision, and Mental Health Counselling benefit claims including:

a) manual and electronic claims capture;

b) claims adjudication;

c) the support of HC's PA, SA, case management, recommendations, PD and post-approval processes;

d) claims completion coaching for Providers and Clients;

e) additional functionality as detailed in the SOW 3.3.10 *Claims Processing*.

1.3.4 Claims Settlement (SOW Article 3.3.11)

This encompasses the finalizing of Claim payment amounts to individual Providers or Clients and the production and distribution of claim statements to them.

1.3.5 Financial Operations (SOW Article 3.3.12)

This encompasses the financial practice of requesting, reconciling, and processing claims payment and recovery amounts with HC.

1.3.6 Provider Claim Verification Program (SOW Article 3.3.13)

This encompasses detecting if claims have been billed in compliance with the terms and conditions of the NIHB Program, identifying any billing irregularities and either recovering monies for ineligible claims or adjusting claims.

1.3.7 Reporting Services (3.3.14)

These services encompass a Business Intelligence (BI) reporting tool, data extracts, and static reports.

1.3.8 Business Management, Quality Assurance, IT Operations and Maintenance Services (SOW Articles 3.1; 3.2; 3.3.15; 3.4, 3.5, 3.6, 3.7)

These services encompass:

a) activities to ensure services comply with NIHB policies and standards;

b) planning and analysis services that offer opportunities to improve the efficiency and effectiveness of the HICPS;

c) quality assurance and performance reporting activities and processes that ensure the business solution (e.g. services and functions) meets the performance standards defined by the Project Authority;

d) activities to ensure that the business solution conforms to laws, regulations and HC and Government of Canada policies and that the solution is adaptive to accommodate any change in laws or regulation;

e) activities to ensure information and data are current and correct as well as secure and private at all times;

f) data collection, use, retention, and disposal;

g) system maintenance and management.

1.4 HICPS Service Delivery Model and Objectives

HICPS Service Delivery Model

The core HICPS services include:

a) Claims Processing and Settlement Services;

b) Call Centre Services;

c) Provider Enrolment and Management Services;

d) Provider and Client Communication Services;

e) Provider Claim Verification Services;

f) Reporting Services.

To deliver these core services according to the NIHB Program objectives of operational sustainability, cost-effectiveness, and financial integrity, the Contractor must apply stringent financial practices and policies. The Contractor must deliver the services within a business management and IT Operations and

Maintenance Framework that is guided by laws, policies, service standards and other requirements and deliverables (as outlined throughout the SOW), and HICPS governance structure. NIHB Program policies are available on the NIHB Program website (http://healthycanadians.gc.ca/health-system-systeme-sante/services/non-insured-health-benefits-services-sante-non-assures/index-eng.php).

Throughout the Contract, HC will maintain the authority and responsibility for all NIHB Program policy and its implementation. The Contractor must render the services called for under this Contract. The Contractor must provide, deploy, and maintain a business solution which must be:

a) robust;

b) scalable, to accommodate volume growth;

c) adaptable, to adjust for business process or rule changes;

d) secure, to maintain the security and privacy of the data;

e) efficient, to deliver the information and services;

f) in accordance with defined service standards and prescribed requirements.

HC will provide the Contractor with the necessary approvals and data required to deliver information and services within the service standard requirements.

HICPS Service Delivery Objectives

HC's service delivery objectives for the HICPS are as follows under SOW Articles 1.4.1 to 1.4.6.

1.4.1 Clear Contractual Relationship

Establish a strategic, long-term contractual relationship with the Contractor based on a clear, mutual understanding of each party's respective roles and responsibilities.

1.4.2 Defined Contractor Services

Define a clear set of Contractor's services that can be measured against clearly defined requirements and service standards as outlined in the SOW, ensuring that HC continues to manage the NIHB Program and Contract in an operationally sustainable manner in order to:

a) reduce errors in claims submission, adjudication and processing;

b) continually improve processes;

c) encourage Providers to use electronic technology for claims submission and payment;

d) contain delivery costs.

1.4.3 Efficient Claims Processing and Payment Services

Ensure fast, efficient, effective, and accurate claims processing and payment services against NIHB Program eligibility and pricing rules and within service standard requirements.

1.4.4 Provider Participation

Encourage Provider participation in the NIHB Program by providing quality information in the official language of the Provider's choice on a timely basis, prompt and accurate payment of eligible benefit claims, clarity of service scope, user-friendly billing procedures, and effective complaint resolution mechanisms.

1.4.5 Robust Business Continuity and Disaster Recovery Measures

Ensure continuity of service by applying management, operational and technical controls to safeguard the confidentiality, integrity and availability of the HICPS solution, data and services and by providing robust and proven disaster recovery and business continuity procedures.

1.4.6 Robust Privacy Measures

The records or personal information managed, accessed, collected, used, disclosed, retained, received, created or disposed of in order to fulfill the requirements of the Contract or maintained under the Contract will remain under the control (as referred to in the *Privacy Act*) of the Project Authority and will be subject to the *Privacy Act* and the *Access to Information Act*.

The Contractor must protect the Client's and the Provider's Privacy in accordance with the laws of Canada, by managing information and data so that they comply with Canada's operational and legal requirements. The Contractor and the Contractor's Subcontractors or agents, if any, must ensure that:

a) all Work is conducted in accordance with Contract Clause 7.14 *Collection and Use of Personal Information by the Contractor*;

b) all aspects of the Work defined in the SOW including claims processing, imaging, archiving, mailing, e-mailing, printing; document destruction, etc. are conducted and retained in Canada;

c) data and data management functions are located and only accessible from within Canada and are physically separate from all other data management functions, directly or indirectly, which are located outside of Canada – this means that data is created, transmitted and stored only in Canada and never passes through another country;

d) all data centres, call centres, centres of operations and records and information storage are located in Canada and are logically segregated from all other Contractor or Subcontractor data or data systems;

e) access to data and data systems is restricted to individuals or entities pre-approved in writing by the Project Authority and the appropriate security levels have been evaluated by PWGSC as defined in the SRCL;

f) the above privacy requirements apply to Disaster Recovery sites, Business Continuity sites, Document Imaging sites, Document Duplication sites, Document Disposal and Destruction sites and offsite storage for hardcopy files and backup tapes;

g) all other privacy and security requirements and standards in the SOW are met.

1.5 Service Delivery Phases

The SOW outlines the scope of the services to be delivered by the Contractor in three primary phases of the Contract including Pre-Implementation, Operations, and Phase-Out.

1.5.1 Pre-Implementation Phase

This phase commences upon Contract Award and ends with the Implementation Date. The Implementation Date is *<either December 1, 2019 or December 1, 2020 to be inserted at Contract Award according to the Contractor's Pre-Implementation Plan approved by the Project Authority>*. In this Phase, the Contractor must customize and/or develop services as required and make ready the business solution required to assume the HICPS operations from the Previous Contractor. To this end, the Contractor must develop, migrate historical data, reconfigure, or customize the solution as necessary to meet the NIHB Program requirements. At the completion of this phase, the HICPS must be fully functional and the Contractor must be fully equipped to commence full service in accordance with the stipulated performance and quality assurance standards. Article 2.0 *Pre-implementation Phase* of the SOW describes the requirements in detail.

1.5.2 Operations Phase

The Operations Phase encompasses the period that commences on the Implementation Date and ceases on the Final Claim Day. Article 3.0 *Operations Phase* of the SOW states the specifications and requirements to be performed or delivered by the Contractor during this phase.

1.5.3 Phase-Out Period

Phase-Out is the period that commences upon formal written notification from the Contracting Authority to the Contractor and extends to and includes the Contract Expiration Date, regardless of whether or not there is a new Contractor performing the subsequent contract. This Phase includes activities that will be undertaken by the Contractor, in addition to Operations Phase activities, to ensure the smooth, efficient, and complete transition to a new contract without interruption of service delivery to Clients or Providers. Article 4.0 *Contract Phase-out* of the SOW describes the requirements in detail.

2.0 Pre-Implementation Phase

The Pre-Implementation Phase is the period from the date of Contract Award to the Implementation Date. This section outlines the requirements to customize and/or develop the services as required and make ready the business solution required to assume the HICPS operations from the Previous Contractor.

2.1 Pre-Implementation Plan

The Contractor must develop and implement a Pre-Implementation Plan. The Plan must be approved by the Project Authority prior to implementation.

2.1.1 Milestone-based Pre-Implementation Plan

The Contractor must revise and/or update as applicable and implement the milestone-based Pre-Implementation Plan submitted with the Contractor's bid. The Plan must cover the Pre-Implementation Phase from the date of Contract Award to the Implementation Date. The Project Authority will provide comments and make recommendations to the Contractor for changes, if applicable, within 5 business days of Contract Award. The Contractor must obtain final approval of the Plan from the Project Authority within 25 business days of Contract Award.

2.1.1.1 At a minimum, the Pre-Implementation Plan must include:

a) a description of the major milestones;

b) a Pre-Implementation Plan schedule detailing the milestones and dependencies between milestones to ensure that all requirements in the SOW will be met, that services are provided without interruption throughout the transition from the Previous Contractor, that Providers currently participating in the Program are effectively re-enrolled, that services and systems are ready for implementation, tested in time to correct deficiencies, and certified and accredited prior

to the Implementation Date (The Contractor and Subcontractors will only receive PROTECTED B data after staff has acquired security clearances and document safeguarding certification from CISD. The Contractor must schedule 10 business days for items requiring the Project Authority's decisions or approvals);

c) an initial risk assessment and analysis identifying each Pre-Implementation risk, whether that risk can be controlled or avoided, the probability of occurrence, the possible impact on service delivery and a sound mitigation strategy for that risk;

d) an effective communication strategy that will establish and maintain ongoing communication with the Project Authority throughout the Pre-Implementation Phase, and regular contact with HC Users and currently registered Providers and other stakeholders to ensure a smooth uninterrupted transition between contracts. All communication materials developed must be in English and French and require the approval of the Project Authority;

e) a governance structure for the Pre-Implementation Phase that clearly sets out the project governance including, but not limited to, the operations management team, the HC management team, the pre-implementation management team, any oversight committees, working groups, etc. The structure should indicate where participation is required of HC personnel and what decision controls will be applied to ensure quick decision making within the project and timely delivery of services. HC will have a project team dedicated to pre-implementation. The team will include management and technical personnel versed in the operational business requirements of the Program. Other HC personnel will be called to assist as-and-when-required during this phase.

2.1.1.2 The Contractor must provide implementation status reports on the 1st business day of the month and the 1st business day following the 15th day of the month on progress against the Pre-Implementation Plan schedule, and participate in regular status meetings to discuss progress with HC.

2.2 HICPS Solution and Services

The Contractor must deliver fully functional and secure HICPS services, in accordance with the requirements detailed in the SOW Article 3.0 *Operations Phase* on or before the Implementation Date.

The Contractor must demonstrate to the Project Authority's satisfaction that it is ready to implement HICPS.

2.2.1 Approval and Implementation

The Project Authority will provide written approval to implement HICPS based on a positive response to:

a) the results of testing (SOW Article 2.2.3 *Standards*);

b) the results of the model office simulation exercise (SOW Article 2.2.3 *Standards*);

c) the results of data migration - loading and conversion (SOW Article 2.3 *Data Migration*);

d) the results of the Security Threat and Risk Assessment (SOW Article 2.2.4 *Security*);

e) the security certification and accreditation of the solution (SOW Article 2.2.4 *Security*);

f) the effectiveness of the Quality Assurance Plan to meet program objectives (SOW Article 3.2 *Quality Assurance*);

g) the effectiveness of the planned financial controls (SOW Article 3.3.12 *Financial Operations*);

h) the completeness of the system documentation (SOW Article 3.6 *HICPS Manuals*);

i) the successful demonstration of the solution requirements (SOW Article 2.2.2 *Solution Requirements*)

j) the successful demonstration that the DRP and BCP objectives are met (SOW Article 3.1.4 *Disaster Recovery Plan and Business Continuity Plan*);

k) the successful demonstration that Providers and Clients can submit claims (SOW Article 3.3.10 *Claims Processing Services)*:

   i. via EDI using software from claims submission software vendors (Providers only);

   ii. through electronic submission;

   iii. manually;

l) the successful demonstration that users can submit all online forms (SOW Article 3.3.3.3 *Online Forms)*;

m) the successful demonstration that all forms submitted to the Contractor are accurately queued for HC review where applicable (SOW Article 3.3.3.3.2 Online Form submission Work Queues);

n) the successful demonstration of the HICPS Website (SOW Article 3.3.3.1 *HICPS Website)*;

o) the successful demonstration that Providers and Clients can create and access a secure web account (SOW Article 3.3.3.2 Provider and Client Secure Web Accounts);

p) the successful demonstration of the Online Drug Benefit List (SOW Article 3.3.7.21 Online Drug Benefit List);

q) the Privacy Audit, demonstrating adherence to the Privacy standards (SOW Article 3.2.2 *Privacy and the Quality Assurance Program*).

2.2.2 Solution Requirements

The Contractor must ensure that all requirements are addressed such that the following outcomes are met:

a) Claims are processed, both manually and electronically, accurately and efficiently, according to the SOW business requirements as of the Implementation Date and within the defined service standards, while ensuring that personal information remains secure and private;

b) Providers and Clients are informed of any business process or rule changes and the impacts on them;

c) Providers and Clients are capable of submitting claims as of the Implementation Date and are supported through the claims submission, processing and payment processes;

d) Providers and Clients can access their personal claims information through a secure web-based interface;

e) Users are trained and supported in their use of the HICPS system;

f) Users have secure access to the information they require from HICPS to continue managing the NIHB Program;

g) Financial controls are in place and working effectively;

h) Business Continuity and Disaster Recovery Plans are in place, have been tested and will be maintained for the duration of the contract;

i) Reporting services are provided accurately and efficiently, according to the SOW business requirements;

j) The Online Drug Benefit List is in place, accurate and working effectively.

2.2.3 Standards

The Contractor must ensure that all solutions, services and reports, as well as the Contractor's system used to implement such are tested and pass Government and HC standards outlined in this SOW prior to the Implementation Date. The Contractor must:

a) ensure that a Test Plan is developed and executed, including a Security Test Plan detailed in SOW Article 3.4.6 *Security Requirements*, to test the HICPS solution and processes, as well as the Contractor's system used to implement such, to ensure they adhere to the requirements defined in the SOW and Contract. Testing must be conducted according to the Test Plan. HC and PSPC/CISD personnel may participate in testing as required;

b) ensure that testing encompasses solution testing, integration testing, regression testing, stress and performance testing, user acceptance testing, security testing, volume testing, and data boundary testing, the validation of electronic data loads (and manual file updates where these are necessary) and report generation;

c) ensure that testing and testing facilities comply with MITS Standards and GSP security requirements and must mirror the production environment (The Contractor must provide written evidence of CISD's confirmation that Facilities testing environment meet the Security Requirements Check List prior to receiving PROTECTED B data - refer to Annex C);

d) demonstrate through a model office simulation exercise to Canada's satisfaction that all of the capabilities used to support HICPS are functioning correctly:

   i. This testing exercise must simulate a model office environment and test the services, processes, procedures, outputs, interfaces, staff knowledge, and solutions developed to support HICPS.
   ii. The Project Authority and the Contractor will provide scenarios and participate in the model office simulation exercise. The scenarios will cover the services requested in the SOW.
   iii. The Contractor must provide all required materials, facilities, personnel, and access to the solution to complete the simulation exercise. The Contractor must prepare and submit a post simulation report to HC within 4 business days of completion of the simulation. The report must identify the results of the simulation highlighting the successes, issues, problems and the proposed course of action including a schedule for correcting issues prior to the Implementation Date;

e) demonstrate to Canada's satisfaction that Providers can submit claims via EDI using software from various claims submission software vendors:

   i. The Contractor must assist Providers and Claims Submission Software Vendors in testing their software with the Contractor's claims processing system and servers used in the delivery of HICPS, and report to HC on the results;
   ii. The Contractor must ensure that all Providers and Claims Submission Software Vendors are informed of any future changes to the data elements and EDI interface that may affect EDI submissions at least 90 calendar days in advance of any change for the duration of the Contract;

f) demonstrate to Canada's satisfaction that Providers and Clients can submit claims electronically;

g) demonstrate to Canada's satisfaction that Clients and Providers can submit claims manually;

h) resolve, to Canada's satisfaction prior to Implementation, all problems encountered during testing.

2.2.4 Security

The Contractor must certify by the following means that HICPS Solution and services meet the security requirements detailed in the SOW prior to the Implementation Date:

a) HC will perform, through an independent third party security firm, a Threat and Risk Assessment (TRA) (see SOW Article 3.4.6.3 *TRA Requirement and Additional IT Security Safeguards*) of the

HICPS solution and services prior to the Implementation Date. Results of this review will be provided to the Contractor in the form of a TRA report. The Contractor must correct, at its own cost, any deficiencies identified through this assessment that are established as requirements in the SOW. The Contractor must provide, at no additional cost, access to its facilities, documentation and resources and must provide all the necessary space, telephones, computers, etc. to conduct this assessment.

b) Once the Contractor has performed all remedial actions, if any, and has rectified all deficiencies, an updated TRA will be submitted to the Project Authority by the third party security firm. The Project Authority will then undertake a certification exercise with the Contractor to demonstrate that the security and operational requirements established for the claims processing system and services have been met and that the security, operational, and financial controls and safeguards operate as intended. The Contractor must correct, at its own cost, any deficiencies identified through this certification exercise that were established as requirements in the SOW. The Contractor must provide access to its facilities, documentation and resources and must provide all the necessary space, telephones, computers, etc. to conduct this assessment. The Project Authority will monitor the certification process.

c) Once the Contractor has performed all remedial actions, if any, and has rectified all deficiencies and a Final Certification Report is submitted, the Project Authority will accredit the HICPS solution and services prior to the solution going into production use. Accreditation signifies that the Project Authority has authorized the solution to operate and has accepted the residual risk, if any, of operating the solution or service based on the certification evidence.

2.2.5 Privacy

Notwithstanding that the Contractor must accept complete responsibility to ensure that the HICPS and the Contractor's systems meet all of the contractual privacy standards prior to the Implementation Date, HC will conduct a privacy audit to ensure compliance with the privacy standards. HC will pay for the services of the external auditor. The Contractor is solely responsible for all other costs associated with the audit, including costs associated with providing access to its facilities, documentation, and resources. The Contractor must provide all the necessary space, telephones, computers, etc. to conduct this assessment.

The Contractor must:

a) develop and deliver to the Project Authority a Privacy Operations Document (SOW Article 3.2.2.1 *Privacy Operations Document*);

b) develop and submit to the Project Authority a Remedial Action Plan identifying the corrective actions to be taken to address any deficiencies found through the privacy audit to ensure the solution and services meet the privacy standards of this Contract;

c) apply any corrective actions and ensure that the HICPS and the Contractor's system meet the Privacy Audit requirements prior to the Implementation Date.

2.2.6 Documentation

The Contractor must demonstrate that the solution's architecture, specifications and designs; operational procedures and administrative procedures and processes for all HICPS services are fully documented in General and Detailed Design Documents and as described in SOW Articles 3.6 *HICPS Manuals* prior to the Implementation Date. The Contractor must obtain Project Authority approval prior to the

Implementation Date for the Administrative Procedures Manual referenced in SOW Article 3.6 *HICPS Manuals*.

2.2.7 Disaster Recovery Plan and Business Continuity Plan

The Contractor must develop, finalize and deliver to HC a HICPS Disaster Recovery Plan and a Business Continuity Plan and obtain Project Authority approval prior to the Implementation Date. Refer to SOW Article 3.1.4 *Disaster Recovery Plan and Business Continuity Plan*.

The Contractor must demonstrate to Canada's satisfaction during the Pre-Implementation Phase that the DRP and BCP objectives are met.

2.2.8 Financial Controls

The Contractor must demonstrate to Canada's satisfaction that policies and procedures relating to financial controls as detailed in SOW Article 3.3.12 *Financial Operations* have been implemented or are ready to be implemented as of the Implementation Date.

2.2.9 Quality Assurance

The Contractor must develop, finalize, and deliver to the Project Authority a Quality Assurance Plan prior to the Implementation Date in accordance with the requirements detailed in SOW Article 3.2 *Quality Assurance*.

2.2.10 Location and Facilities of Work

The Contractor must document locations of all facilities where the Work or portions thereof will be conducted and demonstrate to Canada's satisfaction that facilities are in all respects compliant with contractual requirements.

2.3 Data Migration

The Contractor must convert and load all data provided by the Project Authority into the Contractor's solution system(s).

2.3.1 With regard to data, The Contractor must:

a) provide a conversion methodology using its systems to convert all HICPS data provided by the Project Authority. Refer to Appendix A for volumes of records;

b) clean, convert and load the HICPS data provided by HC from separate data sources. This converted data must be available in the BI Reporting Tool;

c) provide reports on data migration results, including error reports showing failures and the cause of each failure;

d) provide metrics on the accuracy of the HICPS data conversion and data load;

e) repeat cleaning and migration processes until all failures are resolved;

f) validate that all required data conversion and loading are accurately and fully completed and that full historical continuity of data is achieved;

g) ensure system functions with accurately migrated data;

h) ensure that throughout the conversion and data loading exercise the privacy and security of the information is maintained;

i) perform separate reconciliations of active and inactive converted Client records against the same records in the Status Verification System;

j) maintain previous and current benefit item pricing;

k) ensure that data used to create and maintain the NIHB Program benefit information are current as of the Implementation Date.

l) ensure the necessary information to conduct third party claims adjudication rules against provincial, territorial and Worker's Compensation program, and where applicable private plans (see Appendix C, Article 7.0 *Third Party Verification Edits)*, is current as of the Implementation Date and maintained current throughout the life of the Contract.

2.3.2 With regard to paper-based files, the Contractor must:

a) store paper-based files and forms related to claims processed by the Previous Contractor;

b) provide secure transportation and storage of files as detailed in SOW Article 3.3.15 *Records Management*.

2.3.3 With regard to electronic data, the Project Authority will:

a) provide the Contractor with the HICPS data according to the schedule detailed below:

i. a complete description of the form and layout of the electronic records from the existing HICPS data within a time period defined after Contract Award;
ii. an initial complete load of the records in an electronic format, approximately 120 calendar days prior to the Implementation Date;
iii. updates of the initial complete load, which must form the basis for claims processing operations, with the final load one business day before the Implementation date;

b) assess the data validation results.

2.3.4 The Contractor must deliver the conversion and data loading results to the Project Authority for acceptance by the Project Authority.

2.4 Bilingual Training

The Contractor must deliver a training program in both official languages to train designated HC Users on HICPS.

2.4.1 The Contractor must develop and deliver a training program in both official languages based on a train-the-trainer approach. The training program must encompass full solution training and the provision of training materials, such as the HICPS User Manual (SOW Article 3.6 *HICPS Manuals*), for HC Users. This training must cover all procedures required for HC Users to use the system effectively and must provide HC trainees with sufficient expertise to train other staff members in their respective offices. The Contractor must provide the training on an ongoing basis, as required, throughout the life of the Contract.

2.4.2 Training must be made available online. Upon the Project Authority's agreement, training may be conducted at the Contractor's site, in some instances, and the Contractor must accommodate up to 30 HC Users. The training environment must duplicate all aspects of the production environment, including Reporting and EDI interfaces and data from the HICPS solution. It must meet the security and privacy standards of the production environment.

2.4.3 HC will be responsible for:

a) designating in-house trainers to participate in the Contractor-provided training program;

b) participating in the Contractor-provided training program;

c) training the remaining HC Users;

d) providing coaching services to HC Users;

e) the travel and living expenses for HC Users being trained.

2.5 Re-enrolment of Providers

The Contractor must re-enrol Providers prior to the Implementation Date.

2.5.1 The Contractor must develop a strategy, for the Project Authority's approval, to re-enrol NIHB Program Providers. This strategy must describe how the Contractor will re-enrol Providers prior to the Implementation Date, how the Contractor will retain historical data pertaining to previously enrolled Providers and how the Contractor will address current active Providers who have not re-enrolled as of that date. Refer to SOW Article 3.3.1 *Provider Enrolment Services.*

2.5.2 Prior to the Implementation Date, the Contractor must re-enrol Providers who wish to continue with the NIHB Program. The enrolment must be in accordance with Provider Enrolment Services set out in SOW Article 3.3.1 *Provider Enrolment Services*. All communication materials to be made available to the Providers are subject to the Project Authority's prior approval.

2.6 Documentation and Reporting Repository (DRR)

The Contractor must develop and manage an SSL protected, access controlled internet based DRR to post and/or host HICPS documentation, reports and tools and follow ITIL procedures and processes to back up the DRR.

2.6.1 The DRR must be the primary communication channel for document sharing between the Contractor and the Project Authority. The DRR must be fully functional in accordance with the Pre-Implementation Plan detailed in SOW Article 2.1 *Pre-Implementation Plan.*

2.6.2 The Contractor must post and host:

a) HICPS development documentation, manuals (SOW Article 3.6 *HICPS Manuals*), training and support materials (SOW Article 3.7 *HICPS User Training and Support*) to the DRR;
b) all Contractor produced static NIHB Program Management reports, HICPS Operational reports (refer to Appendix H) documentation updates, release notes and user tips and tricks;
c) all tools for managing change requests, release and configuration management for all phases of the Contract. (Refer to SOW Article 3.5 *Operational Support*).

2.6.3 The Contractor must limit access to the DRR in accordance with the security, infrastructure, and design requirements defined in SOW Article 3.4 *Technical Specifications*.

2.6.4 The Contractor must ensure the DRR meets all security and privacy standards defined in the Contract and must be able to substantiate its adherence to these standards upon request from HC.

2.6.5 The Contractor must provide search functionality of all documentation on the DRR. The Contractor must ensure that the documentation is up-to-date.

2.6.6 The Contractor must ensure that the DRR allows for concurrent online commenting and review by HC Users, PSPC Users and the Contractor of the documents hosted in the repository.

2.6.7 The Contractor must ensure the availability of the DRR in accordance with SOW Article 3.4.1.1 *Business Continuity, Availability, and Service Standards* to HC Users.

2.7 Transition Plan

The Contractor must develop and implement a Transition Plan to ensure a smooth transition with the Previous Contractor to ensure uninterrupted HICPS services.

2.7.1 The Contractor must develop and implement a Transition Plan. In order to ensure uninterrupted services, this Plan must identify:

a) the transition of the claim information, provider information, financial information, Provider Claim Verification information and any associated recoveries, and supporting documentation within the Previous Contractor's system;

b) documentation required from the Previous Contractor;

c) the coordination of activities required with the Previous Contractor;

d) a schedule of the activities to be completed including roles and responsibilities;

e) a risk assessment to ensure that all parties are aware of the risks and mitigating actions that must be taken;

f) how the transition plan will be coordinated with the Previous Contractor's phase-out milestones as agreed to by the Project Authority.

2.7.2 No later than 240 calendar days prior to the Implementation Date, the Contractor must meet with the Project Authority and submit a plan for handling unsettled claims as of the Implementation Date. The Project Authority will coordinate and facilitate discussions between the Previous Contractor and the Contractor to obtain agreement on the transition plan.

2.7.3 Upon approval by the Project Authority, the Previous Contractor, and the Contractor, the Contractor must implement the Transition Plan and report to the Project Authority twice a month on the status of the plan activities for which the Contractor is responsible, issues, or obstacles affecting the schedule timelines and corrective actions taken.

2.8 Operations Management Strategy

The Contractor must develop and finalize an HICPS Operations Management Strategy as detailed in SOW Article 3.1.1 *Operations Management Strategy*.

2.8.1 The Contractor must submit the HICPS Operations Management Strategy for the Project Authority's approval in accordance with the Pre-Implementation Plan schedule.

2.9 Annual Operations Plan

The Contractor must develop and finalize an HICPS Annual Operations Plan in accordance with SOW Article 3.1.2 *Annual Operations Plan* for the period from the Implementation Date to the end of the first twelve months of operations.

2.9.1 The HICPS Annual Operations Plan must describe how the Contract must meet the Major Requirements in the first twelve months of the Operations Phase as detailed in SOW Article 3.0 *Operations Phase*.

2.9.2 The Contractor must finalize and deliver the Project Authority approved Annual Operations Plan to the Project Authority 90 calendar days prior to the Implementation date. The Contractor must implement the Annual Operations Plan in accordance with the requirements detailed in SOW Article 3.1.2 *Annual Operations Plan*.

2.10 Contract Project Manager

The Contractor must provide a full time dedicated Contract Project Manager (CPM) as its representative responsible for the pre-implementation phase for successfully delivering the services required under the Contract. The role of the CPM will include, but not limited to:

a) providing oversight on the contractor work progress;

b) acting as a liaison between the Contracting Authority and the Contractor;

c) providing an effective way to monitor and control the deliverables;

d) reviewing the project status reports, project plans and updates, project risks, unresolved issues and project changes;

e) covering all project activities related to the Contractor work specific to the deliverables outlined in the Contract.

3.0 Operations Phase

3.1 Business Management

3.1.1 Operations Management Strategy

The Contractor must implement, maintain, and manage the HICPS according to the Operations Management Strategy. The Contractor is responsible for developing and drafting the Strategy. The Project Authority has final approval.

3.1.1.1 Management Practices

In its HICPS Operations Management Strategy document, the Contractor must describe the management practices the Contractor will implement to ensure that the requirements detailed in the SOW are delivered on schedule in accordance with the Annual Operations Plan (SOW Article 3.1.2 *Annual Operations Plan*). The HICPS Operations Management Strategy document must include, at a minimum:

a) a description of the major objectives against which HICPS will be delivered;

b) a governance structure that demonstrates a clear understanding of the scope, goals, uniqueness and objectives for the management for all benefit areas of HICPS;

c) the conflict resolution processes that will be established to ensure prompt resolution of any conflicts between Contractor personnel and the Project Authority;

d) the conflict resolution processes that will be established to ensure prompt resolution of any conflicts with Providers, Clients, HC Users or Provider software vendors;

e) a back-up plan in order to achieve continuity of service in the event key personnel become unavailable. As a minimum the backup plan should address backfills, recruitment and hiring strategy, obtaining security clearances and training of replacement personnel;

f) an effective communication strategy, which describes the methods of communication that will establish regular contact with Providers, Clients, HC Users and Providers' software vendors, Professional Associations, and keep all stakeholders informed of program changes/updates, etc.;

g) a risk assessment identifying perceived relevant major operational risks, whether each risk can be mitigated, controlled or avoided the probability of occurrence, the possible impact on service delivery, and a sound mitigation strategy for that risk during the Operations Phase of the Contract.

3.1.1.2 Changes to the HICPS Operations Management Strategy

Changes to the Operations Management Strategy require the prior approval of the Project Authority. The Contractor must reflect the approved changes in the Strategy document within 10 business days of the Project Authority's sign-off.

3.1.2 Annual Operations Plan

The Contractor must provide the Project Authority with an HICPS Annual Operations Plan each year of the Operations Phase, and must report to the Project Authority on the progress of the implementation of the planned activities.

3.1.2.1 The Contractor must submit the Annual Operations Plan to the Project Authority 30 calendar days prior to the commencement of each year of the Operations Phase. For the purposes of this Contract, a year is a period of 12 consecutive months commencing on the Implementation Date and recurring on the anniversary of that date.

3.1.2.2 The HICPS Annual Operations Plan describes the major requirements detailed in SOW Article 3.0 *Operations Phase* to be undertaken by the Contractor. The Annual Operations Plan is a collaborative effort between the Contractor and the Project Authority. The Contractor must draft the Plan. The Project Authority has final approval of the Plan.

3.1.2.3 Minimal Plan Requirements

At a minimum, the HICPS Annual Operations Plan developed by the Contractor and approved by the Project Authority must contain the following:

a) a description of the objectives for that operational year;

b) the major initiatives to be undertaken for that year;

c) a schedule detailing all:

   i. deliverables and milestones (such as releases, distribution of Provider and Client communication materials, etc. as defined in SOW Article 3.0 *Operations Phase* and when applicable Article 4.0 *Contract Phase-out*);
   ii. system maintenance windows;
   iii. reports;
   iv. verification parameter updates,
   v. any other activities that will occur on a regular basis.

d) a detailed list of items needing the Project Authority's attention or intervention in order for the Contractor to deliver the initiative.

3.1.2.4 Changes to the HICPS Annual Operations Plan

The Plan is an evergreen document so the Contractor must anticipate changes to the Plan throughout the course of the year based on changing HC priorities and schedules. When there are changes to the HICPS Annual Operations Plan's priorities or schedules, the Contractor must notify the Project Authority of those changes to the Plan within 5 business days prior to the changes being put into effect. The Contractor must ensure that the HICPS Annual Operations Plan documentation is maintained current with any changes throughout the year. The Contractor must obtain the Project Authority's approval for the Plan as well as for any updates to it.

3.1.2.5 New Initiatives

Whenever new initiatives are identified by either the Contractor or HC for implementation during a given operational year, the Contractor must use project management and quality assurance methodologies to manage the development and implementation of these initiatives and to ensure coordination with HC.

3.1.2.6 Monitoring and Reporting on Service Delivery

The Contractor must:

a) monitor all Contractor-delivered services;

b) report on the progress of the planned services, as applicable;

c) provide detailed monthly status reports within 5 business days after month-end that details the status of activities, recurring problems, corrective actions taken and recommendations for improvements in accordance with the requirements and timelines detailed in the SOW or agreed to by the Project Authority.

3.1.2.7 Operational Management Teleconferences and Meeting Schedule

The Contractor must hold regularly scheduled teleconferences and meetings with HC officials. At a minimum, the Contractor must:

a) conduct monthly teleconferences with HC officials;

b) hold face-to-face meetings with HC officials once per quarter, at a location designated by the Project Authority, at the Contractor's expense:

   i. the location will most often be at a HC location (National Capital Region); but on occasion, the Project Authority may request that the meeting be held at the Contractor's location; and in those cases the Contractor will not be responsible for HC travel-related cost;

c) conduct weekly management-level teleconferences, at the Contractor's expense;

d) develop the meeting's agenda with input from the Project Authority;

e) produce the meeting minutes and records of decision (ROD) - The Contractor must circulate the draft minutes and ROD within the first five business days after the meeting date to allow participants sufficient time to review the document and submit comments or corrections. The Contractor must ensure that all submitted corrections have been applied before the next meeting and distributed to all participants three days prior to the next meeting.

3.1.3 Task Authorizations

This Contract includes task authorizations for portions of work to be performed on an "as and when requested" basis. The development of task authorizations (TAs) is intended to be a collaborative process between HC and the Contractor.

3.1.3.1 Development of Task Authorizations (TAs)

The Contractor must participate in the development of TAs. For each TA, and at no additional cost to Canada, the Contractor must:

a) provide up to 100 hours of analysis services (to prepare the analysis proposal). For TA's exceeding 100 hours of analysis, costs may be incurred, upon approval by the Project Authority. There are no analysis hours for Provider Claim Verification TAs;

b) provide cost and resource estimates;

c) provide options and recommendations based on industry best practice for HC's consideration.

3.1.3.2 Management of the Work

The Contractor must manage and perform the work authorized by a signed TA, including:

a) managing and maintaining current the Change Management and Operational Supports as defined in SOW Articles 3.5 *Operational Support*, 3.6 *HICPS Manuals*, and 3.7 *HICPS User Training and Support*;

b) maintaining records on task history, progress, and costs (including timesheets and other invoice justifications);

c) reporting on a monthly basis the status of all TAs - The Contractor must include in the report details on the Contractor employee(s) that worked on a TA: can be anonymized by a assigned employee number), such as:

   i. Breakdown of TA by day and per month by each employee;
   ii. Breakdown of hours per TA per employee and identify the employee's labour category per month;

d) posting the reports to the DRR within 5 business days of month end;

e) making available to HC Users a tool or interface that allows them to monitor a TA's progress (Contractor employee number assigned to TA; plus number of hours worked per Contractor employee number).

3.1.3.3 "As-and-When-Requested" Basis

This Contract includes predetermined task authorizations based on predefined conditions as outlined under certain Articles of this SOW. In cases where there are no predetermined TAs already set out under a SOW Article but deemed necessary by the Project Authority for the purposes of administering the NIHB Program or supporting stakeholder groups, the Project Authority may request a TA for the supply of contracted services or work on an "as-and-when-requested basis". The Project Authority will use a TA process whenever a need has been identified to rapidly access one or more categories of contracted service(s) that are expected to be needed on a continual basis during the remainder of the Contract. In such instances, the actual work to be carried out, timeframes, and deliverables will only be known as-and-when the service(s) will be required during the period of the Contract.

3.1.3.4 Labour Categories

The Contractor must use the labour categories outlined in Appendix F *Task Authorization Labour Categories* to assign resources to Task Authorizations.

3.1.4 Disaster Recovery Plan and Business Continuity Plan

The Contractor must provide, maintain, and implement HICPS Disaster Recovery Plan (DRP) and Business Continuity Plan (BCP) to ensure that critical services and products are continuously delivered to Providers and Clients in the event of a service disruption.

3.1.4.1 Business Continuity Plan (BCP)

The Contractor must provide and maintain the HICPS Business Continuity Plan (BCP) and ensure the continuous delivery of critical services and products, such as claims receipt, adjudication and payment, as well as the HICPS Call Centre will be continuously delivered to Providers and Clients during a service disruption. The BCP must also provide a plan to resume standard business practices, including recovering the Contractor's facility, HICPS data and assets. The Contractor must also ensure that the BCP identifies the necessary resources to support business continuity, including personnel, information, equipment, financial operations, legal counsel, infrastructure protection and accommodations.

3.1.4.2 Disaster Recovery Plan (DRP)

The Disaster Recovery Plan (DRP) generally applies to major, usually catastrophic, events that deny access to services. Examples could include natural (e.g., hurricane, tornado, flood, and fire), human (e.g. operator error, sabotage, implant of malicious code, and terrorist attacks), or environmental (e.g., significant equipment failure, significant software error, telecommunications network outage, and electric power failure).

The Contractor must ensure that the DRP includes a strategy to recover and perform system and service operations at an alternate facility.

3.1.4.3 Continuity Management Plan

In the context of either the DRP or the BCP, the Contractor must provide and maintain a Continuity Management Plan. The Contractor must:

a) update the Plan at least once yearly (complete with names and telephone numbers);

b) share a copy of the Plan with the Project Authority in a format acceptable to the Project Authority;

c) ensure that the Plan includes all pre- and post-disaster/disruption activities, processes and projected response time, as well as include, for example, call lists, vendor information and interdependencies;

d) include a methodology for validating and verifying the integrity and completeness of restored data and data management systems;

e) test both the DRP and BCP annually - the selection of the portions or elements of the overall system being tested must be selected in agreement with and on approval of the Project Authority a minimum of thirty days before the test date. The Project Authority reserves the right to send designated personnel to monitor and participate in the tests; including developing and altering the scenarios during the test (see SOW Article 3.1.4.9 *Annual Testing of the DRP and BCP* for the reporting requirements).

3.1.4.4 Mitigation Strategies

In the Continuity Management Plan, the Contractor must identify and list the potential disruptions to services, the expected duration, the mitigation strategies to reduce these disruptions, and the steps to be taken in case of mitigation failure.

3.1.4.5 Interdependencies with Suppliers, Vendors, and Subcontractors

The Contractor must cover any interdependencies between the Contractor and its suppliers, vendors (including EDI software vendors where applicable), Subcontractors, and HC with respect to the overall DR and BC plans. The Contractor is responsible for ensuring that Subcontractors, suppliers and vendors can also adhere to the approved DR and BC plans.

3.1.4.6 Canadian Security and Canadian Control Requirements

Using a risk management process, the Contractor must ensure that the DRP and BCP activities for systems and services comply with the same security, procedural and Canadian control requirements as normal operations. The Contractor must ensure that Subcontractors, suppliers and vendors also adhere to the security and Canadian control requirements.

3.1.4.7 Triggers for Invoking the BCP and/or DRP

Either HC or the Contractor may trigger the DRP and/or BCP as a result of events similar to those described herein:

a) Disasters
In the event of a disaster, the Contractor must invoke the DRP and/or BCP immediately.

b) Lack of Service
The Project Authority may trigger the BCP in the event of an incident resulting in a lack of service availability, as defined by service standards detailed in SOW Article 3.4.1.1 *Business Continuity, Availability, and Service Standards*.

3.1.4.8 Service Outages

In the event a disaster or incident should occur and results in a service outage, the Contractor must immediately:

a) initiate the appropriate DRP and/or BCP measure(s);

b) officially inform the Project Authority when the DRP and/or BCP is or are initiated;

c) provide the Project Authority with updates at least twice per calendar day on the status of the situation and the remedial actions being taken;

d) ensure timely and on-going communication with Providers and Clients throughout service outages;

e) submit a detailed disaster/incident report to the Project Authority no later than 10 business days following the end of the disaster/incident. The disaster/incident report must include a report on the integrity and completeness of any data that had to be restored;

f) submit a post mortem report detailing causes, remedial action, and preventative measures taken no later than 30 business days after the end of the disaster/incident.

3.1.4.9 Annual Testing of the DRP and BCP

The Contractor must test the DRP and BCP plans annually and submit a report detailing the results of the test to the Project Authority no later than 20 business days following the test. Negative test results will need to be reviewed with the Project Authority and the Contractor will be responsible for making the necessary changes to the plans to ensure positive results at no additional cost.

3.1.4.10 Maximum Downtime

The Contractor must ensure that service outages greater than the limits described below require that the Contractor invoke the DRP and/or BCP. The Project Authority may also invoke the DRP and/or BCP should the Contractor fail to do so.

A DRP and/or BCP event includes the following parameters:

a) a maximum downtime of 24 hours within a 48-hour consecutive hour period for the claims processing system;

b) a maximum downtime of 48 hours within a 72-hour consecutive period for the HICPS Call Centre;

c) a maximum downtime of 72 hours within a 100-hour consecutive period for all other services;

d) service outages less than the limits described herein are to be covered by the service standards defined in SOW 3.4.1.1 *Business Continuity, Availability, and Service Standards* and will not be considered ‘allowable downtime’.

3.2 Quality Assurance

The following outlines the major requirements, and information and service standards, where applicable, for Quality Assurance.

3.2.1 Quality Assurance Program

The Contractor must develop and maintain a HICPS Quality Assurance Program. The Contractor must:

a) provide and maintain an HICPS Quality Assurance Program that ensures

i. accessibility, timeliness and courtesy of services;
ii. responsiveness of staff and systems;
iii. accuracy of data and information collected, managed and disseminated;
iv. adherence to privacy and security standards;
v. services to improve the quality of claims submitted;
vi. process and system efficiency in delivering HICPS in accordance with applicable policies and legislation that meets or exceeds HICPS requirements and service standards;

b) provide the Project Authority with written recommendations including cost estimates for service enhancements to reduce operating costs and improve service delivery quality and performance on an ongoing basis, and proposals for innovations and continuous improvement in areas such as cost reduction, improved operational efficiencies and improved client and provider service, as well as proposals for enhancements based on trends in the industry or best practices from other books of business that the Contractor is aware of;

c) develop, document, implement and maintain all elements of its Quality Assurance Program;

d) submit, for the Project Authority's approval, the quality metrics and service level standards to be applied to the Quality Assurance Program;

e) post to the DRR within 5 business days after month end, a monthly HICPS Operational Report detailing its performance against its established quality metrics (The Contractor must discuss the results of the quality metrics with the Project Authority through the monthly Operational Management Teleconferences and Meetings as detailed in SOW Article 3.1.2.7 *Operational Management Teleconferences and Meeting Schedule*);

f) upon the request of the Project Authority, provide any QA documentation within 3 business days of the request;

g) update and maintain current versions of Quality Assurance Program/ Plan, procedures and related documents;

h) when a possible QA issue is sent by the Project Authority to the Contractor:

   i. create and provide the Project Authority a QA number within 24 hours;
   ii. provide to the Project Authority a response including the results of the Contractor's preliminary investigation, and suggested solution or workaround within 5 business days, or if more time is needed, inform the Project Authority by the 3rd business day;
   iii. bring forward unresolved QA issues to the following Operational Management meeting (see SOW Article 3.1.2.7 *Operational Management Teleconferences and Meeting Schedule*);

i) maintain a QA log:

   i. with the QA timelines clearly outlined in chronological order of dates (user-friendly);
   ii. in a print-friendly format, including page number and the title row showing on each page;
   iii. with the QA status updated within 2 days of any decisions resulting from a Operational Management meeting (see SOW Article 3.1.2.7 *Operational Management Teleconferences and Meeting Schedule*);
   iv. with resolved and closed QAs kept under the same tab as hidden rows.

3.2.2 Privacy and the Quality Assurance Program

As part of its Quality Assurance Program, the Contractor must ensure the management of Privacy as detailed in Protection of Personal Information clauses of this Contract.

3.2.2.1 Privacy Operations Document

The Contractor must produce a Privacy Operations document. This document must describe the following, in addition to any other relevant items:

a) the Contractor's privacy organization, staff and Subcontractor roles and responsibilities, and how they will interact with the Project Authority;

b) a plan to ensure that the Contractor's employees and Subcontractors are appropriately trained and maintain current as it relates to Privacy requirements;

c) how the Privacy requirements will be met initially, managed, monitored, and maintained; including actions to meet legislative requirements documented in the Contract;

d) how the Contractor will perform Privacy Audits and Privacy Impact Assessments on their Subcontractors' systems and processes;

e) a plan detailing the Contractor's actions to prevent, detect, respond, and recover from Privacy incidents.

The Contractor must ensure that the Privacy Operations Plan carries through to the end of the Contract and ensure that it is maintained current with any changes undertaken by the Contractor. The Contractor must obtain Project Authority approval on any changes to the Privacy Operations Plan. The most current version of the plan must be posted by the Contractor on the DRR.

3.2.2.2 Corrective or Mitigation Actions

The Contractor must immediately report to the Project Authority and the Contracting Authority, all Privacy related incidences and corrective or mitigation actions undertaken.

3.2.2.3 Privacy Incident/Report

In the event of a privacy incident/breach, the Contractor must inform the Project Authority immediately and log the incident. The Contractor must assume financial responsibility for all impacts and restitution resulting from a Privacy incident/breach.

The Contractor must provide a quarterly report, and posted to the DRR within 5 days from the quarter's end, to the Project Authority for review on all privacy/personal information protection matters or whenever a breach of privacy event has occurred within 1 business day.

3.2.2.4 Privacy Audit

The Project Authority, at its own expense, will conduct an annual independent privacy audit. Privacy audit results, observations, and recommendations will be reviewed with the Contractor. The Contractor must then produce a corrective measures plan and schedule for the Project Authority's approval. Any corrective measures required to be implemented in order to make the Contractor compliant will be at the expense of the Contractor. The Contractor must provide the Project Authority's officials access to all relevant systems, materials, documentation and resources, and must also provide desks, telephones and computers to the Project Authority or its designated representative while the audit is being conducted.

3.2.2.5 Threat and Risk Assessment (TRA)

At the Project Authority's discretion and cost, a TRA may be conducted on HICPS at any time throughout the life of the Contract. The Contractor must cooperate with the Project Authority as HC conducts this TRA. The Contractor is obligated to work with HC to address any recommendations resulting from the TRA.

3.2.2.6 Privacy Impact Assessment (PIA)

At the Project Authority's discretion and cost, a PIA may be conducted on HICPS at any time throughout the life of the Contract. The Contractor must cooperate with the Project Authority as HC conducts this PIA. The Contractor is obligated to work with HC to address any recommendations resulting from the PIA.

3.2.3 Data - Accuracy, Completeness, and Integrity

Controls are needed to safeguard assets; reduce the risk that financial and non-financial data may be incorrect or corrupt; reduce the potential consequences of errors in financial and non-financial data; ensure proper authorization of transactions and compliance with policies, procedures, laws, and regulations; and ensure the economical and efficient use of resources.

The Contractor must ensure the accuracy and completeness of data captured, and/or communicated through the program to all stakeholders.

3.2.3.1 Internal Controls

The Contractor must document, implement, and maintain adequate internal controls to ensure the probity of all information. An internal control refers to Contractor's actions to mitigate risks and achieve established objectives. The Contractor is responsible for ensuring that the internal controls implemented follow industry standards and Chartered Professional Accountants of Canada (CPA) principles.

3.2.3.2 External Sources

The Contractor is responsible for the accuracy, completeness, and currency of all data obtained from external sources, such as professional associations and provincial or territorial governments.

3.2.3.3 Standards for Written Materials

The Contractor must apply the following standards to all written material produced for HICPS throughout the life of the Contract:

a) Clarity – the Contractor is responsible for ensuring that all of the text in the documents is written so that it can be easily understood in English and French by the intended audience and must, therefore, be:

   i. easy to follow;
   ii. appropriate for its specific target audience;
   iii. consistent in terminology and style;
   iv. reviewed in parallel for both English and French accuracy;
   v. unambiguous;
   vi. logically organized;
   vii. concise and free of redundancies;
   viii. compliant with standard rules of grammar;
   ix. free of typographical errors and spelling errors.

b) Completeness - the documents must provide all the material required to meet the relevant SOW requirement.

c) Accuracy - The information in each document must be factually correct.

d) Consistency - All sections of a document must be consistent with regard to format, organization, terminology, and documentation style.

3.2.4 Other Quality Assurance Measures

3.2.4.1 Data Storage

All electronic and paper files and completed forms relating to claims processing, Providers and Provider Claim Verification are the property of the Project Authority and must be stored by the Contractor in a Government of Canada approved secure area. Refer to SOW Article 3.3.15 *Records Management* for information, including the retention, storage, and transportation of electronic and paper based files.

3.2.4.2 IT and Call Centre Services Management

The Contractor must apply best practices for system development and maintenance and call centre services. For example, but not limited to, problem/incidence management, change management, release & configuration management, testing, and call centre operations.

3.2.4.3 Claims Processing Standards

The Contractor must liaise with claims processing industry organizations that define claims processing standards and provide quarterly updates to the Project Authority on new standards that may affect the provision of HICPS. See SOW Article 3.3.10.1 *Capture and Retain Records for NIHB Claims and Claim Reversals* for standard requirements.

3.2.4.4 Provider Satisfaction Survey

The Project Authority reserves the right to conduct, at Canada's cost, on an annual basis, an independent Provider satisfaction survey of the Contractor's services, based on a statistically valid sample of Providers. Provider satisfaction survey results will be reviewed with the Contractor. As required, the Contractor must produce a Corrective Measures Plan and schedule for the Project Authority's approval and at no cost to Canada. Corrective measures required to increase Provider satisfaction to a satisfactory level for Contractor services are at the expense of the Contractor.

3.2.4.5 HC User Satisfaction Survey

The Project Authority reserves the right to conduct, at Canada's cost, on an annual basis, a HC User satisfaction survey of the Contractor's services. User satisfaction survey results will be reviewed with the Contractor. As required, the Contractor must produce a Correction Measures Plan and Schedule

for the Project Authority's approval. Corrective measures required to increase HC User satisfaction to a satisfactory level for Contractor services are at the Contractor's expense.

3.2.4.6 Client Satisfaction Survey

The Project Authority reserves the right to conduct, at HC's cost, on an annual basis, a Client satisfaction survey of the Contractor's services. Client satisfaction survey results will be reviewed with the Contractor. As required, the Contractor must produce a Correction Measures Plan and Schedule for the Project Authority's approval. Corrective measures required to increase Client satisfaction to a satisfactory level for Contractor services are to be performed at the Contractor's expense.

3.2.4.7 Contract Compliance Audits

Health Canada (HC), Public Works and Government Services Canada (PWGSC), and Indigenous and Northern Affairs Canada (INAC) may periodically undertake audits to be carried out by such persons appointed or approved by the Project Authority to ensure compliance with any element of the Contract. The Contractor and its Subcontractors are obligated to cooperate and provide timely access to the appropriate files, books, records and systems to conduct such audits and must provide any assistance that may reasonably be required to complete these audits. The Contractor must ensure the Project Authority's access to any and all Subcontractors for auditing purposes.

3.3 Service Delivery

3.3.1 Provider Enrolment Services

3.3.1.1 Eligibility Criteria

The Contractor must deliver and maintain Provider Enrolment Services according to NIHB eligibility criteria.

The Project Authority requires that NIHB Providers who submit benefit claims for reimbursement be enrolled in the NIHB Program. To be considered, interested parties must be licensed by the applicable professional authority or governing body to practice or provide eligible services in the province or territory in which a Client obtains a service. As part of the enrolment process, the Contractor must ensure that all NIHB provider eligibility criteria are met and maintained. These include but are not limited to the following:

a) For pharmacies other than those located in Quebec, that they are in good standing with the respective provincial or territorial college to dispense pharmaceutical products in the province or territory where the pharmacy is located. For pharmacies located within Quebec, HC (in partnership with several other federal departments) maintains a master agreement with the *Association québécoise des pharmaciens propriétaires (AQPP)* on behalf of all pharmacies in Quebec who are enrolled to provide services to NIHB Clients.

b) Dentists (including general practitioners and various specialists), denturists, dental hygienists (eligible for independent practice), and other dental practitioners recognized by the NIHB Program and in good standing with the regulatory body in the Province or Territory of practice.

c) MSE Providers must be qualified and hold a valid license, diploma, certificate or degree and be a member of the regulatory association to provide medical supplies and equipment in accordance with specialty assigned and approved in writing by the appropriate NIHB Office.

d) Mental health counselling Providers registered with a legislated professional regulatory body and eligible for independent practice in the province/territory in which the service is being provided. Eligible Providers include: psychologists and social workers with clinical counselling orientation or other legislated bodies. The Project Authority may approve the enrolment of individuals as exceptions where education and training is comparable to registered psychologists or social workers.

e) Opticians, Optometrists or Ophthalmologists who are authorized, licensed and certified in the province/territory in which they practice.

Additional criteria and information may be provided upon Contract Award.

Appendix A provides statistics on the number and location of Providers enrolled in NIHB Program as of April 2016.

3.3.1.2 Existing and New Providers – Support Services

The Contractor must deliver Provider Enrolment Services for existing and new NIHB Providers based on the specifications detailed in SOW Article 3.4 *Technical Specifications* and according to NIHB Provider eligibility and the requirements detailed below.

3.3.1.2.1 The Contractor must:

a) provide information and enrolment assistance services for existing Providers as well as for providers not already enrolled in the NIHB Program in the official language of their choice;

b) deliver Provider enrolment maintenance services including, but not limited to, changes of address and updating of other Provider information;

c) provide information and assistance on NIHB Program enrolment through the HICPS Call Centre, by Provider Secure Web Account, electronic communication, by fax or by mail;

d) establish and manage the HICPS Call Centre Services, in accordance with SOW Article 3.3.2 *HICPS Call Centre Services* to assist providers requesting to enroll in the NIHB Program, and to communicate information to enrolled Providers assisting them in their understanding of the NIHB policies and the correct procedures for submitting claims under the NIHB Program;

e) develop, maintain, and make available to Providers and Clients Claim Submission Kits in accordance with SOW Article 3.3.3 *Provider and Client Communication and Information Services*.

3.3.1.3 Eligible Provider Enrolment in NIHB

The Contractor must provide NIHB Provider Enrolment Services for providers. While the Contractor enrolls the providers, the Project Authority will review and approve all enrolments.

3.3.1.3.1 The Contractor must:

a) verify the provider's eligibility to enrol, or re-enrol in the NIHB Program in accordance with NIHB policies including, but not limited to, establishing that the provider:
   i. is qualified to provide services in accordance with the specialty or specialties assigned to their license;
   ii. holds a valid license or certificate, a valid diploma or degree, and is a current member in good standing with the regulatory body or association in the province or territory in which they practice;
   iii. is not a past participant of the NIHB Program who has been terminated at the request of the Project Authority (unless re-enrolment is approved by the Project Authority);

b) obtain all mandatory data from the enrolling provider including, but not limited to:
   i. all documents required in accordance with the eligibility criteria as defined by the Project Authority, see also SOW Article 3.3.1.1 *Eligibility Criteria*;
   ii. both an individual Provider's information and company information where required;
   iii. any and all Provider office locations and specialties, and ensuring there is a signed agreement covering each location in accordance with NIHB Program Policy, and assign a unique Provider number in accordance with SOW Article 3.3.1.3.1(e) *Eligible Provider Enrolment in NIHB*;
   iv. both Provider's physical address(s) and mailing address in a standardized format and be validated by the Contractor;

v. the Provider's preferred address for receiving payments/statements;
vi. Provider's preferred language of communication;
vii. Provider's preferred method of communication (mail, fax, electronic);
viii. information from Providers regarding Direct Deposit in a secure manner;

c) ensure that Provider signs the agreement or enrolment form and obtains all appropriate documents (e.g. dental kit) before the Provider can submit a claim, unless otherwise agreed to by the Project Authority;

d) forward all enrolment documentation electronically to the Project Authority for approval or denial;

e) enroll the eligible Provider and assign them an appropriate unique NIHB Provider identification number within 3 business days of the Project Authority's approval;

f) draft and send to providers the enrolment decision correspondence (including, but not limited to, welcome or denial letters), as approved by the Project Authority;

g) verify, on an on-going basis, that Providers have maintained a valid license and remain in good standing;

h) report to the Project Authority any Providers who no longer have a valid license or remain in good standing for delisting or termination decision.

3.3.1.4 Providers not enrolled in NIHB

The Contractor must retain a list of providers not enrolled in NIHB but entered into HICPS, including address and contact information, through manual or Client Reimbursements for any possible follow-up.

3.3.1.4.1 The Contractor must:

a) capture information for unenrolled (example provider chooses not to enrol in the NIHB Program) and non-licensed providers (example dental aides);

b) provide an indicator to flag them as non-licensed, where applicable;

c) tag the provider under a unique identifier to be used for all submissions from that provider;

d) exclude them from enrolled Provider reporting and communication;

e) suppress claim statements, if applicable;

f) maintain history and changes to provider information.

3.3.1.5 Maintaining Provider Enrolment Details and Information

The Contractor must maintain and update Provider details and information.

3.3.1.5.1 The Contractor must:

a) retain all signed agreements and enrolment forms in accordance with SOW Article 3.3.15 *Records Management* and make available to the Project Authority within 3 business days;

b) scan and store in a central repository all signed agreements and enrolment forms and make available to view online by HC Users;

c) backdate a Provider's enrolment start date, upon Provider request, up to 30 days from the date of enrolment to facilitate claims processing;

d) obtain Project Authority approval to backdate a Provider's enrolment start date beyond 30 days from the date of enrolment;

e) maintain details of all Provider enrolment historical information and ensure the transfer of all details, historical and financial information of all previous Provider number(s) to the new Provider

as well as any outstanding balances of the previous Provider number(s) to the new Provider when a change of ownership occurs;

f) ensure all approval numbers, authorization numbers, or any other affected system functions that rely on Provider number are automatically transitioned/updated to the new Provider number in cases when a Provider number has changed;

g) modify Provider enrolment details upon request by the Provider or the Project Authority;

h) ensure the integrity of all Provider data entered into the system and for the storage of all related documentation;

i) on a monthly basis, monitor disciplinary actions taken against Providers (and all the representatives that were identified during the enrolment process) by their licensing bodies through publications by the provincial or territorial licensing organizations where available;

j) where available, sign up for alerts for disciplinary actions taken against Providers by their licensing bodies from provincial or territorial licensing organizations;

k) immediately notify the Project Authority of any Providers subject to disciplinary action.

3.3.1.6 End-dating of Delisted or Terminated Providers

The Contractor must identify and end-date, when requested by the Project Authority, delisted Providers (voluntary removal from the Program) and terminated Providers (enforced removal from the Program by HC). In addition, in cases of termination, the Provider is prohibited from enrolling with the NIHB Program in the future unless approved by the Project Authority.

3.3.1.6.1 The Contractor must:

a) provide the ability to flag a Provider who is not eligible to be enrolled in the Program;

b) end-date a Provider within 1 business day of the Project Authority's request;

c) capture the reason, for the Provider being delisted or terminated based on a Project Authority approved predefined list, with an option for free text;

d) assume financial responsibility for any claims paid to end-dated Providers for services rendered or items purchased after the end-date;

e) add a Provider to the Do-Not-Enrol (DNE) list only at the Project Authority's request;

f) draft, for Project Authority approval, and upon approval send a letter of explanation to the Providers who are placed on the DNE list;

g) maintain a national "Do Not Enrol" (DNE) list per benefit type; ensure the most up-to-date DNE list is published to the DRR; and provide HC Users with the ability to sort each list by province and territory.

3.3.1.7 Managing Provider Enrolment Reports

3.3.1.7.1 The Contractor must prepare and post Provider Enrolment Reports quarterly that provides statistics on:

a) the number of new, delisted, and terminated providers in each benefit area and by province or territory;

b) a detailed report for new enrolments, with data elements to be specified by the Project Authority;

c) a detailed report for amendments, with data elements to be specified by the Project Authority;

d) the Provider Enrolment Reports must be submitted within 5 business days of quarter end and make it available to HC Users on the DRR.

3.3.1.7.2 The Contractor must prepare and post Statistical Reports twice a year detailing all claims submitted under the NIHB Program from ineligible providers.

a) The Contractor must prepare a report twice per Contract year:

   i. detailing the claims rejected based on Ineligible Providers - for each claim rejected, the report must detail the claim number, date submitted and or rejected, and identify the provider;
   ii. submitting twice annually within 5 business days of the end of the semi-annual period (May 31 and November 30) the Non-Enrolled Provider Claim Report; and make it available to HC Users on the DRR.

3.3.1.8 Provider Management (PM)

A Provider or office under Provider Management (a managed Provider or office) follows modified benefit rules to access some services overriding the regular NIHB Program benefit rules. A managed Provider may: (a) require a PA/PD for an open benefit; (b) require a PA/PD for an open benefit group with one or more items within the group that remain handled as an open benefit; (c) be denied access to a benefit item or benefit item group; and (d) not require prior approval for a PA/PD benefit.

The contractor must provide an interface through which an HC User can enter a Provider Management (PM) case, capture supporting information, record a decision, and communicate the outcome.

3.3.1.8.1 The contractor must provide the HC User the ability to:

a) search for and select a Provider or office ID;

b) create, edit, view and save Provider Management parameter(s) for a Provider, a Provider and office location combination, or office location;

c) record the duration of the Provider management period with a start and end date, as defined by the Project Authority;

d) record one or more services to be managed where the details for each service may include, but not limited to, the following:

   i. the benefit item or group with item code and item name and/or item group name;
   ii. action to be taken for the item, for example actions could be but not limited to the following :
      - Restrict – Provider must follow PA/PD process;
      - Deny – Provider cannot claim benefit item/group;
      - Allow – Regular NIHB program rules apply; or
      - Open – Provider must follow open-benefit process for PA/PD items and/or groups;
   iii. effective period with a start and end date;
   iv. Prescriber ID or Prescriber group;

e) edit, view and save to the Provider Notepad;

f) view, add and remove documents associated with the managed Provider.

3.3.1.8.2 The Contractor must automatically:

a) include Provider Management in adjudication evaluation, in the priority sequencing determined by the Project Authority;

b) deny payment for services identified by the HC user as restrict or deny for a managed Provider or office;

c) allow payment to clients through Client Reimbursements subject to NIHB Program benefit rules;

d) flag claim lines that were affected by the Provider Management rules while the Provider or their office was under Provider Management;

e) allow combinations of actions within the list of services managed such that:

i. services may be restricted, denied or allowed;
ii. a group of services (benefit group) may be restricted while one or more benefit items (within the benefit group) may be allowed;
iii. a group may be allowed and one or more of the benefits within that group may be denied;
iv. a group or an item may be “open” allowing the Provider(s) to perform the service without prior approval or predetermination;

f) display a Provider Management flag when Provider information is displayed;

g) allow HC Users access to Provider details to see the reason for the Provider Management flag.

3.3.2 HICPS Call Centre Services

3.3.2.1 HICPS Call Centre

The Contractor must deliver, maintain, and staff a dedicated bilingual HICPS Call Centre.

3.3.2.1.1 The Contractor must:

a) maintain a toll-free Call Centre driven by an auto attendant that provides callers with an option to select one of the official languages (English or French), and then the benefit or reason for their call, and then directs the caller to the appropriate queue;

b) provide services to NIHB Clients, HC Users and enrolled or un-enrolled providers with consistent and accurate responses to inquiries and requests on the NIHB Program i.e. Pharmacy, Dental, MSE, Vision Care and Mental Health Counselling benefits;

c) record, date and operator stamp 100% of calls and make these recordings available to HC upon request.

3.3.2.2 Dedicated HICPS Call Centre Services

3.3.2.2.1 The Contractor must support the following service requests through a dedicated HICPS Call Centre. Recognizing that this is not an exhaustive list, the Contractor must support the following:

a) Client verification;

b) benefit eligibility such as Frequency Limits, including Pre-Verification (see SOW Article 3.3.2.3 *Determine Client Eligibility for Benefits (Pre-verification)*;

c) payment, EFT payment, and payment status (claims statement, cheques etc.);

d) processed claims status and statements;

e) PAs, PDs, SAs, Client Reimbursements;

f) Claim submissions or network issues;

g) support for the dedicated HICPS Website (Provider, Client);

h) Provider and Client communications (see SOW Article 3.3.3.4 *Information and Communication Products)*;

i) Provider enrolment with the NIHB program;

j) Provider and Client creation and use of secure web-based accounts;

k) explanation of general claims processing procedures;

l) interpretation of claims processing decisions if requested;

m) interpretation of a NIHB Claims Submission Kit if requested;

n) identifying and verifying Providers or Clients prior to releasing information;

o) transferring calls to HC attendants at any HC call centres or toll-free telephone numbers;

p) services in both official languages.

3.3.2.3 Determine Client Eligibility for Benefits (Pre-verification)

The Contractor must provide a service to determine a client's eligibility prior to treatment. This service allows a Provider and Client to be informed that a client is eligible for program benefits (e.g. Frequency Limited benefits) on the date they call. Pre-verification does not secure payment; it only informs the Provider and Client that as of that day the Client and/or the benefit are eligible.

3.3.2.3.1 The Contractor must perform Pre-Verification, through the Claims Processing Call Centre, to determine both Client and benefit eligibility prior to treatment.

3.3.2.3.2 The Contractor must verify the following:

a) authenticate that the caller is a Provider enrolled and eligible to make the inquiry;

b) authenticate that the caller is a Client eligible to receive services;

c) when using the current date as the date of service:

i. the Client is eligible for the benefit;
ii. the benefit(s) are eligible;
iii. the Provider is eligible to provide the service based on the Provider Management program.
iv. if the benefit(s) is out of frequency, the Contractor must inform the Provider and Client when that Client will become eligible for the benefit.

3.3.2.4 Call Management Reporting Solution

3.3.2.4.1 The Contractor must:

a) use an electronic call management reporting solution that produces reports to verify that all service standards are met as outlined in SOW Article 3.3.2.11.1 *HICPS Call Centre Service Standards*;

b) produce weekly, monthly and annual activity reports that must include volumes and queue wait times according to lines of business (i.e. categories for calls received and benefit area);

c) utilize an electronic call management software reporting solution, e.g. ACD/IVR/PBX as well as use the equipment to accommodate the needs of hearing impaired clients and providers;

d) record and store calls and have the ability to search for stored calls using telephone numbers, call time, call date, or call date range as example search parameters.

3.3.2.5 Voice Messaging

3.3.2.5.1 The Contractor must maintain a voice mail box where:

a) callers are forwarded automatically to a voice messaging solution when the call centre is closed;

b) callers may leave a message after hours or when they do not wish to continue holding for the next available Customer Service Representative (CSR) during busy periods;

c) voice messages are automatically assigned from a queue to the appropriate free CSR;

d) a recorded message with appropriate wording is played when calls are received outside of business hours or during the service interruption to inform callers accordingly.

3.3.2.6 HICPS Call Centre Staff Management

The Contractor must manage and administer all Call Centre services and qualified CSRs to support the workload in accordance with the established Service Level Standards found in SOW Article 3.3.2.11.1 *HICPS Call Centre Service Standards*.

3.3.2.6.1 The Contractor must ensure that:

a) each CSR is dedicated to NIHB business to build their capacity and knowledge;

b) each CSR has completed the necessary ongoing training programs;

c) each CSR dealing with NIHB Clients has completed cultural competency training;

d) all Call Centre staff are up to date with NIHB Program policies as well as adequately trained on frequently asked questions from Providers and clients;

e) each CSR has completed regular and ongoing Privacy training.

3.3.2.7 Calls transferred to the Contractor from HC Staff

The Contractor must resolve issues, within an agreed upon timeframe, that the Project Authority brings to the Contractor's attention on behalf of Providers and Clients to resolve issues; including but not necessarily limited to inquiries into non-payment of claims, cheque tracing, cheque re-issuance, and Provider enrolment issues.

3.3.2.8 Call Transfers

The Contractor must ensure that HICPS Call Centre staff answers all calls using the Live Call Transfer to direct calls to the appropriate HC call centre.

3.3.2.9 Call content records and Call-logs

3.3.2.9.1 The Contractor must:

a) record, process and track the resolution of all requests as well as complaints, concerns and issues conveyed to the HICPS Call Centre;

b) record all incoming calls to Call Centre and make their contents and call logs available to the Project Authority at the Project Authority's request;

c) retain the call logs recorded content and call recordings for 24 months;

d) provide access to HC Users to listen to live call conversations at their discretion for quality assurance purposes;

e) provide 10 randomly selected English and French sample calls recordings for each benefit line on a monthly basis for QA purposes.

3.3.2.10 Frequently Asked Questions (FAQ)

3.3.2.10.1 The Contractor must:

a) develop and maintain current scripts in both official languages for use by HICPS Call Centre staff for responding to frequently asked questions;

b) have appropriate FAQs to deal with crisis situations;

c) develop new scripts when calls on a specific topic are frequently asked;

d) obtain prior approval by the Project Authority on all scripts;

e) make all scripts available at all times on the DRR for the review by the Project Authority (see SOW Article 2.6 *Documentation and Reporting Repository (DRR)*).

3.3.2.11 HICPS Call Centre Service Standard Performance Measurement

3.3.2.11.1 HICPS Call Centre Service Standards

The Contractor must ensure that all HICPS Call Centre service delivery standards outlined in Appendix I. *HICPS Call Centre Service Standards* are met during business hours.

3.3.2.11.2 Performance Measurement and Reporting

The Contractor must ensure performance on the HICPS Call Centre Service Standards is measured on an ongoing basis and results reported to the Project Authority on a monthly basis through operational reports (See SOW Article 3.3.2.12 *Operational Reporting*).

3.3.2.11.3 Service Standard:

A validation report summarizing the results of the Call Centre Service Standards and Performance must be posted to the DRR within 5 business days of the end of the month.

3.3.2.12 Operational Reporting

The Contractor must provide HICPS Call Centre management reports monthly within 5 business days from month's end and reports must be available on the DRR.

3.3.2.12.1 The Contractor must provide statistics on the:

a) number of queries from Providers distributed by query type (e.g. client status, benefit eligibility, pricing, frequency limitations, claim status, complaints, etc.);

b) number of queries from other sources (e.g. client, provider, without a breakdown by query type if there is low volume of such calls);

c) number and percent of calls in English and French, measured separately;

d) number of calls where issues were resolved on first call;

e) number of issues that required follow-up call or escalation prior to resolution;

f) total calls received;

g) number of calls completed by automatic call distributor (ACD)/ Interactive Voice Response (IVR);

h) number of calls abandoned;

i) total calls answered by a live person;

j) average talk time (seconds);

k) number of invalid calls (received outside operational hours);

l) number of HICPS Call Centre service complaints received by category (i.e. system or service) and benefit area;

m) percent of English and French calls answered within service standard, measured separately;

n) call queue waiting time by benefit and by language;

o) number of voice mails received on a daily basis;

p) the number of voice mails returned same day.

3.3.2.12.2 The Contractor must report monthly on the hours of availability of the HICPS Call Centre, including any service delivery failures and allowable downtime in accordance with SOW Article 3.1.4.10 *Maximum Downtime*. The Contractor must post this report on the DRR within 5 business days of month's end.

3.3.2.13 Location of HICPS Call Centre and Data Storage

The Contractor must keep HICPS Call Centre operations and records (data storage) within Canada in accordance with SOW Article 3.4.6.4 *Canadian Location Requirement.*

3.3.2.14 Disaster Recovery and Business Continuity Plan

The Contractor must have a plan in place to ensure that Call Centre services are continuously delivered during service disruptions.

3.3.3 Provider and Client Communication and Information Services

3.3.3.1 HICPS Website

The Contractor must develop, manage, and maintain a current HICPS Website. A partial list of the HICPS Website's content is provided in Appendix G, and other HICPS Website content will be provided by the Project Authority during the Pre-Implementation Phase (see SOW Article 1.5.1 *Pre-Implementation Phase*). All Provider and Client Communication, Documentation, and Information require approval by the Project Authority.

3.3.3.1.1 The Contractor must:

a) make all information available on the HICPS Website in both official languages;

b) obtain Project Authority approval on the HICPS Website architecture and organization of information;

c) provide and maintain appropriate links to HC's NIHB Program online content, where needed;

d) make all forms (interactive) and documents used by Providers and Clients on the Website available for viewing, writing, printing and downloading;

e) provide all other relevant information to support Providers and Clients who are submitting claims;

f) update the HICPS Website as necessary to maintain up-to-date information; in accordance with service standards agreements;

g) provide technical support for the HICPS Website; such as repairing broken links or making fixes when it is not working properly;

h) obtain the Project Authority's approval prior to adding or removing HICPS Website content;

i) archive deleted information;

j) provide archived/stored information to the Project Authority upon request;

k) maintain and have accessible for HC Users a list of archived/stored information;

l) obtain the Project Authority's approval prior to updating links and content on the HICPS Website;

m) ensure the accuracy of the content of the HICPS Website;

n) submit to HC by posting to the DRR within 5 business days from the month's end, a monthly report on the availability and performance of the HICPS Website.

3.3.3.2 Provider and Client Secure Web Accounts

3.3.3.2.1 The Contractor must:

a) provide Providers with the option of creating a secure web account whereby they can access information including, but not limited to:

   i. their personal information;
   ii. claims history;
   iii. status of pending requests, including but not limited to, PA's, PD's
   iv. view, when using the current date as the date of service, if a Client is eligible for a benefit and if the benefit is out of frequency, when they would become eligible for the benefit;

b) make forms accessible (downloadable and saveable with fields that can be completed, printed and submitted online), including providing Providers with the ability to electronically submit claims and PA requests with supporting documentation (not included at this time are Dental pre-determinations see SOW Article 3.4.7 *Integration with Third Party Information or Submission Systems*);

c) support Providers with creating and the maintenance of their web accounts;

d) allow Providers to update their contact information;

e) maintain user-access controls with username and password;

f) ensure the Web Accounts are policy compliant with SOW Article 3.4.6.2 *Policy Compliance*.

3.3.3.2.2 The Contractor must:

a) provide Clients with the option of creating a secure web account whereby they can access information including, but not limited to:

   i. their personal information;
   ii. claims history;
   iii. status of pending requests, including but not limited to, PA's, PD's, Client Reimbursement or Appeals;
   iv. view, when using the current date as the date of service, if they are eligible for a benefit and if the benefit is out of frequency, when they would become eligible for the benefit;

b) make forms accessible (downloadable and saveable with fields that can be completed, printed and submitted online), including providing Clients with the ability to electronically submit claims (i.e. Client Reimbursement requests) with supporting documentation;

c) support Clients with creating and the maintenance of their web accounts;

d) allow Clients to update their contact information;

e) maintain Client-access controls with username and password;

f) ensure the Web Accounts are policy compliant with SOW Article 3.4.6.2 *Policy Compliance*.

3.3.3.3 Online Forms

3.3.3.3.1 The Contractor must:

a) develop and maintain accessible online forms (form content to be provided by the Project Authority), used by Providers, Clients, and where applicable Prescribers, including, but not limited to claim forms, client reimbursement forms, Prior Approvals, special communication letters used for routine tasks, BEQ's, etc. (Not included at this time are Dental pre-determinations see SOW Article 3.4.7 *Integration with Third Party Information or Submission Systems)*;

b) allow the forms to:

   i. be completed online by users the Contractor has authenticated;

ii. include mandatory fields which must be filled out in order for the form to be submitted;
iii. provide error messages to the user;
iv. be downloaded and printed;
v. be submitted electronically, along with supporting documentation when applicable, to the Contractor with an acknowledgement to the user that the submission was successfully sent;

c) maintain the forms as evergreen documents and update as required (noting the date of each version);

d) ensure that NIHB Program forms capture the data required for all benefit areas, with all changes requiring Project Authority approval prior to their publication or distribution;

e) ensure the all online forms are policy compliant with SOW Article 3.4.6.2 *Policy Compliance*.

3.3.3.3.2 Online Form submission Work Queues

3.3.3.3.2.1 For all forms which require an HC User decision or response, the Contractor must:

a) send to HC in an automated format all online submitted forms, documents, requests etc. and place in the appropriate work queue which is benefit and submission type specific for HC review.

3.3.3.3.2.2 The Contractor must provide the HC User with the ability to:

a) retrieve and manage the submitted form, for example PA requests must be able to follow the work flow outlined in SOW Articles 3.3.5.6 *Managing Prior Approvals, Post Approvals,* 3.3.6.11 *Managing Requests for Approval*, 3.3.7.14 *Managing Requests for PAs, SAs, Appeals*, 3.3.8.8 *Managing Prior Approvals, Post Approvals, Automated Post-Approvals*;

b) follow up electronically with the requesting Provider or Client for additional or missing information;

c) send the request decision back to the Contractor for processing and payment, or other types of responses where applicable.

For the submission of Dental Predetermination requests see SOW Article 3.4.7 *Integration with Third Party Information or Submission Systems.*

3.3.3.4 Information and Communication Products

The Contractor must develop Provider and Client communication products as outlined below.

3.3.3.4.1 Newsletters

The Contractor must:

a) prepare in collaboration with the Project Authority quarterly Provider newsletters for each benefit area (Pharmacy, Dental, MSE, Vision Care, and Mental Health Counselling) and quarterly Client newsletters to advise Providers and Clients of NIHB Program policy changes, fee updates, and other relevant information on the NIHB Program;

b) ensure that historical versions of the newsletters are maintained and made accessible on the HICPS Website on the same day as the newsletter is released.

3.3.3.4.2 Newsletter Article Log

The Contractor must:

a) create and maintain a searchable historical log of published newsletter articles;

b) provide HC Users access to the log;

c) ensure that HC Users have the ability to search for articles;

d) ensure that the articles log contains the following searchable fields (but not limited to): the subject or title, date, provider type, benefit area, province (or national), and a short description;

e) update the article log during every newsletter cycle.

3.3.3.4.3 Claim Submission Kits

The Contractor must:

a) prepare, maintain, and annually review and update the Claim Submission Kits which sets out the terms and conditions for the submission of Claims. The Contractor will use these kits to communicate information on the process for submitting NIHB claims for each benefit type (Pharmacy, Dental, MSE, Vision Care, and Mental Health Counselling) in both official languages.

3.3.3.4.4 Benefit Lists or Grids

The Contractor must:

a) post the current benefit list or grid for all benefits and any errata/grid updates, if required, including but not limited to the Drug Benefit List (see SOW Article 3.3.7.21 *Online Drug Benefit List*), dental benefit grids, MSE benefits and criteria, vision care benefit list, and mental health counselling benefits on the HICPS Website;

b) archive previous years' benefit lists or grids for all benefits available and make available to view on the HICPS Website;

c) supply software vendors with benefit pricing updates in a format that can be uploaded into the Provider software.

3.3.3.4.5 Broadcast Messages led by the Contractor

The Contractor must:

a) send Broadcast Messages that communicate NIHB Program policies or procedures information to Providers and Clients at the frequency determined by the Project Authority;

b) deliver the Broadcast Messages to the Providers and Clients, including those who have created secure web accounts, in their preferred method and language of communication including, but not limited to, the HICPS Website, via EDI, e-mail, fax, claims statements, or by mail (at the Contractor's expense);

c) offer other modes of communication as new technologies becomes available, upon approval by the Project Authority;

d) obtain the Project Authority's approval for the content of the Broadcast Messages, audience, distribution method and the timing of distribution.

3.3.3.4.6 Broadcast Messages sent by HC Communications

The Contractor must:

a) maintain electronic distribution lists of Providers and Clients (Provider/Client selected preference: mailing address, fax number, email address, etc.), in a format approved by the Project Authority (e.g. Excel) that can be used by the Project Authority to send out its own communications, as required;

b) provide updated distribution lists of Providers and Clients (mailing/email/fax) to the Project Authority, as communication distribution is required;

c) publish the electronic version of Broadcast Messages produced by HC on the HICPS Website under the appropriate benefit area, and organized by year of publication and region (i.e. Province);

d) provide Providers, Clients and HC Users access to historical Broadcast Messages.

3.3.3.4.7 Health Canada Publications

The Contractor must:

a) post an electronic version of the NIHB Annual Report and provide a link to the corresponding HC publication for Providers and Clients to consult;

b) post Benefit Guides under their respective benefit section (and also by category for MSE benefits) of the HICPS Website and provide a link to the corresponding HC publication for Providers and Clients to consult.

3.3.3.4.8 Frequently Asked Questions

The Contractor must maintain a Frequently Asked Questions section on the HICPS Website in English and French.

3.3.3.4.9 Alerts

The Contractor must:

a) send electronic alerts to Providers and Clients as requested by the Project Authority;

b) provide an English and French general message area on the home page of the HICPS Website reserved exclusively to post alerts and updates;

c) send message(s) to selected Providers or groups of Providers (e.g. specific Provider groups by benefit specialty and by province or territory) and Clients who have enrolled for the secure web account to receive client updates, prompting them to view updates posted to the Website;

d) send time sensitive alerts to Providers and Clients for urgent messages such as system outages within 24 hours of notification by the Project Authority.

3.3.3.5 Communication Products - Development and Dissemination

3.3.3.5.1 Development

The Contractor must, for all information and communication products described in SOW Article 3.3.3.4 *Information and Communication Products:*

a) prepare drafts of communication products, provide the Project Authority with the opportunity to provide input and additional information, and ensure Project Authority approval before publishing new or revised communication and information products;

b) upon request of the Project Authority, review HC developed or information or communication products and provide input and information as required.

3.3.3.5.2 Dissemination

To disseminate communication and information products described in SOW Article 3.3.3.4 *Information and Communication Products*, the Contractor must:

a) maintain a distribution list of Providers, Vendors, Clients, and Organizations that HC Users can also populate;

b) for newsletters and broadcast messages, disseminate regularly as per preference of the recipient, including but not limited to e-mail, fax, paper via mail, and by benefit (or benefits) type;

c) for other documents and information published on the HICPS Website (e.g. claims submission kits, benefits lists or grids), disseminate only upon request, as per preference of recipient (e-mail, fax, paper via mail);

d) disseminate website alerts electronically;

e) offer other modes of dissemination as new technologies becomes available, upon approval by the Project Authority.

3.3.3.5.3 Translation

The Contractor must:

a) ensure all Provider and Client communication products are available in both official languages, ensure that any translation work is completed within 10 business days from the date that the Project Authority provides the approved version;

b) ensure that any translations go through a quality assurance process before publication or distribution;

c) obtain the Project Authority's approval on all translated documents.

3.3.3.5.4 Language

The Contractor must:

a) use clear and concise language when communicating with Providers and Clients;

b) make available all communication products in both official languages;

c) respond to Providers and Clients in their preferred language (i.e. English or French);

d) develop and utilize and maintain an evergreen lexicon (terminology dictionary) to ensure consistent use of terminology in both English and French, as approved by the Project Authority when developing communication materials.

3.3.3.5.5 Flexibility

The Contractor must allow flexibility when the Project Authority requests changes to evergreen documents in accordance with NIHB Program decisions, at no cost to Canada, including but not limited to, changes to:

a) content or writing style;

b) font type or size;

c) information layout;

d) colour scheme;

e) terminology (including updates to lexicon as needed (refer to section 3.3.3.5.4(d) *Language*).

3.3.3.5.6 Quality Assurance

The Contractor must:

a) develop and document Quality Assurance procedures for approval by the Project Authority, apply testing and quality assurance procedures in maintaining the HICPS Website and producing and/or publishing the Provider and Client communication materials;

b) ensure that appropriate quality assurance (QA) procedures have been performed - all communication materials require the Project Authority's approval.

3.3.3.5.7 Service Standards

The Contractor must:

a) maintain HICPS Website availability in accordance with Article 3.4.1.1(c) *Business Continuity, Availability and Service Standards*;

b) use standard infrastructure and application monitoring tools in order to measure and report on service standards posted to the DRR on a monthly basis;

c) disseminate newsletters within 10 business days of receiving Project Authority approval;

d) disseminate Broadcast messages within 5 business days of receiving Project Authority approval;

e) post HICPS Website material within 2 business days of receiving Project Authority approval;

f) send time sensitive alerts to Providers and Clients for urgent messages such as system outages within 24 hours of notification by the Project Authority.

3.3.3.6 Establishment of Governance

3.3.3.6.1 The Contractor must:

a) assign an employee as a Web master;

b) ensure that this Web master posts approved documents (by the Project Authority) on the HICPS Website or otherwise distributed in accordance with agreed upon timelines.

3.3.3.7 Information Management

The Contractor must retain all paper and electronic communication and information products developed by the Contractor and approved by the Project Authority, and make them accessible to the Project Authority and HC Users, as needed.

3.3.3.8 Meetings

The Contractor must schedule teleconference meetings with the Project Authority, minimum monthly, or more frequently as needed, to discuss issues related to Communications.

3.3.3.9 Communication with Providers and Claims Submission Software Vendors

The Contractor must ensure that all Providers and Claims Submission Software Vendors are informed of any future changes to the data elements and EDI interface that may affect EDI submissions at least 90 calendar days in advance of any change.

3.3.3.10 Provider and Client Communication Reports

The Contractor must provide Provider and Client Communication Reports quarterly and post them to the DRR, within 5 business days of quarter end, for the Project Authority's review.

3.3.3.10.1 The Contractor must ensure that the Provider and Client Communication Reports provide statistics on the following, but not limited to:

a) number and types of items mailed, faxed and emailed to Providers and Clients, by benefit type by quarter, by jurisdiction;

b) number of paper copy items requested by item in each quarter by jurisdiction;

c) number of clients registered and newly registered for the Client secure web account and their communications preferences;

d) number of Provider registered and newly registered for the Provider secure web account and their communication preferences;

e) number of enrolled Providers and their communications preferences;

f) Provider and Client communication preferences, including mode (paper, electronic), and official language choice by benefit area, jurisdiction.

3.3.3.10.2 The Contractor must maintain and report on the Distribution List of Providers and include changes to addresses, e-mail addresses, telephone numbers and fax numbers in the report.

3.3.3.10.3 The Contractor must maintain and report on the Distribution List of Clients and include changes to Clients' addresses, e-mail addresses, and telephone numbers (etc.) in the report.

3.3.3.10.4 The Contractor must provide statistics to the Project Authority as requested on the HICPS Website traffic including, but not limited to statistics:

a) by Benefit type;

b) by Webpage visited;

c) document downloads;

d) by total number of visits;

e) by Province and Territory.

3.3.4 Dental Benefit Requirements

3.3.4.1 Dental Benefit Maintenance

The Contractor must maintain the list of dental health professional associations' procedure codes; create and maintain a Provincial-Territorial Dental Associations pricing table; update and maintain NIHB Dental Benefit information including pricing schedules; and provide and maintain an interface through which HC Users can maintain and update NIHB Dental Benefit information.

The NIHB Dental Schedule is based on procedure codes supplied by dental health professional associations and NIHB unique procedure codes. Within the Dental Schedule each of these procedure codes associated to the data elements representing the NIHB Dental policy(ies) for each dental specialty in each of the provinces and territories.

3.3.4.1.1 Create and Maintain a Master List of Procedure Codes

The NIHB Dental Benefit services are based on the procedure codes supplied by Canadian dental health professional associations and NIHB Unique Procedure Codes which make up the master list of procedure codes.

3.3.4.1.1.1 The Contractor must:

a) create and maintain a master list of procedure codes with their effective start and end date, and update the list on an annual basis within 20 business day prior to the date the Canadian dental health professional associations lists become effective, if available;

b) inform the Project Authority of additions, and updates in descriptions to procedure codes, in advance of their effective date;

c) retain and display the historical changes made to each procedure code.

3.3.4.1.2 Create and Maintain a Provincial-Territorial Dental Associations Pricing Table

The Contractor must maintain the Provincial-Territorial Dental Associations Pricing Table ensuring the list is current and accurate when fee guides are published by the respective provincial or territorial dental associations.

3.3.4.1.2.1 The Contractor must:

a) add or update the Provincial-Territorial Pricing Table on an annual basis, prior to the effective date of the fee guide from the provincial or territorial dental associations;

b) retain and display the historical changes made to each procedure code and fees (includes laboratory fees) with a start and end date;

c) liaise with the respective province and territory to ensure the Provincial-Territorial Pricing Table is current at all times (i.e. change in price, omissions of procedure code(s) and inform the Project Authority as required;

d) inform the Project Authority if a fee guide is not received prior to its effective date;

e) request a fee guide from the Project Authority when an association does not maintain a fee guide for a province or territory;

f) liaise with the respective dental associations to ensure benefit pricing is current at all times;

g) be responsible for the claim adjudication costs for claims that were adjudicated using any out-of-date information and for any transaction fees for correcting these errors;

h) provide HC Users the ability to view and export procedure codes and fees (including laboratory fees).

3.3.4.1.3 Create and Edit NIHB Unique Procedure Codes

The Contractor must provide an interface through which a HC User can create and edit NIHB Unique Procedure Codes. NIHB Unique Procedure Codes are used to track and report on dental procedures not defined by national, provincial or territorial dental associations.

3.3.4.1.3.1 The Contractor must provide the HC User with the ability to:

a) continue to use NIHB Unique Procedure Codes already in use;

b) create, edit, and end-date NIHB Unique Procedure Codes with:

   i. alphanumeric Procedure Code;
   ii. procedure Name in English and French;
   iii. Start Date and End Date;
   iv. additional fields as per regular procedure codes;

c) use NIHB Unique Procedure Codes in an identical manner to regular procedure codes.

3.3.4.1.4 Create and Edit NIHB Dental Schedule

The Contractor must create and update the NIHB Dental Schedule as requested by the Project Authority, with the following information, including but not limited to:

a) jurisdiction;

b) dental specialty;

c) procedure code;

d) equivalent code;

e) schedule type;

f) professional fee;

g) commercial lab eligibility and fee;

h) internal lab eligibility and fee;

i) start date;

j) end date;

k) procedure name;

l) alternative procedure name;

m) alternative procedure code;

n) policy rule values for:

i. tooth class and sub-class;
ii. dentition code;
iii. age predetermination if required;
iv. provincial plan min/max age;
v. provincial plan COB required;
vi. Frequency Limits over time;
vii. NIHB Program Verification Edit reference/description;
viii. other policy related values as required (see Appendix C, Article 4.2 "*Dental benefit eligibility edit*s");

o) data from the Provincial-Territory Pricing Table:

i. Province/Territory;
ii. dental specialty;
iii. procedure code;
iv. effective date (start);
v. expiry date (end);
vi. professional fee;
vii. commercial lab fee eligibility, and fee if applicable;
viii. internal lab fee eligibility, and fee if applicable.

3.3.4.1.5 Search the NIHB Dental Schedule

The Contractor must provide an interface through which a HC User can search and view the results for NIHB Dental Schedule. The Contractor must provide the HC User with the ability to:

a) search for a procedure code using one, multiple or all values within one or more fields, but not limited to, the following elements:

i. jurisdiction;
ii. procedure code;
iii. effective date;
iv. all active records;
v. all end-dated records;
vi. dental specialty;
vii. procedure name;
viii. schedule type;

b) search with additional elements in the selection list to represent:

i. all values;
ii. negation of the selection;
iii. wildcard matching on alpha, numeric, and alpha-numeric values;

c) restrict the search result to display:

i. the current record for each matched procedure code;

ii. the current and up to 3 previous records for each matched procedure code (default);
iii. all matched records;

d) view the search result but not limited to (sorted by most recent effective date first, by default):

i. jurisdiction
ii. dental specialty;
iii. procedure code;
iv. schedule type;
v. professional fee;
vi. commercial lab eligibility and fee (if applicable);
vii. internal lab eligibility and fee (if applicable);
viii. start date;
ix. end date;

e) sort each column in ascending or descending order (with an indicator of the active sort order and sorting over all search results, not just those visible onscreen);

f) view and edit the procedure details for the record selected from the search results;

g) print the selected records to a local printer.

The Contractor must also provide the ability to export the selected records to a file, with the ability to select all record fields or the displayed fields for the matched records. After exporting, the Contractor must ensure that a HC User has the ability to upload the new file (see SOW Article 3.3.4.1.8 *Upload and Update NIHB Dental Schedule*).

3.3.4.1.6 View Details of NIHB Dental Schedule

The Contractor must provide an interface through which a HC User can, after searching, view the details of a procedure code within the NIHB Dental Schedule. With the procedure details displayed, but not limited to, as follows:

a) jurisdiction;

b) dental specialty;

c) procedure code;

d) equivalent code;

e) schedule type;

f) professional fee;

g) commercial lab eligibility and fee, if applicable;

h) internal lab eligibility and fee, if applicable;

i) start date;

j) end date;

k) procedure name;

l) alternative procedure name;

m) alternative procedure code;

n) policy rule values for:

i. tooth class and sub-class;
ii. dentition code;

iii. age predetermination if required;
iv. provincial plan min/max age;
v. provincial plan COB required;
vi. Frequency Limits over time;
vii. NIHB Policy Verification edit reference/description;
viii. other policy related values as required (see Appendix C, Article 4.2 "*Dental benefit eligibility edits*");

o) data from the Provincial-Territory Pricing Table:

i. Province/Territory;
ii. dental specialty;
iii. procedure code;
iv. effective date (start);
v. expiry date (end);
vi. professional fee;
vii. commercial lab fee eligibility, and fee if applicable;
viii. internal lab fee eligibility, and fee if applicable.

3.3.4.1.7 Update the NIHB Dental Schedule

3.3.4.1.7.1 Add, Update and Copy Single Record

The Contractor must provide an interface through which a HC User can add, update and copy procedure code details within the single record as follows:

a) add a new NIHB Procedure Code by, but not limited to, populating all mandatory and optional fields to create a new record with Procedure Code, Dental Specialty, Province/Territory, Start Date, and End Date;

b) update or copy an existing NIHB procedure code by first searching on, but not limited to:

i. Province/Territory;
ii. Procedure Code;
iii. Start Date
iv. End Date;
v. Dental Specialty;

c) display the matching record showing the detailed view of the Dental Schedule record (as above) and also displaying any language dependent fields in both languages;

d) edit the displayed fields and update the existing record;

e) copy all populated fields to a new record with a different, or same, Province/Territory, Procedure Code, Dental Specialty, Start Date, and End Date;

f) warn the user when overwriting an existing record. Requiring a second confirmation before proceeding;

g) revert to the state prior to the changes.

3.3.4.1.7.2 Add, Update and Copy Multiple Records

The Contractor must provide an interface through which a HC User can add, update and copy procedure code details within multiple records as follows:

a) add a new NIHB Procedure Code on multiple records by, but not limited to populating all mandatory and optional fields to create a new record with Procedure Code, Dental Specialty, Province/Territory, Start Date, and End Date;

b) update or copy an existing NIHB procedure code by first searching on, but not limited to:

i. Province/Territory;

ii. Procedure Code;
iii. Start Date
iv. End Date;
v. Dental Specialty;

c) Make bulk updates to the fields of the selected records from the search results with:
   i. editing one or more field values in the detail view;
   ii. copy all populated fields to the selected records with a different, or same, Province/Territory, Procedure Code, Dental Specialty, Start Date, and End Date;

d) prior to changes being made a confirmation screen displays the total number of records affected and a summary showing the affected field name with existing and new values;

e) warn the user when overwriting an existing record. Requiring a second confirmation before proceeding;

f) revert to the state prior to the changes.

3.3.4.1.8 Upload and Update NIHB Dental Schedule

The Contractor must provide an interface through which a HC User can upload and update NIHB Dental Schedule Data to affect changes to more than one record at a time.

3.3.4.1.8.1 The Contractor must provide the HC User with the ability to:

a) locate a local file containing the data changes;

b) upload into the test environment and immediately verify the consistency of the data, with a report of errors by line number, field and error;

c) if error free, load the data into the production environment and update the NIHB Dental Schedule;

d) receive a warning message if the change will overwrite records that have are currently active;

e) generate pre-defined reports from both the test environment and production environment showing before and after values of the changed records and highlighting changes and values outside predefined ranges, as specified by the Project Authority, such as new fee is greater than 5% of previous;

f) revert to the prior state.

3.3.4.1.8.2 Upon request by the Project Authority the Contractor must:

a) accept a file of NIHB Dental Schedule data changes from the HC User;

b) verify the consistency of the data file prior to applying the changes in the file;
   i. upload into the test environment for Project Authority validation;
   ii. load the data and update the NIHB Dental Schedule in the production environment, within 5 business days of receiving approval from the Project Authority;

c) generate pre-defined reports from both the test environment and production environment showing before and after values of the changed records and highlighting changes and values outside predefined ranges, as specified by the Project Authority, such as new fee is greater than 5% of previous;

d) communicate with the HC User the status of the update;

e) have the ability to revert to the prior state if required.

3.3.4.1.9 Update NIHB Dental Schedule Item Fees

The Contractor must provide an interface through which a HC User can update fees in the Dental Schedule to affect changes to more than one procedure code at a time. As an alternative to updating dental fees by entering a new fee (in dollars and cents) it must be possible to update fees based on their relationship to other fees. For example Dental Specialty fee might be set at 120% of General Practitioner (GP) fee or the GP fee might be set to 80% of the provincial/territory fee.

3.3.4.1.9.1 The Contractor must provide the HC User with the ability to

a) select all or specific procedure codes in a:
   i. dental specialty;
   ii. jurisdiction;

b) update the selected records as a percentage of:
   i. a dental specialty;
   ii. a provincial or territorial dental association fee guide; or
   iii. the NIHB Dental Schedule;

c) set a percentage to 4 decimal places, such as 80.12%, representing a multiplier of 0.8012;

d) set a percentage either above or below 100%, such as 20.12% or 180.12%;

e) revert to the state prior to the changes.

3.3.4.2 Produce and Publish NIHB Dental Benefit Grids

The Contractor must produce and update the NIHB Dental Benefit Grids for each province/territory on an annual basis or when requested by the Project Authority.

3.3.4.2.1 The Contractor must:

a) update the NIHB Dental Benefit Grids templates within 15 business days of the Project Authority request;

b) on an annual basis, or more frequently when requested produce the draft NIHB Dental Benefit Grids for Project Authority approval:
   i. in English and French;
   ii. for each province and territory;
   iii. for each dental specialty, as determined by the Project Authority;

c) within 10 business days of receiving Project Authority approval, post to the HICPS Website and distribute according to Provider preference SOW Article 3.3.3.4.4 *Benefit Lists or Grids*.

3.3.4.3 Managing Predeterminations, Post-determinations, Automated Post-determinations

3.3.4.3.1 Manage Predeterminations

The Contractor must provide an interface through which a HC User can enter and update a Predetermination (PD), capture supporting items, record decision(s) and communicate the outcome.

3.3.4.3.1.1 The Contractor must provide the HC User with the ability to:

a) search for a Client and create a PD from the Client Screen with the client details populated automatically;

b) display and search a Client's existing PDs;

c) enter Provider details or search for a Provider with the selected Provider details populated automatically;

d) automatically verify both the Provider and the Client eligibility against the start and end date of the PD;

e) amend the end date, if applicable (default end date is one year from start date);

f) select and unselect the recipients of the PD Confirmation Letter;

g) add, edit, and delete PD lines for a maximum of 30 lines per PD;

h) select one or multiple Consultant Review fillable forms for each PD line and place it in a queue for Consultant Review (see SOW Article 3.3.4.3.2 *Consultant Specific Review*);

i) automatically generate a unique PD alphanumeric number;

j) edit the PD number, if required and HICPS must validate that the new number is unique;

k) amend a PD line that has not been claimed against;

l) Create, Update, File, Settle, Amend, Cancel, Transfer, Delete a PD;

m) populate the PD result, where applicable, to the Client's CR record (see SOW Article 3.3.9.12 *Client Reimbursements*) and populate the claim lines with the PD number where appropriate;

n) view a Mandatory Information List of required documents to support the unique list of procedures entered in the PD lines (see SOW Article 3.3.9.5 *Verifying Mandatory Information*);

o) mark items as being present or missing;

p) request the missing items from the Provider or Client using a generated Missing Information Letter (see SOW Article 3.3.9.6 *Requesting and Receiving Missing Items or Additional Information*);

q) attach, remove, rename, and delete documents and associate it with the entire PD or PD line(s) (see SOW Article 3.3.9.7 *Capturing and Retaining Documents*);

r) capture claim line designation(s) (e.g. Jordan's Principle) as determined by the Project Authority;

s) adjudicate the PD against NIHB Adjudication Edits with the results reflected against each PD line;

t) override adjudication result and adjust approved amounts according to policy, and capture in the Internal Notepad in the PD, the reason for the adjudication error and the override action;

u) override, accept or hold a decision on each PD line, such that the PD may show a mixture of approved, denied or on hold (pending) decisions;

v) automatically generate Confirmation Letter messages based on the PD line result – the adjudication error and the override action;

w) view generated Confirmation Letter messages in the General Notepad for review and modification if necessary;

x) automatically record the User ID and the timestamp for Adjudication;

y) update the Client Notepad, General Notepad, and Internal Notepad;

z) view, print, and send the PD Confirmation Letter(s) to the selected recipients;

aa) save PD Confirmation Letter(s) to the PD, with the ability view and print;

bb) send, print, suppress or re-send a PD Confirmation Letter to the Provider or the Client;

cc) view:

i. General, Internal and Client Notepads
ii. Tooth Information
iii. Frequency History

iv. Claims History
v. PD Documents
vi. Radiographs
vii. The PD or individual PD lines were transferred to (or from)
viii. PD Confirmation Letter(s)
ix. The PD Confirmation Letter(s) distribution outcome showing sent by method, date sent, retries, and delivery result;
x. Changes to the PD

dd) view explanations and help on coded information used on the screen. Such as, but not limited to, error codes, override actions, item details, etc.

3.3.4.3.1.2 The Contractor must, at a minimum, automatically populate the PD fields with the following dates for each PD line: received, on-file, PD start, settled, deleted, cancelled, and all amended dates. The Contractor must also ensure that HC Users have the ability to override a date field.

3.3.4.3.1.3 The Contractor must record the User ID and the timestamp for Adjudication.

3.3.4.3.2 Consultant Specific Review

3.3.4.3.2.1 The Contractor must provide HC Users the ability to:

a) retrieve the consultant specific review form and have it auto-populate with the PD details and the internal notes;

b) copy and paste information from another document into the form;

c) enter the decision, rational for the decision and other notes using free text;

d) agree to a consultant attestation statement;

e) save, add, amend, replace the Review Form and attach multiple review forms to a PD line.

3.3.4.3.3 Transfer a Predetermination

The Contractor must provide an interface through which a HC User can transfer an entire PD or selected PD Lines to another Provider.

3.3.4.3.3.1 The Contractor must provide the HC User with the ability to:

a) Transfer an entire PD to another Provider and cancel the initial PD, the original PD must be marked as transferred and can no longer be claimed against;

b) Select multiple unclaimed PD lines, and transfer the PD lines, the transferred lines on the original PD must be marked as transferred and can no longer be claimed against. Any remaining lines on the original PD, not transferred, can be claimed against;

c) All notes and reference documents from transferred lines or PD's must also be transferred to the new PD.

3.3.4.3.4 Manage Post-determinations

The Contractor must provide an interface through which a HC User can enter a Post-determination, capture supporting items, record decision(s) and communicate the outcome.

The Contractor must provide the HC User with the ability to:

a) Create, Update, File, Settle, Amend, Cancel, Delete a Post-determination request (see SOW Article 3.3.4.3.1 *Manage Predeterminations*) with a retroactive start date to support Post-determinations, with a field indicating the record is a post-determination PD.

3.3.4.3.5 Manage Automated Post-determinations

3.3.4.3.5.1 The Contractor must:

a) generate an automated post-determination request when a claim is submitted to the Contractor and it is missing a valid PD number or a frequency maximum has been reached, or other scenarios as defined by the Project Authority;

b) send to HC in an automated pre-populated (Client, Provider, and Claim line details, attachments where applicable) post-determination format and placed in a queue for HC review.

3.3.4.3.5.2 The Contractor must provide the HC User with the ability to:

a) retrieve and manage the post-determination in accordance with SOW Article 3.3.4.3.4 *Manage Post-determinations*;

b) send the post-determination request back to the Contractor for processing and payment.

3.3.4.4 Tooth Information – shows the Client's present, missing, or extracted teeth.

The Contractor must:

a) display a representation of a tooth chart, with tooth numbering and an indication of teeth present, missing or extracted for primary and permanent teeth;

b) display a legend of any present, missing or extracted tooth symbols used;

c) automatically update when an extraction or complete denture has been paid;

d) allow the HC User to update missing and present teeth in real time;

e) display tooth history (PD, Claims) of dental services for the tooth in question.

3.3.5 Mental Health Counselling Benefit Requirements

Currently, the Mental Health Counselling benefit provides up to a maximum of 20 one-hour sessions per original PA request over a 20 week period. Eligible billable services under the Mental Health Counselling benefit may include: Initial assessment (maximum of 2 one hour sessions) performed by Provider; and Counselling sessions on a fee-for-service basis as per the type of counselling (e.g. individual, family, or group counselling).

3.3.5.1 Mental Health Counseling Item Maintenance

The Contractor must maintain the list of Mental Health Counseling items. The NIHB Mental Health Counseling Benefit policies determine the items that make up the list, including but not limited to, assessments and sessions.

3.3.5.1.1 The Contractor must create an item list with the

a) alphanumeric or numeric item code;

b) item name in English and French;

c) additional fields as provided by the Project Authority at Contract Award.

3.3.5.1.2 Contracted Service Standard

a) requests for additions or changes to an item by the Project Authority must be completed within 10 business days.

3.3.5.2 Setting and Updating Price File for Mental Health Items

The Contractor must maintain the Price File for Mental Health benefit items as directed by the Project Authority.

3.3.5.2.1 The Contractor must:

a) add or update the following values for each item, by mental health counsellor specialty, by jurisdiction including, but not limited to:
   i. hourly rates defined as the maximum amount NIHB will allow for the item;
   ii. Price effective date and end date.

3.3.5.2.2 Service Standard

a) Requests for additions or changes to an item by the Project Authority must be completed within 10 business days.

3.3.5.3 Creating and Maintaining the Pricing Schedule and Categories

The Contractor must create and maintain pricing schedules, pricing categories and lists of items associated with each distinct pricing category. The Contractor must also provide HC users with the ability to define the rules within each pricing category.

3.3.5.3.1 Pricing Schedule and Category Setup

The Contractor must:

a) create and maintain pricing schedules where a pricing schedule is defined as a collection of pricing categories for a HC defined group of providers within a jurisdiction (Jurisdictions typically are provinces and territories but may also include other arrangements);
b) add one or more pricing category to each pricing schedule as required by the Project Authority where a pricing category is a set of pricing rules that apply to all items associated with the pricing category;
c) assign a free text description for the pricing category based on Project Authority approval;
d) update and maintain the items within each pricing category according to the Project Authority's direction.

3.3.5.3.2 View the Pricing Schedule and Pricing Categories

The Contractor must provide the HC User with the ability to view the:

a) pricing schedule details for a specific jurisdiction;
b) pricing schedule effective date and end date;
c) pricing category details for a Pricing Schedule;
d) pricing category description;
e) pricing category per mental health counsellor specialty;
f) pricing rules for each pricing category including but not limited to:
   i. individual hourly rate;
   ii. group hourly rate;

g) following values:

i. value limit as a percentage or dollar amount;
ii. a maximum dollar value for the pricing rule.

3.3.5.3.3 Service Standards

The Contractor must respond to requests for updates by the Project Authority to the pricing category or pricing category name within 10 business days.

3.3.5.4 Set Benefit Status and Coverage Details,

The Contractor must create and maintain the coverage details for each Mental Health Counseling item by setting the benefit status, setting specific limits, relating a specific Frequency Limit, or defining other supporting information as directed by the Project Authority.

3.3.5.4.1 The Contractor must:

a) add the coverage details;

b) set and amend the effective date;

c) set and amend the end date;

d) set and amend the benefit status to, including but not limited to the following:

i. Requires PA;
ii. Exception;
iii. Exclusion;

e) limit coverage to a specific age range (minimum and maximum age);

f) set Frequency limits;

g) set if Private and/or Public COB required;

h) set the Age Predetermination if required;

i) set the NIHB Program Verification Edit reference/description;

j) set other policy related values as required (see Appendix C, Article 4 "*Benefit Verification Edits*").

3.3.5.5 Searching and Viewing the Mental Health Counseling Benefit Items

Contractor must provide HC Users with the ability search and view the details for an item that contains the specifics of the item, related pricing rules, benefit status, and operational directives.

3.3.5.5.1 Search for an Item(s)

The Contractor must provide the HC User with the ability to:

a) search for and view the Mental Health Benefit item using, but not limited to, the following criteria individually or in combination:
i. jurisdiction;
ii. item code;
iii. effective date;
iv. all active items;
v. all end-dated items;
vi. Mental Health Counsellor Specialty;
vii. Mental Health Counsellor area of expertise;
viii. item name;

b) view the full details for item selected in the search results;

c) select item for use in a workflow that initiated the search (for example, when processing a request for an item, the user identifies the item using the search capability described);

d) view the full details once an item is identified in workflow that initiated the search (for example, once the item has been identified in a workflow, the user is able to access the details to verify information to support their decision or action).

3.3.5.5.2 View the Item Details

The Contractor must provide the HC User with the ability to:

a) view the item details, where applicable including, but not limited to:
   i. item ID;
   ii. item name;

b) view the following item details by jurisdiction including, but not limited to:
   i. HC benefit status and effective start and end date;
   ii. unit rate (e.g. hourly rate, group rate);
   iii. maximum rate effective date;
   iv. rate category;
   v. Frequency Limit description including the ability to access the Frequency Limit;

c) view, edit and save the operational directives for the item selected which provide the HC User instructions on the appropriate actions in processing a request for the item:
   i. operational directives (may consist of a large amount of text);
   ii. allow HC user to upload or update documents related to the item;

d) view, edit and save the operational directive fields including, but not limited to:
   i. description;
   ii. administrative procedures;
   iii. exception criteria;
   iv. rationale for de-listing;
   v. special considerations.

3.3.5.5.3 Service Standard

The Contractor must respond to Project Authority requests for updates to the item details within 10 business days.

3.3.5.6 Managing Prior Approvals, Post Approvals

3.3.5.6.1 Manage Prior Approvals

The Contractor must provide an interface through which a HC User can enter and update a Prior Approval (PA), capture supporting items, record decision(s) and communicate the outcome.

3.3.5.6.1.1 The Contractor must provide the HC User with the ability to:

a) search for a Client and create a PA from the Client Screen with the client details populated automatically;

b) display and search a Client’s existing PAs;

c) enter Provider details or search for a Provider with the selected Provider details populated automatically;

d) set the PA as either an original request or a request for an extension;

e) enter the assessment start and end date;

f) enter the treatment plan start and end date;

g) enter the total quantity requested (number of hours);

h) enter the received date;

i) enter start date and end dates for the PA, with the default end date being 20 weeks from the start date;

j) verify both the Provider and the Client eligibility against the start date of the PA;

k) amend the end date, if applicable;

l) select and unselect the recipients of the PA Confirmation Letter;

m) add, edit, and delete PA lines for a maximum of 30 lines per PA;

n) capture the proposed number of counselling sessions;

o) capture the type of sessions, including but not limited to:

   i. face-to-face (individual/family);
   ii. tele-health (phone, video-conference etc.);
   iii. group sessions;

p) capture claim line designation(s) (e.g. Jordan's Principle) as determined by the Project Authority;

q) automatically generate a unique PA alphanumeric number;

r) edit the PA number, if required and HICPS must validate that the new number is unique;

s) amend a PA line that has not been claimed against;

t) Create, Update, File, Settle, Amend, Cancel, Transfer, Delete a PA;

u) populate the PA result, where applicable, to the Client's CR record (see SOW Article 3.3.9.12 *Client Reimbursements*) and populate the claim lines with the PA number where appropriate;

v) view a Mandatory Information List of required documents to support the items entered in the PA lines (see SOW Article 3.3.9.5 *Verify Mandatory Items*);

w) mark items as being present or missing;

x) request the missing items from the Provider or Client using a generated Missing Information Letter (see SOW Article 3.3.9.6 *Requesting and Receiving Missing Items or Additional Information*);

y) attach, remove, rename, and delete documents and associate it with the entire PA or PA line(s) (see SOW Article 3.3.9.7 *Capturing and Retaining Documents*);

z) adjudicate the PA against NIHB Adjudication Edits with the results reflected against each PA line;

aa) override adjudication result and adjust approved amounts according to policy, and capture in the Internal Notepad in the PA, the reason for the adjudication error and the override action;

bb) override, accept or hold a decision on each PA line, such that the PA may show a mixture of approved, denied or on hold (pending) decisions;

cc) ability to automatically generate Confirmation Letter messages based on the PA line result – the adjudication error and the override action;

dd) view generated Confirmation Letter messages in the General Notepad for review and modification if necessary;

ee) automatically record the User ID and the timestamp for Adjudication;

ff) update the Client Notepad, General Notepad, and Internal Notepad;

gg) view, print, and send the PA Confirmation Letter(s) to the selected recipients;

hh) save PA Confirmation Letter(s) to the PA, with the ability view and print;

ii) send, print, suppress or re-send a PA Confirmation Letter to the Provider or the Client;

jj) view:

i. General, Internal and Client Notepads
ii. Frequency History
iii. Claims History
iv. PA Documents
v. the PA or individual PA lines were transferred to (or from)
vi. PA Confirmation Letter(s)
vii. the PA Confirmation Letter(s) distribution outcome showing sent by method, date sent, retries, and delivery result;
viii. Changes to the PA

kk) view explanations and help on coded information used on the screen. Such as, but not limited to, error codes, override actions, item details, etc.;

ll) copy information in an original PA screen into a subsequent to be used as the basis for the next PA.

The Contractor must automatically:

a) reduce the quantity and dollar amounts to NIHB Program limits within the approval details where appropriate;

b) reduce the quantity and dollar amounts on the PA until the authorized limits have been reached.

3.3.5.6.1.2 The Contractor must provide HC Users with the ability to:

a) track denied PA's and the reason for rejection through a drop down list with standard reasons, plus optional free text for 'Other' non-standard reasons.

3.3.5.6.2 Transfer a Prior Approval

The Contractor must provide an interface through which a HC User can transfer an entire PA or selected PA Lines to another Provider.

3.3.5.6.2.1 The Contractor must provide the HC User with the ability to:

a) Transfer an entire PA to another Provider and cancel the initial PA, the original PA must be marked as transferred and can no longer be claimed against;

b) Select multiple unclaimed PA lines, and transfer the PA lines, the transferred lines on the original PA must be marked as transferred and can no longer be claimed against. Any remaining lines on the original PA, not transferred, can be claimed against;

c) All notes and reference documents from transferred lines or PA's must also be transferred to the new PA.

3.3.5.6.3 Manage Post Approvals

The Contractor must provide an interface through which a HC User can enter a Post Approval, capture supporting items, record decision(s) and communicate the outcome.

The Contractor must provide the HC User with the ability to:

a) Create, Update, File, Settle, Amend, Cancel, Delete a Post Approval request (see SOW Article 3.3.5.6.1 *Manage Prior Approvals)* with a retroactive start date to support Post Approvals, with a field indicating the record is a post approval.

3.3.6 MSE Benefit Requirements

3.3.6.1 MSE Item List

The Contractor must implement an MSE item list to allow items to be organized by a hierarchical structure.

3.3.6.1.1 The Contractor must:

a) implement a hierarchical structure for the MSE Item list including, but not limited to:
   i. category;
   ii. sub-category or sub-categories;
   iii. item type;
   iv. item;
b) add or remove categories, sub-categories and item types within the hierarchical structure and re-organize the associated items or elements affected as a result of updates as the Project Authority requires;
c) edit the names of existing categories, sub-categories and item types as the Project Authority requires;
d) implement an item type ID based on a code approved by the Project Authority.

3.3.6.2 MSE Item List Maintenance

The Contractor must maintain the list of MSE items and where directed by the Project Authority associate items with professional associations, provincial and territorial programs.

3.3.6.2.1 The Contractor must:

a) add to or update MSE items as required by the Project Authority which may include using third-party sources of information identified by the Project Authority;
b) add or update the following information for each item including, where applicable, but not limited to:
   i. category;
   ii. sub-category;
   iii. item type name and item type ID;
   iv. item name;
   v. benefit status;
   vi. BEQ;
   vii. item id (CPHA compliant pseudo-DIN);
   viii. manufacturer;
   ix. item specialty and sub-specialty (see Appendix C, Article 2.3 “*Qualified Provider edit*”);
   x. equipment or supply designation.
c) add or update equivalent records from professional associations, such as the Alberta Association of Orthotists and Prosthetists (AAOP), and provincial or territorial benefit plans, such as the

Assistive Devices Program (ADP) in Ontario, where available, to equivalent items within the MSE item list as directed by the Project Authority;

d) for each equivalent record from the provincial or territorial benefit plans or professional association the following information to be added or updated including, but not limited to:

i. the provincial or territorial benefit plans or professional association the record belongs to
ii. provincial or territorial benefit plan and/or professional association item ID
iii. provincial or territorial benefit plan and/or professional association item name
iv. if item is covered or an exception within provincial or territorial benefit plan;
v. effective start and end date related to the provincial or territorial benefit plan's status;
vi. frequency limits applied to the item within the provincial or territorial benefit plans for reference purposes;
vii. pertinent pricing information available for reference purposes.

For example:
The item within the MSE item list is the 'California ECO spinal orthosis'.

This item is also included in the NIHB AAOP Price Schedule. The item ID is O-SP-24. The stated price the item is $710.

Alberta's Aids to Daily Living program also lists this item on the provincial benefit plan with an item code of O117 and a frequency limit of 1 every 2 years.

Each record from these two sources is to be added and maintained within the master record for the California ECO spinal orthosis.

3.3.6.2.2 Contracted Service Standard – MSE Items Information Maintenance:

a) requests for additions or changes to an item by the Project Authority must be completed within 10 business days.

3.3.6.3 Setting and Updating Price File for MSE Items

The Contractor must maintain the Price File for MSE items as directed by the Project Authority.

3.3.6.3.1 The Contractor must:

a) add or update the following values for each item by jurisdiction including, but not limited to:
i. Unit price defined as the maximum amount NIHB will allow for the item;
ii. Price effective date.

3.3.6.3.2 Contracted Service Standard – MSE Items Information Maintenance:

a) requests for additions or changes to an item by the Project Authority must be completed within 10 business days.

3.3.6.4 Creating and Maintaining the Pricing Schedule

The Contractor must create and maintain pricing schedules, pricing categories and lists of items associated with each distinct pricing category. The Contractor must also provide HC users with the ability to define the rules within each pricing category.

3.3.6.4.1 Pricing Schedule and Category Setup

The Contractor must:

a) create and maintain pricing schedules where a pricing schedule is defined as a collection of pricing categories for a HC defined group of providers within a jurisdiction (Jurisdictions typically are provinces and territories but may also include other arrangements);

b) add one or more pricing category to each pricing schedule as required by the Project Authority where a pricing category is a set of pricing rules that apply to all items associated with the pricing category;

c) assign a free text description for the pricing category based on Project Authority approval;

d) update and maintain the items within each pricing category according to the provincial or territorial benefit schedules or the Project Authority's direction;

e) update the pricing schedule according to a rate specified by the Project Authority e.g. Consumer Price Index.

3.3.6.4.2 View and Maintain Pricing Schedule

The Contractor must provide the HC User with the ability to:

a) access, view, edit and save the pricing schedule details for a specific jurisdiction;

b) set the pricing schedule effective date allowing the date to be a future date without influencing the logic of the pricing schedule currently in effect based on date of service.

3.3.6.4.3 View and Maintain Pricing Categories

The Contractor must provide the HC User with the ability to:

a) view, edit and save the pricing category details for a Pricing Schedule;

b) view the pricing category description;

c) set a pricing category as either Defined Costs (DC) or Actual Acquisition Cost (AAC);

d) select one or more of the following pricing rules for each pricing category including but not limited to:

   i. cost upcharge;
   ii. tolerance;
   iii. mark up;
   iv. Manufacturers' Suggested Retail Price (MSRP) minus a % discount;
   v. Professional fee;

e) set the following values with 2 decimal places for each pricing rule including, but not limited to:

   i. value limit as a percentage or maximum dollar amount;
   ii. limit % mark-up based on allowed item cost on the claim, as a sliding scale;
   iii. the order in which the rules may be combined as determined by HC (For example, an item may have a tolerance allowance of 3% and a mark-up of 7.5%. The mark up is applied to the combined unit cost and the calculated tolerance amount).

3.3.6.4.4 Service Standards

The Contractor must respond to Project Authority requests for updates to the pricing category or pricing category name outside of the update frequencies within 10 business days.

3.3.6.5 Searching and Viewing MSE Benefit Items

Contractor must provide HC Users with the ability to manage the details for an item that contains the specifics of the item, related pricing rules, benefit status, and operational directives.

3.3.6.5.1 Search for an Item type or Item(s)

The Contractor must provide the HC User with the ability to:

a) search for a MSE item type or item using, but not limited to, the following criteria individually or in combination:

   i. category;
   ii. sub-category;
   iii. item type name and item type ID;
   iv. item ID (CPHA compliant pseudo-DIN);
   v. item ID from an equivalent record (as defined in SOW article 3.3.6.2 *MSE Item List Maintenance*);
   vi. item name;
   vii. Manufacturer;
   viii. benefit status;
   ix. BEQ;
   x. if item is discontinued or not;

b) view the results of the search including but not limited to the following data:

   i. category;
   ii. sub-category;
   iii. item type ID and item type name;
   iv. item id (CPHA compliant pseudo-DIN);
   v. item name;
   vi. manufacturer;
   vii. benefit status;
   viii. BEQ;
   ix. if item is discontinued or not;

c) view the full details for item selected in the search results;

d) select item for use in a workflow that initiated the search (for example, when processing a request for an item, the user identifies the item using the search capability described);

e) view the full details once an item is identified in workflow that initiated the search (for example, once the item has been identified in a workflow, the user is able to access the details to verify information to support their decision or action).

3.3.6.5.2 View Item type or Item Details

The Contractor must provide the HC User with the ability to:

a) view the item details, where applicable including, but not limited to:

   i. category;
   ii. sub-category or sub-categories;
   iii. item type name and item type ID;

iv. item id (CPHA compliant pseudo-DIN);
v. item name;
vi. Manufacturer;
vii. item specialty;
viii. all current Benefit Exception Questionnaires (BEQs) in both official languages including the ability to preview the BEQ;

b) view the following item details by jurisdiction including, but not limited to:

i. HC benefit status and effective start and end date;
ii. MSRP;
iii. unit price;
iv. Lowest Cost Equivalent (LCE) price;
v. price effective date;
vi. pricing category;
vii. Frequency Limit description including the ability to access the Frequency Limit;

c) view, edit and save the operational directives for the item selected which provide the HC User instructions on the appropriate actions in processing a request for the item:

i. operational directives (may consist of a large amount of text);
ii. allow HC user to upload or update documents related to the item;

d) view, edit and save the operational directive fields including, but not limited to:

i. description;
ii. administrative procedures;
iii. exception criteria;
iv. rationale for de-listing;
v. special considerations;

e) view the equivalent record details associated to the item including, but not limited to:
i. the provincial or territorial benefit plans or professional association the record belongs to;
ii. provincial or territorial benefit plan and/or professional association item ID;
iii. provincial or territorial benefit plan and/or professional association item name;
iv. if item is covered or an exception within provincial or territorial benefit plan;
v. effective start and end date related to the provincial or territorial benefit plan’s status;
vi. frequency limits applied to the item within the provincial or territorial benefit plans;
vii. pertinent pricing information available.

3.3.6.5.3 Service Standard

The Contractor must respond to Project Authority requests for updates to the item and item type details outside of the update frequencies within 10 business days.

3.3.6.6 Set Benefit Status and Coverage Details

The Contractor must provide HC Users with the ability to create and maintain the coverage details for each MSE item by allowing a HC User to set the benefit status, set specific limits, relate a specific Frequency Limit, or define other supporting information.

3.3.6.6.1 The Contractor must provide the HC User with the ability to:

a) view, edit and save the coverage details by each province or territory for each MSE item;

b) set the date for which the coverage details and end-date will be in effect for each province or territory;

c) set the benefit status to, but not limited to, one of the following:

i. Open Benefit;

ii. Prior Approval;
iii. Exception;
iv. Exclusion;
v. Non-Benefit;
vi. Discontinued;

d) select a Frequency Limit defined in a supporting workflow (see SOW Article 3.3.6.7 *Managing a Frequency Limit* for details);

e) limit coverage to a specific age range (minimum and maximum age);

f) limit coverage to a specific gender.

3.3.6.6.2 Other Coverage Details

The Contractor must provide the HC User with the ability to:

a) select an auto adjudication query from predefined list to be applied to one to many benefit items or item types and enforced during claim adjudication (See SOW Article 3.3.6.8 *Managing the Auto Adjudications* for details);

b) select a Frequency Limit defined in a supporting workflow (see SOW Article 3.3.6.7 *Managing a Frequency Limit* for details);

c) view the item group(s) associated with item including the ability to access the item group details (see SOW Article 3.3.6.9 *Managing Groups of MSE Items* for details);

d) attach a minimum of 15 BEQs in both English and French to the item by selecting the BEQs from a predefined list;

e) view BEQ's effective date;

f) ability to preview a BEQ associated to item.

3.3.6.7 Managing a Frequency Limit

Contractor must provide HC Users with the ability to view, create, and maintain Frequency Limits and apply them to one or multiple MSE item types or items as needed. The Contractor must allow the HC User the ability to define the maximum quantity and time period the maximum is evaluated over to ensure the maximum quantity is not exceeded without a Prior Approval (PA).

3.3.6.7.1 The Contractor must provide the HC User with the ability to:

a) search for a Frequency Limit by name or items that have the Frequency Limit associated to it;

b) view the search results list of Frequency Limits including the name, description and effective date;

c) view the full Frequency Limits details for the Frequency Limit selected in the search results;

d) view, add, edit and save a Frequency Limit;

e) set the date for which the Frequency Limit as defined will be in effect for each jurisdiction including a date in the future (see SOW Article 3.3.9.15 *Data Record Management* for details);

f) set the description for the Frequency Limit;

g) set the maximum quantity of an item allowed within the period defined when limit is set as a Frequency Limit;

h) set the period of time defined as a number of days, months, or years that the maximum amount is allowed.

3.3.6.8 Managing the Auto Adjudication

The Contractor must provide HC Users with an interface with the ability to create and maintain auto adjudication query parameters to be used within the adjudication process. An auto adjudication query allows HC Users to define complex rules (for example prerequisites) that are to be evaluated by the solution when an item is claimed and a specified result occurs (as defined by the Project Authority), with no HC intervention.

3.3.6.8.1 The Contractor must provide the HC User with the ability to:

a) search for an auto adjudication query by name or items referenced within the auto adjudication query;

b) view the search results list of auto adjudication query including the name, description and effective date;

c) access the auto adjudication query details from the list;

d) view, edit and save the auto adjudication query details through an easy to use and intuitive user interface for users with limited technical skills;

e) create new auto adjudication query and provide a name;

f) set the date for which the auto adjudication query as defined will be in effect for each jurisdiction including a date in the future (see SOW Article 3.3.9.15 *Data Record Management* for details);

g) set a description for the auto adjudication query;

h) create a set of criteria, for the item or item group, and the following information individually or in combination as input for the query:

   i. Client's relevant claim history;
   ii. Client's demographic details;
   iii. Provider details;
   iv. Provider group;
   v. Prescriber details available in Claim;
   vi. Prescriber group ID;

i) Define specific actions to be executed based on the results of the query. Outcomes available (including POS messaging to Providers) from the query evaluation include but are not limited to:

   i. evaluate using a specific Frequency Limit;
   ii. approve Claim;
   iii. in cases when the claim doesn't meet the prerequisites, return message to Provider to resubmit for PA;
   iv. reject the Claim;

j) preview auto adjudication query results are correct using existing HICPS data.

3.3.6.8.2 The Contractor must:

a) verify and validate the auto-adjudication parameters selected by the Project Authority;

b) notify the Project Authority of the verification and validation results;

c) optimize and implement the auto-adjudication query as directed by the Project Authority.

3.3.6.9 Managing Groups of MSE Items

The Contractor must provide the HC User with the ability to create and maintain groups of items where each item within the group shares the eligibility with the others (So that the group of items can be used in an approval record, as being eligible for the client or not eligible for the client.) For example, a palliative care item group, where once a Client has been approved for one of the items within the item group, the HC user will determine if it's appropriate to add the group, all other items in the group are eligible for the Client without adding them to an approval individually.

3.3.6.9.1 The Contractor must provide the HC User with the ability to:

a) search for an item group by name, or items within the item group;

b) view the search results list of item groups including the item group name and effective dates, with history;

c) access the item group details from the search results;

d) view the item group details including, but not limited to, subgroup name, item type ID and name, item name and item ID for items added to an item group, effective date, whether it is active or not;

e) view, set, edit and save the item group details;

f) create a new item group;

g) set the date for which the item group as defined will be in effect including a date in the future. See SOW Article 3.3.9.15 *Data Record Management* for details;

h) set a name for the item group;

i) add and remove item types, items and/or subgroups;

j) set a description for the item group.

3.3.6.10 Benefit Exception Questionnaires (BEQ)

The Contractor must provide the HC User with the ability to create and maintain BEQ forms.

3.3.6.10.1 Search and View

The Contractor must provide the HC User with the ability to:

a) search for BEQ's and view the current BEQs associated to an item or item type for each language.

3.3.6.10.2 Manage BEQ's

The Contractor must provide the HC User with the ability to:

a) add a new BEQ record;

b) access letter template workflow to create, edit, save and select a BEQ(s) to attach to an item or item type;

c) add or archive one to many predefined values for each BEQ with no limit to the number;

d) manage predefined values for English and French for all BEQs including:

i. adding or archive values that can be selected for a specific BEQ;
ii. editing the text for existing values.

3.3.6.11 Managing Requests for Approval

3.3.6.11.1 Managing Requests for PAs, SAs, Appeals

The Contractor must provide HC Users with the ability to create requests for specific type of approvals. Included in every request is the Client, Provider and item information, the ability to send and receive supporting documentation such as a BEQ and record the decision.

The Contractor must provide the HC User the following abilities for each case type:

a) create, edit, view and save a Prior Approval case including the PA case specifics outlined in SOW Article 3.3.6.13 *Prior Approval Specifics* and automatically generate a unique case record ID for the PA;

b) create, edit, view and save a Special Authorization case including the SA case specifics outlined in SOW Article 3.3.6.14 *Special Authorization Specifics* and automatically generate a unique case record ID for the request;

c) create, edit, view and save an Appeal case including the Appeal specifics outlined in SOW Article 3.3.9.16.3 *Appeal Process for Pharmacy and MSE Benefits*);

d) enter the reason for the case type using the following, but not limited to, items:
   i. Prior Approval;
   ii. Post-Approval;
   iii. Client reimbursement;
   iv. Appeal

e) search for the Client and automatically populate the Client details;

f) view full Client details, when required;

g) search for the Provider and automatically populate the Provider details;

h) view the full Provider details, when required;

i) enter Prescriber details in the case including but not limited to:
   i. prescriber licence number, prescriber name;
   ii. prescriber phone number, fax number;
   iii. language preference (HC User to be prompted if not set);

j) verify both the Provider and the Client eligibility against the start date of the case;

k) enter up to 5 item IDs or search for each item requested and populate the case with the item details;

l) add as many 15 additional item IDs as necessary, up to 20 lines in total;

m) enter an equivalent record code and have the solution automatically populate the NIHB item code (See SOW Article 3.3.6.2.1 (c) and (d) *MSE Item List Maintenance)*;

n) add a value for the AAC, mark up and total price fields up to $999,999.99 for each line item, in (6,2) digit pricing;

o) capture claim line designation(s) (e.g. Jordan's Principle) as determined by the Project Authority;

p) view the item details specific to the jurisdiction identified while maintaining their view of the request. Information to be displayed includes, but not limited to:
   i. operational directives;
   ii. Frequency Limit;

q) enter comments specific to each item requested;

r) set and amend the case status to:
   i. filed;
   ii. settled;
   iii. amended;
   iv. on-hold;
   v. denied; or
   vi. canceled;

s) enter comments for the case;

t) select and send to the prescriber or Provider one or more BEQs specific to an item within request by fax or other secure electronic means;

u) create a letter or other type of document using the workflow in SOW Article 3.3.9.6 *Requesting and Receiving Missing Items or Additional Information*;

v) manage documents attached to the record using the workflow in SOW Article 3.3.9.7 *Capturing and Retaining Documents*;

w) indicate the case was reviewed;

x) add an MSERC recommendation (see SOW Article 3.3.6.12 *Recommendations)*

y) set or update the request status for each item using one, but not limited to, of the following statuses:
   i. approved;
   ii. approved on history; or
   iii. denied;

z) generate and display a unique authorization number;

aa) enter a case record ID of an existing case as a cross reference to the current case, including the ability to search for the case to be used as the reference;

bb) view the cross referenced case details when required;

cc) select and comment on the predefined criteria values for each item requested;

dd) provide a free text summary of the decision;

ee) enter general comments for the Confirmation Letter;

ff) view, print, and automatically send the Confirmation Letter(s) by fax or other secure electronic means to the selected recipients with the Provider being the default value;

gg) suppress the sending of Confirmation Letter, when appropriate, when the case is settled.

3.3.6.12 Recommendations

MSE Review Centre (MSERC)

HC Users may choose to send a PA request to the MSERC for recommendation. The recommendation made by MSERC provides more information for an adjudication decision.

3.3.6.12.1 The Contractor must ensure that all PA requests default to PA status = Not for MSERC.

3.3.6.12.2 The Contractor must ensure that HC Users have the ability to:

a) mark a PA request on the PA entry screen as routed to MSERC for review as either regular (status = For MSERC) or urgent (status = For urgent MSERC) or cancelled (status = cancelled);

b) amend the status as required;

c) allow adjudication of a PA with a different decision than the MSERC recommendation decision.

3.3.6.12.3 The Contractor must provide a separate “Recommendation” workflow within the MSE benefit tab.

The Contractor must automatically:

a) pre-populate the recommendation with:

i. Client information based on the Client Details;
ii. PA information;
iii. reviewer’s name and credentials;
iv. today’s date;
v. PA creation date.

3.3.6.12.4 The Contractor must provide HC Users with the ability to provide within the recommendation a:

a) summary of information submitted;

b) reason for request;

c) recommendation decision;

d) recommendation rationale;

e) additional information for Provider;

f) internal notes.

3.3.6.12.5 The Contractor must provide HC Users with the ability to:

a) add (a) new item line(s) in a recommendation to allow for the recommendation of an item different than the item(s) requested;

b) to set a recommendation decision and recommendation rationale on an individual line item on a PA;

c) select a recommendation rationale from a repository of frequently used rationales. Examples of frequently used rationales include, but are not limited to:

i. information meets criteria for the requested item;
ii. frequency violation; or
iii. cost is above NIHB maximum pricing;

d) input or select a recommendation decision.

3.3.6.12.6 The Contractor must provide HC Users with the ability to input a more lengthy recommendation rationale (justification) of up to 9000 characters attached to the relevant PA line item.

3.3.6.12.7 The Contractor must provide HC Users with the ability to include only pertinent information of a document (for example screen shots) into the summary of information, additional information, or internal notes areas.

3.3.6.12.8 The Contractor must provide HC Users with the ability to draft, save prior to completion, print and generate a recommendation document with:

a) Client information based on tombstone data;

b) PA information into the recommendation document;

c) Request data (item number, item name, quantity, and price);

d) Summary of information submitted;

e) Reason for request;

f) Recommendation decision rationale and date;

g) Additional information;

h) Internal notes;

i) Reviewer's name and credentials.

3.3.6.12.9 The Contractor must provide HC Users with the ability to save the recommendation document in the Solution and link to the PA, SA, and case record.

3.3.6.12.10 The Contractor must provide HC Users the ability to change for requests under review at MSERC restrict setting the status of a PA to cancel until the recommendation status is set to "cancelled".

3.3.6.12.11 The Contractor must provide HC Users with the ability to:

a) set recommendation statuses as one of the following (non-exhaustive list):
   i. initial review;
   ii. internal consultant review;
   iii. external consultant review;
   iv. recommendation completed review;
   v. on hold review; or
   vi. cancelled;

b) select recommendation the status on each line item on a PA from the following non exhaustive list:
   i. approve;
   ii. approve as exception;
   iii. conditional approval;
   iv. hold (remind reviewer weekly until Hold is removed);
   v. denied; or
   vi. conditional Approval as exception;

c) save and print the recommendation document before and after the recommendation has been made;

d) restrict a user from canceling a request for review once the review request has gone to the external consultant, with the ability to override as determined by the Project Authority.

3.3.6.12.12 The Contractor must automatically:

a) track the status of a request as well as indicate where a request is in the recommendation process;

b) track the date of a change in status;

c) maintain status change at line level;

d) link recommendation rationale related to a PA line item;

e) maintain recommendation decision on a PA status by each line item, during and after the review.

3.3.6.12.13 The Contractor must provide HC Users with the ability to:

a) search for Claims by Client and by item or item group within a date range;

b) search for PA by Client and by item within a date range;

c) search for Claims by Client and by recommendation#, Last Name, Client ID, or Item Category within a date range;

d) search by Provider for a specific item.

3.3.6.13 Prior Approval Specifics

Contractor must provide HC the ability to record the details for the PA including the ability for the user to validate the details against HC's verification edits.

3.3.6.13.1 The Contractor must provide the HC User with the ability to:

a) enter the details for each item requested including but not limited to:

i. total quantity;
ii. start and end date of authorization period;
iii. if system to use standard pricing and fees or exception pricing/costs and fees (see Appendix C, Article 6 "*Cost Verification edits*" for details on how this indicator is evaluated);
iv. item cost, markup amount, and total dollar amount if exception pricing selected;
v. private or public coordination of benefits (COB);
vi. third party COB amount defined as the balance outstanding after the primary insurer was billed or amount already paid by third party;

b) view calculated total requested dollar amount when exception pricing is selected;

c) use the pricing rules details as the default values as the basis of the approval for each item requested;

d) edit the approval details for each item requested;

e) verify requested item details against all applicable program limits and pricing details including the ability to re-verify the details if information is changed;

f) view warning(s) related to verification edits for each item if the edit is not satisfied;

g) view warning(s) for each item at any point after the warning(s) was provided.

3.3.6.13.2 The Contractor must automatically:

a) validate whether the COB dollar amount is less than or equal to what the HC total dollar amount covered by the NIHB Program would be had the Claim come solely to HC, unless the HC User defines otherwise;

b) reduce the quantity or dollar amounts to NIHB Program limits within the approval details where appropriate;

c) require HC Users to edit request details in specific situations, defined by the Project Authority, prior to completing the request - examples include incomplete or incompatible data;

d) calculate or recalculate requested and total dollar amounts when any value is added or updated.

3.3.6.14 Special Authorization Specifics

The Contractor must provide HC Users with the ability to record the details of a special authorization (SA) including setting details specific to SAs including a prescriber group and item group. The SA is intended to provide the authorization or restriction of an item or item group over any period of time with more flexibility than a PA. As a result, the Contractor must ensure that HC Users have the ability to easily amend information within the SA to meet the needs of the situation.

3.3.6.14.1 The Contractor must provide the HC User with the ability to, if applicable:

a) indicate that the Provider when recorded on the SA must be included within all Claim(s) for the item(s) or item type requested;

b) identify a prescriber, when applicable, and require the HC User to enter both prescriber ID and name for the SA and display the name, city and province, phone and fax numbers, and communication and language preference;

c) view the prescriber details once the prescriber is identified including, but not limited to:

i. prescriber ID;
ii. prescriber name;
iii. clinic name, city, province;
iv. language preference (English or French), communication preference (mail, fax, email);

d) indicate that the prescriber ID when entered on the SA must be included within all Claim(s) when the item(s) requested on the SA are approved;

e) enter or search for an item group or item number for each SA using the item group/item number search workflow (SOW Article 3.3.6.5.1 *Search for an Item type or Item(s)*) with the item group name displayed when the item group is identified through the search;

f) enter or search for an item or item group for each SA using the SOW Article 3.3.6.5 *Searching and Viewing MSE Benefit Items* workflows and the SOW Article 3.3.6.9 *Managing Groups of MSE Items* workflows;

g) enter approval details for each item or item group for the SA including, but not limited to:

i. start and end date of the SA period;
ii. indication that the Client is eligible or not eligible for the item;
iii. Minimum and/or Maximum days' supply; Total Days' Supply allowed;
iv. Minimum and/or Maximum Quantity; Total Quantity allowed;
v. prescriber licence number for this request including the ability to search for the prescriber using the related search workflow;

h) verify requested item details against all applicable program limits and pricing details including the ability to re-verify the details if information is changed;

i) view warning(s) related to verification edits for each item if the edit is not satisfied;

j) view warning(s) for each item at any point after the warning(s) was provided.

3.3.6.14.2 The Contractor must automatically require user to edit request details in specific situations, defined by the Project Authority, prior to completing the request based on verification edits. Examples include incomplete or incompatible data.

3.3.6.15 Transfer a Prior Approval

The Contractor must provide an interface through which a HC User can transfer an entire PA or selected PA lines to another Provider.

3.3.6.15.1 The Contractor must provide the HC User with the ability to:

a) Transfer an entire PA to another Provider and cancel the initial PA, the original PA must be marked as transferred and can no longer be claimed against;

b) Select multiple unclaimed PA lines, and transfer the PA lines, the transferred lines on the original PA must be marked as transferred and can no longer be claimed against. Any remaining lines on the original PA, not transferred, can be claimed against;

c) All notes and reference documents from transferred lines or PA's must also be transferred to the new PA.

3.3.6.16 Manage Automated Post-approvals

3.3.6.16.1 The Contractor must:

a) generate an automated post-approval request when a claim is submitted to the Contractor and it is missing a valid PA number or a frequency maximum has been reached, or other scenarios as defined by the Project Authority;

b) send to HC in an automated pre-populated (Client, Provider, and Claim line details, attachments where applicable) post-approval format and placed in a queue for HC review.

3.3.6.16.2 The Contractor must provide the HC User with the ability to:

a) retrieve and manage the post-approval in accordance with see SOW Article 3.3.6.11 *Managing Requests for PAs, SAs, Appeals;*

b) send the post-approval request back to the Contractor for processing and payment.

3.3.6.17 Case Record History Search

The Contractor must provide HC Users the ability to search for cases using one to many search criteria, to view the results of the search and access the details of the cases within the results.

3.3.6.17.1 The Contractor must provide the HC User with the ability to:

a) search for request case records using, but not limited to, the following elements individually or in combination:

i. Client ID including ability to search for a Client through accessing the Client search (SOW Article 3.3.9.2 *Managing Client Details*);
ii. Provider ID including ability to search for a Provider through accessing the provider search (SOW Article 3.3.9.3 *Searching for a Provider*);
iii. item including ability to search for an item through accessing the item search (SOW Article 3.3.6.5.1 *Search for an Item type or Item(s)*);
iv. item Group ID including ability to search for an item group through accessing the item group search (SOW Article 3.3.6.9 *Managing Groups of MSE Items*);
v. case number, case type (PA, SA, Appeal, Auto Approval);
vi. request type (PA, Client reimbursement);
vii. PA (prior approval) number;
viii. review status, date reviewed, reviewed by;
ix. request status (Approved, Denied), date request status set, request status set by;
x. record status (Filed, Settled, Amended), date record status set, record status set by;
xi. assigned to, date assigned;
xii. benefit status;
xiii. document received date, notification sent date;
xiv. text search of summary and/or comments allowing for search terms used to be in combination;

b) view case record search results including, but not limited to, the following elements:

i. Case number, case type;
ii. Client ID;
iii. Client Consideration (e.g. FNHA, COB, etc.);
iv. item number/item group ID, item name/item group name;
v. PA number;
vi. SA number;
vii. review status and date reviewed;
viii. record status and date record status set;

ix. request status and date request status set;
x. dates such as document received, case reviewed, Provider notified;
xi. assigned to and date;

c) view and edit the case record details (see SOW Article 3.3.6.11 *Managing Requests for Approval*) for the record selected.

3.3.7 Pharmacy Benefit Requirements

3.3.7.1 Pharmacy Item List Maintenance

The Contractor must maintain the list of Pharmacy items ensuring that the list is current and accurate to the information available on the market.

3.3.7.1.1 The Contractor must:

a) add to or update Pharmacy items on a routine and frequent basis as required by the Project Authority including, but not limited to:

i. all items with a Drug Identification Number (DIN) as determined by the Drug Products Database of HC;
ii. over the counter products with a DIN;
iii. natural health products that have an Natural Product Number (NPN) by the Natural Health Products Directorate of HC;
iv. pseudo-DINs(PDIN), which are used for items eligible under the drug benefit program that do not bear DINs issued by HC's Therapeutic Products Directorate (TPD) or require an alternate number by which to bill a pharmacy item - PDINs can be assigned by provincial formularies or by HC;

b) add or update the following information for each item including, but not limited to:

i. item ID defined as the item's DIN, PDIN or NPN;
ii. item name, strength and dosage form;
iii. manufacturer;
iv. chemical name;
v. generic product status;
vi. federal drug schedule;
vii. ATC, AHFS and GPI (or equivalent identifiers) with descriptions;

c) add or update the following information for each item by jurisdiction including, but not limited to:

i. NAPRA, provincial or territorial drug schedule;
ii. Whether the item is on a jurisdiction's formulary, exception within a jurisdiction's formulary or not on a formulary;
iii. effective start and end date related to provincial or territorial formulary status;

d) update and maintain the Unlisted Compound Codes as defined by the current CPHA standard;

e) set the following information when an item is discontinued by the TPD, manufacturer or HC:

i. date the item to be discontinued where the date can be set to a date in the future;
ii. benefit status to discontinued;
iii. benefit status effective date to the discontinued date;

f) set the following values when an item is added to the NIHB pharmacy item list:

i. item coverage review status to Not Reviewed. See SOW Article 3.3.7.5 *Pharmacy Item Coverage Review* for details on the item coverage review status;

ii. benefit status to Not Determined. See SOW Article 3.3.7.6 *Set Benefit Status and Coverage Details* for details on the benefit status;

g) add items or update item details upon request from HC and maintain Projected Authority requested changes to the item with subsequent item updates.

3.3.7.1.2 The Contractor must:

a) provide and maintain a Drug Utilization Review (DUR) that provides, including but not limited to, standard drug interactions and duplicate therapy warnings as Claims are processed and transmits this information to Providers at the point of sale;

b) provide the ability to the HC User to view the drug to drug interactions associated with a given DIN;

c) assess and verify the Pharmacy item details added to or updated are correct and complete through a quality assurance process outlined in the Quality Assurance Program (see SOW Article 3.2 *Quality Assurance*);

d) ensure that HC Users have the ability to view the Unlisted Compound Code list.

3.3.7.1.3 Contracted Service Standard – Pharmacy Items Information Maintenance

The Contractor must ensure that:

a) updates are made on frequent basis to ensure that the Pharmacy items information is current with marketable items and provincial formularies and federal drug schedules, within 10 business days of receiving the updated information from the sources listed in SOW Article 3.3.7.1.1, *Pharmacy Item List Maintenance*;

b) the various information sources advise the Contractor of updates;

c) requests for additions or changes to an item by the Project Authority must be completed within 5 business days.

3.3.7.2 Setting the Pricing for an Item

The Contractor must maintain pricing details of all Pharmacy items ensuring pricing is current and based on information from the provincial and territorial plans or any other agreed upon pricing source.

3.3.7.2.1 The Contractor must:

a) add or update the following values for each item by jurisdiction including, but not limited to:

i. unit price;
ii. Lowest Cost Equivalent (LCE) price, LCE reference DIN, PDIN, NPN, set by the provincial or territorial formulary or HC; and/or
iii. Maximum Allowable Cost for a select group of items;
iv. interchangeability indicator;
v. item package size;
vi. price effective date based on the source of the price, including but not limited to, provincial or territorial formulary, supplier, or NIHB;

b) use provincial and territorial formularies, the McKesson Price file (or similar sources) or wholesaler and, in exceptional cases where the other sources do not provide a unit price, the manufacturer's price or HC defined price is to be applied. Sources of pricing to be defined by the Project Authority upon Contract Award;

c) change the pricing source, parameters or update frequency as requested by the Project Authority;

d) implement interim price changes on HC request as the situation demands - for example, back-order, shortage or other circumstance;

e) notify HC when the item pricing information is updated or when there are any issues with the pricing update, an estimated completion date and when the update is complete;

f) follow up with the provincial or territorial drug plans or wholesalers to obtain pricing updates;

g) request Project Authority approval when required to use the manufacturer's pricing plus customary upcharges;

h) assess and verify the pricing data added is correct through a quality assurance process outlined in the Quality Assurance Program (SOW Article 3.2 *Quality Assurance*).

3.3.7.2.2 Contracted Service Standard – Item Pricing Maintenance:

The Contractor must ensure that:

a) updates to be made to the price files are completed within 10 business days of receiving the updated information from the sources listed in SOW Article 3.3.7.2.1, *Setting the Pricing for an Item*;

b) the various information sources advise the Contractor of the updates;

c) requests for updates by the Project Authority must be completed within 5 business days.

3.3.7.3 Creating and Maintaining the Pricing Schedule

The Contractor must create and maintain Pricing Schedules, pricing categories, and lists of items associated with each distinct pricing category. The Contractor must also ensure that HC Users have the ability to define the rules within each pricing category and pricing schedule.

3.3.7.3.1 Pricing Schedule and Category Setup

The Contractor must:

a) create and maintain Pricing Schedules (pricing schedules have pricing rules for different categories of items) where a Pricing Schedule is defined as a set of distinct pricing rules for a distinct group of items (e.g. the maximum fee for CADs by be different than the maximum fee for OTCs) for a HC defined group of Providers within a jurisdiction (jurisdictions typically are provinces and territories but may also include other arrangements (e.g. if subset of Providers located in a province have a different maximum fee or MU than that of the rest of the Providers in the province);

b) add one or more pricing categories to each Pricing Schedule as required by HC where a pricing category is a set of pricing rules that apply to all items within the pricing category;

c) associate items and/or Unlisted Compound Codes with a pricing category as required by HC based on provincial or territorial drug schedule, item type or other parameter;

d) provide a free text description for the pricing category based on HC input such as the provincial drug schedule or other descriptor;

e) update and maintain the items within each pricing category according to the provincial or territorial drug schedule or HC's direction.

3.3.7.3.2 View and Maintain Pricing Schedule

The Contractor must provide the HC User with the ability to:

a) access, view, edit and save the Pricing Schedule details for a specific jurisdiction;

b) set the Dossette fee (see Appendix C., Article 6.1.4.4 "*Dossette Fee Eligibility edit*") for the Pricing Schedule;

c) set the pricing schedule effective date allowing the date to be a future date without influencing the logic of the pricing schedule currently in effect based on date of service.

3.3.7.3.3 View and Maintain Pricing Categories

The Contractor must provide the HC User with the ability to:

a) view, edit and save the pricing category details for a Pricing Schedule;

b) view the pricing category description;

c) set a pricing category as either Defined Costs (DC) or Actual Acquisition Cost (AAC);

d) select one or more of the following pricing rules for each pricing category including but not limited to:

   i. cost upcharge
   ii. tolerance;
   iii. mark up;
   iv. dispensing fee;
   v. Dossette fee;

e) set the following values with 2 decimal places for each pricing rule including, but not limited to:
   i. indicate that the rule applies to items categorized as either formulary or non-formulary;
   ii. value limit as a percentage or dollar amount;
   iii. limit % mark-up/dispensing fee limits based on allowed item cost on the claim, as a sliding scale;
   iv. a maximum dollar value for the pricing rule;
   v. Claim volume amount, represented as a range, to which the rule applies;
   vi. the order in which the rules may be combined as determined by HC (*For example, an item may have a tolerance allowance of 3% and a mark-up of 7.5%. The mark-up is applied to the combined unit cost and the calculated tolerance amount)*.

f) view the maximum day supply dispensing limit.

3.3.7.3.4 Calculate Claim line volume

The Contractor must calculate, record, and reset as requested by the Project Authority, the paid claim line volume for a Provider to be used in the evaluation of a Claim, in accordance with SOW Article 3.3.7.3.3 (e) (iv) *View and Maintain Pricing Categories*.

3.3.7.3.5 Service Standard

The Contractor must ensure that:

a) creation of the price categories and the pricing schedules are completed within 10 business days of receiving the information from the sources listed in SOW Article 3.3.7.3.1, *Pricing Schedule and Category Setup* (or for more complex changes, on a service standard agreed to by the Project Authority);

b) the various information sources advise the Contractor of updates;

c) requests for additions or changes to a pricing category or pricing schedule by the Project Authority outside the regular update frequencies must be completed within 5 business days.

3.3.7.4 Managing Pharmacy Items

Contractor must provide HC Users with the ability to manage the details for an item that contains the specifics of the item, benefit status, and operational text used in the adjudication process by the Contractor and HC.

3.3.7.4.1 Search for an Item(s)

The Contractor must provide the HC User with the ability to:

a) search for a Pharmacy item using, but not limited to, the following criteria individually or in combination:

   i. item ID;
   ii. item name, strength or dosage form;
   iii. manufacturer;
   iv. chemical name;
   v. ATC, AHFS or GPI (or equivalent identifiers) with descriptions;
   vi. benefit status;
   vii. BEQ
   viii. item coverage review status;
   ix. if item is discontinued or not;

b) view the results of the Pharmacy item search including but not limited to the following data:

   i. item ID;
   ii. item name, strength and dosage form;
   iii. manufacturer;
   iv. chemical name;
   v. ATC, AHFS and GPI (or equivalent identifiers) with descriptions;
   vi. benefit status;
   vii. BEQ
   viii. drug review status with effective date;
   ix. if item is discontinued or not with the end date;

c) access the item details for item selected in the search results;

d) select item for use in a workflow that initiated the search (for example, when processing a request for an item, the user identifies the item using the search capability described);

e) access item details once an item is identified in workflow that initiated the search (for example, once the item has been identified in a workflow, the user is able to access the details to verify information to support their decision or action).

3.3.7.4.2 View, Edit and Save Item Details

The Contractor must provide the HC User with the ability to:

a) view the item details including, but not limited to:

   i. item ID defined as the item's DIN, PDIN or NPN;
   ii. item name, strength and dosage form;
   iii. manufacturer;
   iv. chemical name;
   v. generic product status;
   vi. federal drug schedule;
   vii. ATC, AHFS and GPI (or equivalent identifiers) with descriptions;
   viii. if emergency dispense allowed;

ix. all current Benefit Exception Questionnaires (BEQs) in both official languages including the ability to preview the BEQ;
x. predefined criteria values associated to BEQ selected;
xi. groups to which the item is associated (see SOW Article 3.3.7.9 *Managing Groups of Pharmacy Items*);

b) view the following item details by jurisdiction including, but not limited to:

i. HC benefit status and effective start and end date;
ii. unit price;
iii. Lowest Cost Equivalent (LCE) price set by the provincial or territorial formulary or HC;
iv. LCE reference DIN, PDIN, NPN (where applicable);
v. interchangeability in accordance with provincial or territorial formulary;
vi. item package size;
vii. price effective date based on the source of the price;
viii. NAPRA, provincial or territorial drug schedule for each jurisdiction;
ix. indication if item is on jurisdiction's formulary, exception within jurisdiction's formulary or not on formulary;
x. effective start and end date related to provincial or territorial formulary status;
xi. pricing category;
xii. Frequency Limit description including the ability to access the Frequency Limit;
xiii. Auto Adjudication Query name including the ability to access the query;
xiv. item group reference including ability to access the item group details;

c) calculate the unit and HC LCE price based on a selected Pricing Schedule by applying the appropriate mark ups/tolerances/upcharges even if an item is not on the DBL;

d) view, edit and save the operational directives for the item selected which provide the HC User instructions on the appropriate actions (example: send questionnaire to physician) in processing a request for the item:

i. operational directives may consist of a large amount of text;
ii. Contractor must provide access to the full text of the directives easily and efficiently;

e) set whether an emergency dispense is allowed to be authorized by HC's Drug Exception Centre staff with applicable details;

f) view, edit and save the clinical directives, for the item selected that are distinct and separate from the operational directives, including:

i. clinical directives may include a large amount of text;
ii. item coverage review status and date;
iii. indication related to drug review status;
iv. coverage criteria;
v. clinical information.

3.3.7.4.3 Create and Edit Items

The Contractor must at the Project Authority's request:

a) update the item details including, but not limited to:

i. item ID defined as the item's DIN, PDIN or NPN;
ii. item name, strength, dosage form;
iii. manufacturer;
iv. chemical name;

v. generic product status;
vi. federal drug schedule;
vii. ATC, AHFS and GPI (or equivalent identifiers) with descriptions;

b) update the following item details by jurisdiction including, but not limited to:

i. provincial coverage status and effective start and end date;
ii. unit price;
iii. Lowest Cost Equivalent (LCE) price, LCE reference DIN, PDIN, NPN, which may be set by the provincial or territorial formulary or HC;
iv. interchangeability in accordance with provincial or territorial formulary;
v. item package size;
vi. price effective date based on the source of the price;
vii. NAPRA, provincial or territorial drug schedule for each jurisdiction;
viii. indication if item is on jurisdiction's formulary, exception within jurisdiction's formulary or not on formulary;
ix. effective date related to provincial or territorial formulary status;
x. pricing category;

c) add a new item to the pharmacy item list populating all item details;

d) update the pharmacy item details for a number of items;

e) mark a record to not be updated with a subsequent item update by the Contractor.

3.3.7.4.4 Service Standard

The Contract must:

a) action requests for additions or changes to the item details by the Project Authority within 5 business days;

b) assess and verify on a weekly basis that all Pharmacy item and item details are correct through a quality assurance process outlined in the Quality Assurance Program (SOW Article 3.2 *Quality Assurance*).

3.3.7.4.5 Create and Edit PDIN Items

The Contractor must provide the HC User with the ability to:

a) create, edit and save PDIN details including, but not limited to:

i. item name, strength, dosage form;
ii. manufacturer;
iii. chemical name;

b) enter, edit and save the following item details by jurisdiction including, but not limited to:

i. provincial coverage status and effective start and end date;
ii. unit price;
iii. Lowest Cost Equivalent (LCE) price, LCE reference DIN, PDIN, NPN, which may be set by the provincial or territorial formulary or HC;
iv. interchangeability in accordance with provincial or territorial formulary;
v. item package size;
vi. price effective date based on the source of the price;
vii. indication if item is on jurisdiction's formulary, exception within jurisdiction's formulary or not on formulary;
viii. effective date related to provincial or territorial formulary status;

ix. pricing category;

c) add a new item to the pharmacy item list populating all item details that are available to be edited.

3.3.7.5 Pharmacy Item Coverage Review

Contractor must provide HC Users with the ability to manage the coverage review for all items within the Pharmacy items list allowing the HC User to capture documentation, maintain the item's coverage review record, and send communication to external parties.

3.3.7.5.1 The Contractor must provide the HC User with the ability to:

a) view, edit and save the pharmacy item coverage review status details for each pharmacy item;

b) update the Pharmacy item coverage review status for a number of items using the multiple item update workflow (see Article 3.3.7.12 *Ability to Edit Information for Multiple Pharmacy Items* for details);

c) set or update the item coverage review status using the following values:

i. not reviewed;
ii. under review by external;
iii. under review by HC;
iv. under review for new indication;
v. review completed;

d) manage the predefined list item coverage review status values that can be selected;

e) set the indication(s) associated to the item review status;

f) record comments specific to the coverage review;

g) record dates for the following events:

i. submission received;
ii. management approval;
iii. decision communicated to manufacturer;

h) record the link to the online CADTH or other committee decision for use in online version of the Drug Benefit List;

i) identify an attached document that represents HC decision on item review status for use in online version of the Drug Benefit List;

j) create a letter or other type of document using the workflow in SOW Article 3.3.9.6 *Requesting and Receiving Missing Items or Additional Information*;

k) capture and manage documents attached to record using the workflow in SOW Article 3.3.9.7 *Capturing and Retaining Documents*.

3.3.7.6 Set Benefit Status and Coverage Details

The Contractor must ensure that HC Users have the ability to create and maintain the coverage details for each Pharmacy item by allowing the HC User to set the benefit eligibility, associate BEQs and define other supporting information.

3.3.7.6.1 The Contractor must provide the HC User with the ability to:

a) view, edit and save the coverage details by jurisdiction for each Pharmacy item;

b) set the date for which the coverage details as defined will be in effect for each jurisdiction including a date in the future (see SOW Article 3.3.9.15 *Data Record Management* for details);

c) update the coverage details for a number of items using the multiple item update workflow;

d) set or update the benefit status to one of the following, including, but not limited to:

i. Open Benefit;
ii. Limited Use;
iii. Exception;
iv. Exclusion;
v. Non-Benefit;
vi. Not Determined;
vii. Discontinued;

e) select message returned to Provider if Claim is rejected based on a benefit status from a predefined list;

f) create and manage the predefined list of messages that can be selected (list to be populated by messages supported by CPHA standard by default);

g) set message in addition to the standard message that is tailored to the situation informing the Provider of the limit, amount remaining or other pertinent information based on the data with the Claim;

h) set the following cost limits for the item:

i. maximum value allowed per Claim;
ii. set the Short Term Dispense policy limit according to NIHB guidelines (see Appendix C, Article 4.3.10 "*Short Term Dispense Policy edit*");
iii. indicate whether or not item is eligible under the trial prescription program;
iv. indicate whether or not item is eligible for Dossette dispense fee;
v. indicate whether or not the item is eligible for an alternate pricing category (for example, an over-the-counter (OTC) item is to be paid using the pricing category for control access drugs);

i) limit coverage to a specific age range (minimum and maximum age);

j) limit coverage to a specific sex, where limited to options supported in Client demographic record;

k) select one to many prescriber types from a predefined list defined by the Project Authority that cannot claim the item, based on the prescriber's reference ID;

l) modify the maximum day supply dispensing limit from the default for an individual item (For example, HC only allows a 30-day supply of narcotics per Claim.)

3.3.7.6.2 Other Coverage Details

The Contractor must provide the HC User with the ability to:

a) select an auto adjudication query from predefined list to be applied to one to many benefit items and enforced during claim adjudication (See SOW Article 3.3.7.8 *Managing the Auto Adjudication* for details);

b) select a Frequency Limit defined in a supporting workflow (see SOW Article 3.3.7.7 *Managing a Frequency Limit* for details);

c) set a dose fraction up to 5 decimal places (e.g. 0.00001) and the dose fraction unit of measure (grams, milligrams);

d) set a unit of measure fraction for different forms of the same drug (for example: 1 tablet equals 5ml of liquid of the same drug);

e) view the item group(s) associated with item including the ability to access the item group details (see SOW Article 3.3.7.9 *Managing Groups for Pharmacy Items* for details);

f) attach a minimum of 15 BEQs in both English and French to the item by selecting the BEQs from a predefined list;

g) view BEQ's effective date;

h) ability to preview a BEQ associated to item;

i) view predefined criteria based on the BEQs selected (see SOW Article 3.3.7.11 *Manage Criteria and Benefit Exception Questionnaires (BEQ)* for details);

j) indicate whether or not item is to be included in the online or print version of the Drug Benefit List.

3.3.7.7 Managing a Frequency Limit

Contractor must provide HC Users with the ability to create, and maintain one or more Frequency Limits and apply them to one or multiple Pharmacy items as needed. The Contractor must allow the HC User the ability to define the maximum quantity or dose and time period the maximum is evaluated over, including a specific capability to evaluate different items using an equivalency to ensure the maximum quantity is not exceeded without a Prior Approval (PA).

3.3.7.7.1 The Contractor must provide the HC User with the ability to:

a) search for a Frequency Limit by name or items that have the Frequency Limit associated to it;

b) view the search results list of Frequency Limits including the name, description and effective date;

c) access the Frequency Limits details from the list;

d) view, add, edit and save one or more Frequency Limits per item;

e) set the date for which the Frequency Limit as defined will be in effect for each jurisdiction including a date in the future (see SOW Article 3.3.9.15 *Data Record Management* for details);

f) set the description for the Frequency Limit;

g) set whether the limit is a dose-conversion limit or a Frequency Limit;

h) set the maximum quantity of an item allowed within the period defined when limit is set as a Frequency Limit;

i) set the maximum quantity up to 5 decimal places (e.g. 0.00001) and unit of measure (grams, milligrams) allowed within the period defined when limit is set as a dose-conversion where the item's dose fraction value is multiplied by the quantity claimed to determine if the amount claimed exceeds the limit or the quantity needs to be reduced;

j) set the period of time defined as a number of days, months, or years that the maximum amount is allowed;

k) set the accumulation period of time as either the past or the future (e.g. Duration of the accumulation period is a rolling period that checks the time in claims history, as of the current Date of Service (DOS), to confirm if the quantity on the current DOS exceeds the allowable quantity for the period. Or setting a period in the future using the DOS: Setting the start of a period as the DOS of a paid unreversed claims of a new accumulation period, and setting the end date of the accumulation period as the start date, plus time specified in the frequency limit, plus1day.);

l) set the period of time defined as number of days, months, or years that has to elapse before a claim for the item can be claimed again once the limit has been reached (lock-out)

(For example, levofloxacin has a limit of 11 tablets over a 14 day period. The period starts on the service date of the first claim. Once the 14 days has elapsed, the client is locked out for an additional 14 days before they can claim levofloxacin again).

3.3.7.8 Managing the Auto Adjudication

The Contractor must provide HC Users with an interface with the ability to create and maintain auto adjudication query parameters to be used within the adjudication process. An auto adjudication query allows HC Users to define complex rules (for example prerequisites) that are to be evaluated by the solution when an item is claimed and a specified result occurs (as defined by the Project Authority), with no HC intervention.

3.3.7.8.1 The Contractor must provide the HC User with the ability to:

a) search for an auto adjudication query by name or items referenced within the auto adjudication query;

b) view the search results list of auto adjudication query including the name, description and effective date ;

c) access the auto adjudication query details from the list;

d) view, edit and save the auto adjudication query details through an easy to use and intuitive user interface for users with limited technical skills;

e) create new auto adjudication query providing a name;

f) set the date for which the auto adjudication query as defined will be in effect for each jurisdiction including a date in the future (see SOW Article 3.3.9.15 *Data Record Management* for details);

g) set a description for the auto adjudication query;

h) create a set of criteria, for the item or item group, and the following information individually or in combination as input for the query:

i. Client's relevant claim history;
ii. Client's demographic details;
iii. Provider details;
iv. Provider group;
v. Prescriber details available in Claim;
vi. Prescriber group ID;

i) define specific actions to be executed based on the results of the query. Outcomes available (including POS messaging to Providers) from the query evaluation include but are not limited to:

i. evaluate using a specific Frequency Limit;
ii. approve Claim;
iii. in cases when the Claim doesn't meet the prerequisites, return message to Provider to resubmit the claim for HC review;

j) preview auto adjudication query results are correct using existing HICPS data.

As an example, Clients managing diabetes:

- *with insulin will be allowed 500 test strips per 100 days;*
- *with diabetes medication with a high risk of causing low blood sugar will be allowed 400 test strips per 365 days;*

- *with diabetes medication with a low risk of causing low blood sugar will be allowed 200 test strips per 365 days;*
- *with diet/lifestyle therapy only (no insulin or diabetes medications) will be allowed 200 test strips per 365 days;*

Using the example above, the auto adjudication query criteria could be defined as if the Client's Claim history included insulin then evaluates the Claim using the Frequency Limit specific to allowing 500 test strips per 100 days. If the Client's Claim history included diabetes medication (metformin for example), then evaluate using the appropriate Frequency Limit.

3.3.7.8.2 The Contractor must:

d) verify and validate the auto-adjudication parameters selected by the Project Authority;

e) notify the Project Authority of the verification and validation results;

f) optimize and implement the auto-adjudication query as directed by the Project Authority.

3.3.7.9 Managing Groups of Pharmacy Items

The Contractor must provide the HC User with the ability to create and maintain groups of items where each item within the group shares the eligibility with the others (can be eligible or not eligible). For example, HC currently has a palliative care item group where once a Client has been approved for one of the items within the item group, the HC user will determine if it's appropriate to add the group, all other items in the group are eligible for the Client without adding them to an approval individually.

3.3.7.9.1 The Contractor must provide the HC User with the ability to:

a) search for an item group by name, or items within the item group;

b) view the search results list of item groups including the item group name and effective dates, with history;

c) access the item group details from the search results;

d) view the item group details including, but not limited to, subgroup name, item ID, item name and/or name of the GPI (or equivalent identifier) for items added to an item group, effective date, whether it is active or not;

e) view, set, edit and save the item group details;

f) create a new item group;

g) set the date for which the item group as defined will be in effect for each jurisdiction including a date in the future. See SOW Article 3.3.9.15 *Data Record Management* for details;

h) set and edit a name for the item group;

i) add and remove items and/or GPI (or equivalent identifiers), and/or subgroups;

j) set a description for the item group.

3.3.7.10 Managing the Drug Utilization Edit

The Contractor must create and maintain groups or subgroups of chemical entities for the Drug Utilization edit (see Appendix C, Article 4.3.5 "*Drug Utilization edit")*. This rejection indicates potential overuse/ abuse of specified drug entities. For example:

Use of OAT Therapy for treatment of opioid dependency, and at the same time, use of one or more opioid drug entities:

- Use of three or more different opioid drug entities.
- Use of three or more different benzodiazepine drug entities.
- Use of three or more opioid drug entities, and three or more drug entities and three or more benzodiazepine drug entities.

3.3.7.10.1 The Contractor must:

a) create and maintain groups and sub groups for chemical entities, as directed by the Project Authority, to be used in the edit to support the Drug Utilization Edit defined in Appendix C Article 4.3.5 "*Drug Utilization edit*".

3.3.7.10.2 The Contractor must provide the HC User with the ability to:

a) search for the group(s) by name, or items within the group;

b) view the search results list of groups including the group name and effective dates, with history;

c) access the group details from the search results;

d) view the group details including, but not limited to, subgroup name, item ID, item name and/or name of the GPI (or equivalent identifier) for items added to an group, effective date, whether it is active or not.

3.3.7.11 Manage Criteria and Benefit Exception Questionnaires (BEQ)

The Contractor must provide the HC User with the ability to create, maintain, and run reports on criteria for an item or items, the BEQ form, the published version of the criteria for the online or print version of the Drug Benefit List.

3.3.7.11.1 Search and View

The Contractor must provide the HC User with the ability to:

a) search for criteria details by name, items associated to criteria or both;
b) view the search results list of criteria details including the name in English and French and effective dates;
c) view the full criteria details from the search results including the following:
   i. current BEQs associated for each language;
   ii. BEQ status of public or DEC use only;
   iii. predefined criteria for BEQ;
   iv. Drug Benefit List text.

3.3.7.11.2 Manage Criteria

The Contractor must provide the HC User with the ability to:

a) add a new BEQ record;

b) view, edit and save the criteria details;

c) set a title and description for the criteria;

d) set the date for which the criteria as defined will be in effect including a date in the future (see SOW Article 3.3.9.15 *Data Record Management* for details);

e) access letter template workflow to create, edit, save and select a BEQ(s) to attach to the criteria details (see SOW Article 3.3.9.8 *Maintaining Document Templates*);

f) view the publication status value as either public or DEC use only;

g) add or archive one to many predefined values for each BEQ with no limit to the number;

h) manage predefined values for English and French for all BEQs including:

i. adding or archiving values that can be selected for a specific BEQ;
ii. editing the text for existing values;

i) set the text for criteria to be presented on the print and online Drug Benefit List allowing for characters in English and French;

j) format and set the layout of the DBL text using current word processing software functionality.

3.3.7.12 Ability to Edit Information for Multiple Pharmacy Items

The Contractor must provide the HC User with the ability to update the details for a number of items to facilitate the management of the Pharmacy item list. For example, if the age limit for an item with multiple strengths and forms is updated, HC Users must have the ability to select all strengths and forms of the item to update in a single change.

3.3.7.12.1 The Contractor must provide the HC User with the ability to:

a) search for items to update including the ability to search for an item through accessing the item search (see SOW Article 3.3.7.4.1 *Search for an Item(s)* for details);

b) view results provided through item search;

c) select one to many items to be updated;

d) edit and save the values specific to the information details for all items selected.

3.3.7.12.2 The Contractor must automatically:

a) display list of items being updated;

b) display a warning on save that the items selected will be updated.

3.3.7.13 Managing a Pharmacy Provider Group

The Contractor must provide HC Users with the ability to create and maintain groups of Pharmacy benefit Providers that can be used in various workflows.

3.3.7.13.1 The Contractor must provide the HC User with the ability to:

a) search for a Pharmacy benefit Provider Group by:

i. Provider Group ID;
ii. Provider Group name;
iii. individual Provider ID associated to a group;
iv. individual Provider name associated to a group;

b) view search results, including:

i. Provider Group ID;
ii. Provider Group name;

c) access the Provider Group details for the record selected from the search results;

d) view the following details for each Provider:

i. Provider ID, business name;
ii. Province or Territory;
iii. phone and fax numbers;
iv. communication preference;
v. enrolment start and end dates;

e) create a new provider group with a unique Provider Group ID;

f) record the Provider Group name that is unique;

g) add one or more Providers to a group or remove one or more from a group;

h) search for Providers using the Provider search workflow (see SOW Article 3.3.9.3 *Searching for a Provider* for details).

3.3.7.14 Managing Requests for PAs, SAs, Appeals

The Contractor must provide HC Users with the ability to create requests for specific type of cases. Included in every request is the Client, Provider and item information, the ability to send and receive supporting documentation such as a BEQ and record the decision.

3.3.7.14.1 The Contractor must provide the HC User the following abilities for each case type:

a) create, edit, view and save a Prior Approval case including the PA case specifics outlined in SOW Article 3.3.7.15 *Prior Approval Specifics* and automatically generate a unique case record ID for the PA;

b) create, edit, view and save a Special Authorization case including the SA case specifics outlined in SOW Article 3.3.7.16 *Special Authorization Request Specifics* and automatically generate a unique case record ID for the request;

c) create, edit, view and save an Appeal case including the Appeal specifics outlined in SOW Article 3.3.9.16.3 *Appeal Process for Pharmacy and MSE Benefits*);

d) enter the reason for the case type using the following, but not limited to, items:
i. Prior Approval;
ii. emergency dispense;
iii. Post-Approval;
iv. prescriber initiated;
v. Client reimbursement;
vi. Appeal;

e) search for the Client and automatically populate the Client details;

f) view full Client details, when required;

g) search for the Provider and automatically populate the Provider details;

h) view the full Provider details, when required;

i) enter Prescriber details in the case including but not limited to:

i. prescriber licence number, prescriber name;
ii. prescriber phone number, fax number;
iii. language preference (HC User to be prompted if not set);

j) verify both the Provider and the Client eligibility against the start date of the case and issue a warning if there is a conflict, but allow the HC User to override;

k) enter up to 3 item IDs or search for each item requested and populate the case with the item details;

l) add as many additional item IDs as necessary;

m) capture claim line designation(s) (e.g. Jordan's Principle) as determined by the Project Authority;

n) view the item details specific to the jurisdiction identified while maintaining their view of the request. Information to be displayed includes, but not limited to:

   i. operational directives, dose fraction, emergency dispense allowed, Frequency Limit, short term dispense policy, interchangeability, Dossette eligibility, and other policy driven details;

o) enter comments specific to each item requested;

p) set the case status to:
   i. filed;
   ii. settled;
   iii. amended;
   iv. denied; or
   v. canceled;

q) enter comments for the case;

r) select and send to the prescriber one or more BEQs specific to an item within request by fax or other secure electronic means;

s) create a letter or other type of document using the workflow in SOW Article 3.3.9.6 *Requesting and Receiving Missing Items or Additional Information*;

t) manage documents attached to the record using the workflow in SOW Article 3.3.9.7 *Capturing and Retaining Documents*;

u) indicate the case was reviewed;

v) enter a Pharmacist Specific Review (clinical recommendation) when required (see SOW Article 3.3.7.14.2 *Pharmacist Specific Review* for details);

w) set or update the request status for each item using one, but not limited to, of the following statuses:

   i. approved;
   ii. approved on history; or
   iii. denied;

x) generate and display a unique authorization number;

y) enter a case record ID of an existing case as a cross reference to the current case, including the ability to search for the case to be used as the reference;

z) view the cross referenced case details when required;

aa) select and comment on the predefined criteria values for each item requested;

bb) provide a free text summary of the decision;

cc) enter general comments for the Confirmation Letter;

dd) view, print, and automatically send the Confirmation Letter(s) by fax or other secure electronic means to the selected recipients with the Provider being the default value;

ee) suppress the sending of Confirmation Letter, when appropriate, when the case is settled;

ff) cancel cases when appropriate, and send cancellation notification to a recipient(s) (default being the initiator of the request (e.g. Provider and/or Prescriber).

3.3.7.14.2 Pharmacist Specific Review (Clinical Recommendation)

Each case type is subject to pharmacist's review. Where required, the clinical recommendation is linked to each case and provides the clinical rational for the coverage decision.

3.3.7.14.2.1 The Contractor must provide the HC User with the ability to:

a) set the reason for review using, but not limited to, the following values individually or in combination:
   i. due for review;
   ii. hit frequency limit maximum;
   iii. dose increase;
   iv. post tapering letter;
   v. other prompts for reassessment; or
   vi. initial request;
b) enter, using free text, the requested drug, dose, frequency;
c) enter the daily equivalent dose values and unit of measure for drugs of concern as defined by the Project Authority;
d) view the requested drug, dose, frequency and daily equivalent dose values from cross referenced previous case;
e) enter the decision, rationale for the decision and next steps separately using free text;
f) enter comments;
g) agree to a pharmacist attestation statement;
h) indicate the case is for a Client on a Special Program (see SOW Article 3.3.7.20 *Display Clients on a Special Program*)
i) indicate the case is of special interest (see SOW Article 3.3.9.2.1(g)(xvi) *Managing Client Details*;
j) set case for review in the work queue using a predefined interval as required by the Project Authority (see SOW Article 3.3.7.18.1(a)(iii) *Work Queue)*;
k) print the clinical recommendation
l) view and edit clinical note information in accordance with SOW Article 3.3.9.2.1(g) *Managing Client Details* for each recommendation.

3.3.7.14.2.2 The Contractor must automatically:

a) calculate and set the approval type for cases specified by the Project Authority based on the information recorded within the request (Examples are the request being approved as requested, approved with changes, approved as an exception and approved as frequency exception).

3.3.7.15 Prior Approval Specifics

Contractor must provide HC the ability to record the details for the PA including the ability for the user to validate the details against HC's verification edits.

3.3.7.15.1 The Contractor must provide the HC User with the ability to:

a) enter the details for each item requested including but not limited to:
   i. total quantity;
   ii. number of refills;

iii. start and end date of authorization period;
iv. indication that No Substitutions requested;
v. if system to use standard pricing and fees or exception pricing/costs and fees (see Appendix C, Article 6 *Cost Verification Edits*) for details on how this indicator is evaluated;
vi. item cost, markup amount, dispense fee and total dollar amount if exception pricing selected;
vii. private or public coordination of benefits (COB);
viii. third party COB amount defined as the balance outstanding after the primary insurer was billed or amount already paid by third party;

b) view and update as necessary the solution calculated total requested dollar amount when HC User defines pricing;

c) use the pricing rules details as the default values as the basis of the approval for each item requested;

d) edit the approval details for each item requested;

e) verify requested item details against all applicable program limits and pricing details including the ability to re-verify the details if information is changed;

f) view warning(s) related to verification edits for each item if the edit is not satisfied;

g) view warning(s) for each item at any point after the warning(s) was provided.

3.3.7.15.2 The Contractor must automatically:

a) validate whether the COB dollar amount is less than or equal to what the HC total dollar amount covered by the NIHB Program would be had the Claim come solely to HC, unless the HC User defines otherwise;

b) reduce the quantity or dollar amounts to NIHB Program limits within the approval details where appropriate, with the ability for an HC User to override;

c) require user to edit request details in specific situations, defined by the Project Authority, prior to completing the request - examples include incomplete or incompatible data;

d) calculate or recalculate requested and total dollar amounts when any value is added or updated.

3.3.7.16 Special Authorization Request Specifics

The Contractor must provide HC Users with the ability to record the details of a special authorization (SA) including setting details specific to SAs including a prescriber group, Provider group, and item group. The SA is intended to provide the authorization or restriction of an item or item group over any period of time with more flexibility than a PA. As a result, the Contractor must ensure that HC Users have the ability to easily amend information within the SA to meet the needs of the situation. As an example of an amendment, the prescriber identified when the SA is initiated could be away requiring a new prescriber be identified for a client enrolled in the PMP program.

3.3.7.16.1 The Contractor must provide the HC User with the ability to, if applicable:

a) indicate that the Provider (or Provider within a Provider Group) when recorded on the SA must be included within all Claim(s) for the item(s) requested;
b) identify a prescriber or prescriber group and require the HC User to enter both prescriber ID and name for the SA through the workflow in SOW Article 3.3.7.19 *Managing a Prescriber Group* and display the name, city and province, phone and fax numbers, and communication and language preference;

c) view the prescriber group details once the prescriber group is identified including, but not limited to:
   i. prescriber group ID;
   ii. prescriber group name;
   iii. clinic name, city, province;
   iv. language preference (English or French), communication preference (mail, fax, email);

d) display prescriber group record once a group is identified;

e) indicate that the prescriber ID or prescriber ID within a prescriber group when entered on the SA must be included within all Claim(s) when the item(s) requested on the SA are approved;

f) enter or search for an item group or item number for each SA or SA line using the item group/item number search workflow (SOW Article 3.3.7.4.1 *Search for an Item(s)*) with the item group name displayed when the item group is identified through the search;

g) enter or search for an item or item group for each SA using the workflows SOW Article 3.3.7.4 *Managing Pharmacy Items* and SOW Article 3.3.7.9 *Managing Groups of Pharmacy Items*;

h) enter approval details for each item or item group for the SA including, but not limited to:
   i. start and end date of the SA period;
   ii. indication that the Client is eligible or not eligible for the item;
   iii. Minimum and/or Maximum days' supply per dispense; Total Days' Supply allowed;
   iv. Minimum and/or Maximum Quantity per dispense; Total Quantity allowed;
   v. if No Substitutions are Allowed;
   vi. prescriber licence number of prescriber group ID for this request including the ability to search for the prescriber group using the related search workflow and access to the prescriber group once identified (SOW Article 3.3.7.19 *Managing a Prescriber Group*);

i) view current daily dose limits for each of the drugs of concern that has a dose equivalent value (opioids, benzodiazepines, stimulants, gabapentin and others that may be identified);

j) override the maximum dose equivalent frequency or quantity limit for any item with a quantity or dose limit (e.g. Opioids, benzodiazepines) for a specific Client via the SA specifics, overriding the previous limit set be it the default HC limit or previous user defined value, (For example: A Client who is currently on a dose above the default limit, the HC User must have the ability to establish an MEQ "client specific" limit);

k) verify requested item details against all applicable program limits and pricing details including the ability to re-verify the details if information is changed;

l) view warning(s) related to verification edits for each item if the edit is not satisfied;

m) view warning(s) for each item at any point after the warning(s) was provided.

3.3.7.16.2 The Contractor must automatically:

a) require user to edit request details in specific situations, defined by the Project Authority, prior to completing the request based on verification edits. Examples include incomplete or incompatible data.

3.3.7.17 Case Record History Search

The Contractor must provide HC Users the ability to search for cases using one to many search criteria, to view the results of the search, and access the details of the cases within the results.

3.3.7.17.1 The Contractor must provide the HC User with the ability to:

a) search for request case records using, but not limited to, the following elements individually or in combination:
   i. Client ID including ability to search for a Client through accessing the Client search in SOW Article 3.3.9.1 *Searching for a Client*;
   ii. Provider ID including ability to search for a Provider through accessing the Provider search in SOW Article 3.3.9.3 *Searching for a Provider*;
   iii. item including ability to search for an item through accessing the item search (SOW Article 3.3.7.4.1 *Search for an Item(s)*);
   iv. item Group ID including ability to search for an item group through accessing the item group search (SOW Article 3.3.7.9 *Managing Groups of Pharmacy Items*);
   v. case number, case type (PA, SA, Appeal, Auto Approval);
   vi. request type (PA, Client reimbursement, Emergency Dispense, Appeal, etc.);
   vii. PA (prior approval) number;
   viii. review status, date reviewed, reviewed by;
   ix. request status (Approved, Denied), date request status set, request status set by;
   x. record status (Filed, Settled, Amended), date record status set, record status set by;
   xi. assigned to, date assigned;
   xii. benefit status;
   xiii. marked as a special interest case (see SOW Article 3.3.9.2(g)(xvi) *Managing Client Details*);
   xiv. document received date, notification sent date;
   xv. text search of summary and/or comments allowing for search terms used to be in combination;

b) view case record search results including, but not limited to, the following elements:
   i. Case number, case type;
   ii. Client ID;
   iii. Client Consideration (e.g. FNHA, PMP, COB, etc.);
   iv. item number/item group ID, item name/item group name;
   v. PA number;
   vi. SA number;
   vii. review status and date reviewed;
   viii. record status and date record status set;
   ix. request status and date request status set;
   x. dates such as document received, case reviewed, Provider notified;
   xi. assigned to and date;
   xii. special Interest status;

c) view and edit the case record details (see SOW Article 3.3.7.14 *Managing Requests for PAs, SAs, Appeals*) for the record selected.

3.3.7.18 Work Queue

The Contractor must provide HC Users with the ability to manage cases through a work queue allowing cases to be assigned to HC analysts for their review and completion.

3.3.7.18.1 The Contractor must automatically:

a) populate the work queue using, but not limited to, the following elements individually or in combination:
   i. cases where a document has been associated within a time frame defined by the Project Authority associated to the case either manually or automatically;
   ii. cases where the review required flag has been set either manually or automatically;
   iii. cases where the date for review assigned within specific workflows has been reached - for example, where a user has marked a record to be reviewed in 3 months using the date this was recorded as the start of the period;

b) default sort results in an ascending order to display oldest at the top, with the ability to filter as necessary.

3.3.7.18.2 The Contractor must provide the HC User with the ability to:

a) filter the work queue using, but not limited to, the following elements individually or in combination:
   i. document received date;
   i. review status, date reviewed, reviewed by;
   ii. record status (Filed, Settled, Amended), date record status set, record status set by
   iii. assigned to, date assigned;
   iv. item including ability to search for an item through accessing the *Managing Pharmacy Items* search workflows (see SOW Article 3.3.7.4.1 *Search for an Item(s)*);
   v. benefit status;
b) view list of cases within the work queue including but not limited the following elements for each record:
   i. case number, case type;
   ii. Client ID, Client's special consideration;
   iii. Provider ID;
   iv. item ID / Item Group ID, item name / item group name;
   v. approval number, record status and date status set ;
   vi. request status and date, Review Status;
   vii. dates such as document received, case reviewed, provider notified;
   viii. assigned to and date;
   ix. special interest status;
c) assign a case to be reviewed by a particular group, role or user defined by the Project Authority;
d) refresh search results without having to re-enter search criteria;
e) view and or edit case details from search results;
f) view, edit, save to case with option to print Clinical Recommendation template for records selected see SOW Article 3.3.7.14.2 *Pharmacist Specific Review*).

3.3.7.19 Managing a Prescriber Group

The Contractor must allow HC Users to manage groups of prescribers to be used within the claims adjudication process whereby all prescribers ID's within a prescriber group are interchangeable on Claims when a specific prescriber ID is entered, for example when a client is restricted through the PMP.

3.3.7.19.1 The Contractor must provide the HC User with the ability to:

a) search for a prescriber group by:
   i. group ID;
   ii. group name;
   iii. professional licence number within a group;
   iv. prescriber's name within a group;
b) view search results, including:
   i. prescriber group ID;
   ii. prescriber group name;
   iii. clinic name, city, province;
c) access the prescriber group details for the record selected from the search results;
d) create, edit, view and save prescriber group details;

e) record a unique prescriber group name;
f) record the clinic name, city, province, phone and fax numbers, language preference (English or French), communication preference (mail, fax, email);
g) add one to many prescribers to the group including their surname and given name, professional licence number and the province or territory to which the professional licence number applies, prescriber ID reference. Professional licence number is required for each prescriber listed;
h) remove prescribers from an existing group;
i) access and view all prescriber group change history for the prescriber group selected.

3.3.7.19.2 The Contractor must automatically:

a) generate and display a unique prescriber group ID validating that the prescriber group does not already exist.

3.3.7.20 Display Clients on a Special Program

The Contractor must allow HC Users the ability to manage Clients on a Special Program related to a condition or risk. The Contractor must support HC in documenting the Client's enrolment and activation of the authorization of the item or item groups or restriction from accessing certain items or item groups to be used in the adjudication process.

3.3.7.20.1 Managing Special Programs

The Contractor must provide the HC User with the ability to:

a) capture the Client's special program record within client details;
b) view the Client's demographic information including surname, given name, alias surname, alias given name, date of birth, gender, Client ID while managing the special program record;
c) restrict access to the special program record to users with a specific role or permission;
d) create, view, edit, save the special program record;
e) select a special program as defined by HC, including but not limited to:
    i. PMP;
    ii. palliative;
    iii. renal;
f) record the date of the review;
g) record the Client's enrolment status specific to a special program as required by HC ;
h) select items and/or item groups that the Client will either be restricted to claim for and/or allowed to claim for including the ability to search based on the item or item group workflow (SOW Article 3.3.7.4 *Managing Pharmacy Items* and SOW Article 3.3.7.9 *Managing Groups of Pharmacy Items*) (All claims for the item or within the item group identified in special interest record to be treated in the same manner as a SA for the item or item group);
i) view the items and/or item groups restricted or allowed for the Client;
j) indicate if the item group or item is allowed or restricted;
k) reset the Client enrolment status effectively removing any item or item group from their profile for each individual item or item group and retain history;
l) create a letter or other type of document using the workflow in SOW Article 3.3.9.6 *Requesting and Receiving Missing Items or Additional Information*;
m) manage documents attached to record using the workflow in SOW Article 3.3.9.7 *Capturing and Retaining Documents*.

3.3.7.20.2 Prescription Monitoring Program (PMP)

The Contractor must provide the HC User the following abilities when managing Clients enrolled in the Prescription Monitoring Program (PMP) to:

a) record reason for entry when enrolling Client in PMP including, but not limited to:
   i. Methadone;
   ii. Suboxone;
   iii. Kadian;
   iv. risk score;
   v. special case;
   vi. other, see comments;

b) record the province where the Provider of the service is located;

c) record the authorizing prescriber, prescriber group or Provider including the ability to select prescriber group or Provider through accessing the associated search workflow as needed;

d) record the date of the authorization;

e) remove an authorizing professional and record the date;

f) view history of authorizing professional and the start and end dates of their authorization.

3.3.7.21 Online Drug Benefit List

3.3.7.21.1 Provision of an Online Drug Benefit List

The Contractor must host, populate and maintain a public facing online drug benefit list in French and English Online Drug Benefit List (Online DBL). The List must be updated on a frequent and routine basis with changes made to Pharmacy items.

3.3.7.21.1.1 The Contractor must:

a) make accessible all items marked as on the HC formulary including the details for each item as required herewith in;

b) make accessible the benefit status and related coverage details in effect and not details that have a future effective date;

c) make accessible a PDF version of the BEQs marked public;

d) produce a printable version of the DBL content current to the date when it is printed – the format of printed version to be defined by the Project Authority at Contract Award;

e) produce an exportable version of the DBL content to a to a file format required by the Project Authority current to the date when it is exported. The format of exported version to be defined by the Project Authority at Contract Award.

3.3.7.21.2 The Contractor must provide the HC User with the ability to:

a) access the searchable Drug Benefit List from publically accessible Website;

b) view static information regarding overall program and policies;

c) print the entire DBL and the availability of this option should be obvious to the Users;

d) export the entire DBL to a file format required by the Project Authority;

e) access and view PDF version of the BEQ(s) when viewing the details of a drug;

f) search by the following criteria individually or in combination:

i. DIN/NPN/PDIN;
ii. item name, strength and dosage form;
iii. chemical name;
iv. AHFS class;
v. manufacturer;
vi. Benefit Coverage Status;
vii. Pharmacy Item Review Status;

g) view the Pharmacy Item Review Status search results with the following information:

i. DIN/NPN/PDIN;
ii. item name, strength and dosage form;
iii. chemical name;
iv. AHFS class;
v. manufacturer;
vi. Benefit Coverage Status;

h) view single pharmacy item details with the following information:

i. DIN/NPN/PDIN;
ii. item name, strength and dosage form;
iii. chemical name;
iv. AHFS class;
v. manufacturer
vi. Benefit Coverage Status;
vii. Pharmacy Item Review Status and Access Drug Review Status details;
viii. Limited Use Criteria;
ix. associated BEQ form;

i) view list of all BEQs in a single list;

j) view drug review status including, but not limited to:

i. HC Benefit Status;
ii. associated indication;
iii. date added/removed;
iv. reason for action;
v. link to CADTH decision;
vi. ability to view DTAC and/or expert committees decision.

3.3.7.21.3 Service Standard – Online Drug Benefit List:

The Contractor must:

a) ensure content of the Online Drug Benefit List is current within 5 business days of the pharmacy item list used by HC Users;

b) notify the Project Authority within 1 business day when there is an issue with the Online Drug Benefit List Website and when the issue has been resolved;

c) meet the Website standards outlined in SOW Article 3.3.3.1 *HICPS Website*.

3.3.8 Vision Care Benefit Requirements

3.3.8.1 Vision Care Item Maintenance

The Contractor must maintain the list of Vision Care Benefit items. The NIHB Vision Care Benefit policies determine the items that make up the list, including but not limited to, eye exams, dispensing services, repair services, eyewear products, and tints, and coatings.

3.3.8.1.1 The Contractor must create an item list with the:

a) alphanumeric or numeric item code;

b) item name in English and French;

c) item start Date and End Date;

d) Vision Care Provider Speciality;

e) additional fields as provided by the Project Authority at Contract Award.

3.3.8.1.2 Contracted Service Standard

a) requests for additions or changes to an item by the Project Authority must be completed within 10 business days.

3.3.8.2 Setting and Updating Price File for Vision Care Benefit Items

The Contractor must maintain the Price File for Vision Care benefit items as directed by the Project Authority.

3.3.8.2.1 The Contractor must:

a) add or update the following values for each item by jurisdiction including, but not limited to:
   i. Unit price defined as the maximum amount NIHB will allow for the item;
   ii. Price effective date.

3.3.8.2.2 Service Standard

a) requests for additions or changes to an item by the Project Authority must be completed within 10 business days.

3.3.8.3 Creating and Maintaining the Pricing Schedule

The Contractor must create and maintain pricing schedules, pricing categories and lists of items associated with each distinct pricing category. The Contractor must also provide HC users with the ability to define the rules within each pricing category.

3.3.8.3.1 Pricing Schedule and Category Setup

The Contractor must:

a) create and maintain pricing schedules where a pricing schedule is defined as a collection of pricing categories for a HC defined group of providers within a jurisdiction (Jurisdictions typically are provinces and territories but may also include other arrangements);

b) add one or more pricing category to each pricing schedule as required by the Project Authority where a pricing category is a set of pricing rules that apply to all items associated with the pricing category;

c) assign a free text description for the pricing category based on Project Authority approval;

d) update and maintain the items within each pricing category according to the Project Authority's direction;

e) update the pricing schedule according to a rate specified by the Project Authority e.g. Consumer Price Index.

3.3.8.3.2 View the Pricing Schedule and Pricing Categories

The Contractor must provide the HC User with the ability to view the:

a) pricing schedule details for a specific jurisdiction;

b) pricing schedule effective date.

c) pricing category details for a Pricing Schedule;

d) pricing category description;

e) pricing category as either Defined Costs (DC) or Actual Acquisition Cost (AAC);

f) pricing rules for each pricing category including but not limited to:

i. cost upcharge;
ii. tolerance;
iii. mark up;
iv. Manufacturers' Suggested Retail Price (MSRP) minus a % discount;
v. Professional fee;

g) following values:

i. value limit as a percentage or dollar amount;
ii. limit % mark-up based on allowed item cost on the claim, as a sliding scale;
iii. a maximum dollar value for the pricing rule;
iv. the order in which the rules may be combined as determined by HC (For example, an item may have a tolerance allowance of 3% and a mark-up of 7.5%. The mark up is applied to the combined unit cost and the calculated tolerance amount).

3.3.8.3.3 Service Standards

The Contractor must respond to Project Authority requests for updates to the pricing category or pricing category name within 10 business days.

3.3.8.4 Set Benefit Status and Coverage Details

The Contractor must create and maintain the coverage details for each Vision Care item by setting the benefit status, setting specific limits, relating a specific Frequency Limit, or defining other supporting information as directed by the Project Authority.

3.3.8.4.1 The Contractor must:

a) add the coverage details;

b) set and amend the effective date;

c) set and amend the end date;

d) set and amend the benefit status to, including but not limited to the following:

i. Direct billing;
ii. Requires PA;
iii. Exception;
iv. Exclusion;

e) limit coverage to a specific age range (minimum and maximum age);

f) set Frequency limits;

g) set the Provincial Plan Min/Max age;

h) set if Provincial Plan COB required;

i) set Left eye, right eye, both

j) set a Diopter calculator (cylinder, sphere, prism, add value, etc.);

k) set the Age Predetermination if required;

l) set the NIHB Program Verification Edit reference/description;

m) set other policy related values as required (see Appendix C, Article 4 "*Benefit Verification Edits*").

3.3.8.5 Searching and Viewing the Vision Care benefit Item

Contractor must provide HC Users with the ability search and view the details for an item that contains the specifics of the item, related pricing rules, benefit status, and operational directives.

3.3.8.5.1 Search for an Item(s)

The Contractor must provide the HC User with the ability to:

a) search for and view the Vision Care Benefit item using, but not limited to, the following criteria individually or in combination:

i. Jurisdiction;
ii. Item Code;
iii. Effective Date;
iv. All active items;
v. All end-dated items;
vi. Vision Care Specialty;
vii. Item Name;

b) view the full details for item selected in the search results;

c) select item for use in a workflow that initiated the search (for example, when processing a request for an item, the user identifies the item using the search capability described);

d) view the full details once an item is identified in workflow that initiated the search (for example, once the item has been identified in a workflow, the user is able to access the details to verify information to support their decision or action).

3.3.8.5.2 View the Item Details

The Contractor must provide the HC User with the ability to:

a) view the item details, where applicable including, but not limited to:

i. item ID;
ii. item name;
iii. manufacturer;
iv. item specialty;

b) view the following item details by jurisdiction including, but not limited to:

i. HC benefit status and effective start and end date;
ii. Professional Fee
iii. MSRP;
iv. unit price;
v. Lowest Cost Equivalent (LCE) price;
vi. price effective date;
vii. pricing category;

viii. Frequency Limit description including the ability to view the Frequency Limit details;

c) view, edit and save the operational directives for the item selected which provide the HC User instructions on the appropriate actions in processing a request for the item:

i. operational directives (may consist of a large amount of text);
ii. allow HC user to upload or update documents related to the item;

d) view, edit and save the operational directive fields including, but not limited to:

i. description;
ii. administrative procedures;
iii. exception criteria;
iv. rationale for de-listing;
v. special considerations.

3.3.8.5.3 Service Standard

The Contractor must respond to Project Authority requests for updates to the item details within 10 business days.

3.3.8.6 Managing a Frequency Limit

The Contractor must maintain Frequency Limits as directed by the Project Authority and apply them to one or multiple Vision Care items as needed. The Contractor must update the maximum quantity and time period the maximum is evaluated over to ensure the maximum quantity is not exceeded without a Prior Approval (PA).

3.3.8.6.1 The Contractor must provide the HC User with the ability to:

a) search for a Frequency Limit by name or items that have the Frequency Limit associated to it;

b) view the search results list of Frequency Limits including the name, description and effective date;

c) view the full Frequency Limits details for the Frequency Limit selected in the search results;

d) view the description for the Frequency Limit;

e) view the maximum quantity of an item allowed within the period defined when limit is set as a Frequency Limit;

f) view the period of time defined as a number of days, months, or years that the maximum amount is allowed.

3.3.8.7 Managing the Auto Adjudication

The Contractor must provide HC Users with an interface with the ability to create and maintain auto adjudication query parameters to be used within the adjudication process. An auto adjudication query allows HC Users to define complex rules (for example prerequisites) that are to be evaluated by the solution when an item is claimed and a specified result occurs (as defined by the Project Authority), with no HC User intervention.

3.3.8.7.1 The Contractor must provide the HC User with the ability to:

a) search for an auto adjudication query by name or items referenced within the auto adjudication query;

b) view the search results list of auto adjudication query including the name, description and effective date;

c) access the auto adjudication query details from the list;

d) view, edit and save the auto adjudication query details through an easy to use and intuitive user interface for users with limited technical skills;

e) create a new auto adjudication query providing a name;

f) set the date for which the auto adjudication query as defined will be in effect for each jurisdiction including a date in the future (see SOW Article 3.3.9.15 *Data Record Management* for details);

g) set a description for the auto adjudication query;

h) create a set of criteria, for the item or item group, and the following information individually or in combination as input for the query:

i. Client's relevant claim history;
ii. Client's demographic details;
iii. Provider details;
iv. Provider group;
v. Prescriber details available in Claim;
vi. Prescriber group ID;

i) Define specific actions to be executed based on the results of the query. Outcomes available (including POS messaging to Providers) from the query evaluation include but are not limited to:

i. evaluate using a specific Frequency Limit;
ii. approve Claim;
iii. in cases when the claim doesn't meet the prerequisites, return message to Provider to resubmit for PA;
iv. reject the Claim;

j) preview auto adjudication query results are correct using existing HICPS data.

3.3.8.7.2 The Contractor must:

a) verify and validate the auto-adjudication parameters selected by the Project Authority;

b) notify the Project Authority of the verification and validation results;

c) optimize and implement the auto-adjudication query as directed by the Project Authority.

3.3.8.8 Managing Prior Approvals, Post Approvals, Automated Post-Approvals

3.3.8.8.1 Manage Prior Approvals

The Contractor must provide an interface through which a HC User can enter and update a Prior Approval (PA), capture supporting items, record decision(s) and communicate the outcome.

3.3.8.8.1.1 The Contractor must provide the HC User with the ability to:

a) search for a Client and create a PA from the Client Screen with the client details populated automatically;

b) display and search a Client's existing PAs;

c) enter Provider details or search for a Provider with the selected Provider details populated automatically;

d) enter start and end dates for the PA;

e) automatically verify both the Provider and the Client eligibility against the start date of the PA;

f) amend the end date, if applicable;

g) select and unselect the recipients of the PA Confirmation Letter;

h) add, edit, and delete PA lines for a maximum of 30 lines per PA;

i) capture claim line designation(s) (e.g. Jordan's Principle) as determined by the Project Authority;

j) automatically generate a unique PA alphanumeric number;

k) edit the PA number, if required and HICPS must validate that the new number is unique;

l) amend a PA line that has not been claimed against;

m) Create, Update, File, Settle, Amend, Cancel, Transfer, Delete a PA;

n) populate the PA result, where applicable, to the Client's CR record (see SOW Article 3.3.9.12 *Client Reimbursements*) and populate the claim lines with the PA number where appropriate;

o) view a Mandatory Information List of required documents to support the items entered in the PA lines (see SOW Article 3.3.9.5 *Verifying Mandatory Information*);

p) mark items as being present or missing;

q) request the missing items from the Provider or Client using a generated Missing Information Letter (see SOW Article 3.3.9.6 *Requesting and Receiving Missing Items or Additional Information*);

r) attach, remove, rename, and delete documents and associate it with the entire PA or PA line(s) (see SOW Article 3.3.9.7 *Capturing and Retaining Documents*);

s) adjudicate the PA against NIHB Adjudication Edits with the results reflected against each PA line;

t) override adjudication result and adjust approved amounts according to policy, and capture in the Internal Notepad in the PA, the reason for the adjudication error and the override action;

u) override, accept or hold a decision on each PA line, such that the PA may show a mixture of approved, denied or on hold (pending) decisions;

v) automatically generate Confirmation Letter messages based on the PA line result – the adjudication error and the override action;

w) view generated Confirmation Letter messages in the General Notepad for review and modification if necessary;

x) automatically record the User ID and the timestamp for Adjudication;

y) update the Client Notepad, General Notepad, and Internal Notepad;

z) view, print, and send the PA Confirmation Letter(s) to the selected recipients;

aa) save PA Confirmation Letter(s) to the PA, with the ability view and print;

bb) send, print, suppress or re-send a PA Confirmation Letter to the Provider or the Client;

cc) view:

i. General, Internal and Client Notepads
ii. Frequency History
iii. Claims History
iv. PA Documents
v. the PA or individual PA lines were transferred to (or from)
vi. PA Confirmation Letter(s)
vii. the PA Confirmation Letter(s) distribution outcome showing sent by method, date sent, retries, and delivery result;
viii. Changes to the PA

dd) view explanations and help on coded information used on the screen. Such as, but not limited to, error codes, override actions, item details, etc.;

ee) copy information in an original PA screen into a subsequent to be used as the basis for the next PA.

3.3.8.8.1.2 Rejected requests

The Contractor must provide HC Users with the ability to:

a) track denied PA's and the reason for rejection through a drop down list with standard reasons, plus optional free text for 'Other' non-standard reasons.

3.3.8.9 Transfer a Prior Approval

The Contractor must provide an interface through which a HC User can transfer an entire PA or selected PA Lines to another Provider.

3.3.8.9.1 The Contractor must provide the HC User with the ability to:

a) transfer an entire PA to another Provider and cancel the initial PA, the original PA must be marked as transferred and can no longer be claimed against;

b) select multiple unclaimed PA lines, and transfer the PA lines, the transferred lines on the original PA must be marked as transferred and can no longer be claimed against. Any remaining lines on the original PA, not transferred, can be claimed against;

c) all notes and reference documents from transferred lines or PA's must also be transferred to the new PA.

3.3.8.10 Manage Post Approvals

The Contractor must provide an interface through which a HC User can enter a Post Approval, capture supporting items, record decision(s) and communicate the outcome.

The Contractor must provide the HC User with the ability to:

a) Create, Update, File, Settle, Amend, Cancel, Delete a Post Approval request (see SOW Article 3.3.8.8.1 *Manage Prior Approvals)* with a retroactive start date to support Post Approvals, with a field indicating the record is a post approval.

3.3.8.11 Manage Automated Post-approvals

3.3.8.11.1 The Contractor must:

a) generate an automated post-approval request when a claim is submitted to the Contractor and it is missing a valid PD number or a frequency maximum has been reached, or other scenarios as defined by the Project Authority;

b) send to HC in an automated pre-populated (Client, Provider, and Claim line details, attachments where applicable) post-approval format and placed in a queue for HC review.

3.3.8.11.2 The Contractor must provide the HC User with the ability to:

a) retrieve and manage the post-approval in accordance with SOW Article 3.3.8.10 *Manage Post-approvals*;

b) send the post-approval request back to the Contractor for processing and payment.

3.3.9 Common Benefit Requirements

3.3.9.1 Searching for a Client

The Contractor must provide the HC User with the ability to search and view the results for the Client Record in several workflows. Examples include as a sub-search in search or to identify the Client as part of a request workflow. Once the Client has been identified, the Contractor must ensure that the HC User has the ability to view certain Client information.

3.3.9.1.1 The Contractor must provide the HC User with the ability to:

a) search for a Client using, but not limited to, the following elements individually or in combination:
   i. Client ID or alternate number associated to the Client;
   ii. surname, given name;
   iii. band number or name, family number;
   iv. gender;
   v. date of birth;
   vi. special consideration such as client affiliation (e.g. FNHA), PDA/PMP enrolment or COB status;

b) view search results, including, but not limited to:

   i. Client ID;
   ii. surname, given name;
   iii. band number or name, family number;
   iv. gender;
   v. date of birth;
   vi. special consideration such as client affiliation (e.g. FNHA), PDA/PMP, COB status;

c) view and edit the Client details for the record selected from the search results;

d) select Client for use in associated workflow that initiated the search;

e) view the Client demographic details once the Client is identified in associated workflow that initiated the search, including, but not limited to:

   i. surname, given name, alias surname, alias given name, DOB, gender;
   ii. Client ID;
   iii. special considerations such as PDA/PMP enrolment, client affiliation (e.g. FNHA) or COB statuses;

f) view and edit the Client demographic record once the Client is identified in associated workflow that initiated the search;

g) create a unique temporary Client Record for infant Clients not already registered, including a Client ID number (IN#), based on one of their eligible parent/guardian's client numbers. The new record must be linked to the parent's record but claim history must be recorded separately from the parent's Claims (for example: the infant's claims must not be placed in the parent's record).

3.3.9.2 Managing Client Details

The Contractor must provide the HC User with the ability to display and manage supporting Client and benefit history information when viewing Client, PA/PD/SA/CR and Appeal records.

3.3.9.2.1 The Contractor must provide the HC User access to, but not limited to, the following supporting information for all benefit areas:

a) **Client Details –** shows Client details, and the Contractor must:

   i. display Client identifiers (Client ID, alternate numbers, surname, given name, date of birth and gender);
   ii. display Client details as supplied by the SVS feed and do not allow editing (see Appendix D);
   iii. display Client details not supplied by the SVS feed as required by the Project Authority and allow editing and updating of Client details including, but not limited to, address, email address, telephone number, fax number, direct deposit information, COB indicator; Client Health Context indicator; Appeal indicator;

iv. display Client details and allow editing of all fields, except for the Client ID numbers, for temporary infant records;
v. display and allow editing of the details regarding the Client's affiliations - the Contractor must ensure that the HC User has the ability to capture at least 5 distinct affiliation values per Client, their status and effective period;
vi. display any special handling text for the Client;
vii. allow the Contractor or a HC User to indicate that a current address is no longer valid (because the last communication was returned undelivered) so that the Contractor no longer uses that address.

b) **Client Notepad** – displays a chronological history of Client notes made by users (Contractor and HC) from all benefit areas, and the Contractor must:

i. display Client identifiers (number, surname, given name, date of birth and gender);
ii. display an area to add a new note as freeform text or select from a HC predefined list of benefit-specific phrases – After entering the new note the interface will automatically populate the User ID and timestamp and place the note at the top of the list of notes;
iii. allow the user to prioritize one or multiple notes so it appears at the top of the list, regardless of its creation date;
iv. display existing notes in a chronological order with the most recent note at the top and displaying the User ID, date, and note content - a prioritized note must appear at the top of the list and highlighted to distinguish it;
v. allow the user to filter on the creator source, third party coverage and/or the benefit area - the creator source can be All, HC or Contractor - the benefit area can be All, Dental, Pharmacy, MSE, Vision Care or Mental Health Counselling (MHC);
vi. allow the user to filter the list by date, User ID or search string within the note's content;
vii. allow the user to select notes and move them to history.

c) **Claims History** - shows a chronological history (newest to oldest) of all claims made by and on behalf of the Client, including those entered today but not adjudicated or processed, and the Contractor must:

i. display Client identifiers (number, surname, given name, date of birth and gender);
ii. search based on any individual or a combination of the following: service date range, benefit type (Dental, Pharmacy, MSE, Vision Care, Mental Health), benefit item, Frequency Limit, PA/PD/SA, CR, Appeal, number, document number or registration number;
iii. allow the user to filter on "Settled" or "All" claim lines;
iv. allow the user to filter on one or a combination of all data fields (e.g. Therapeutic Class, Category name) as specified by the Project Authority;
v. display each benefit item claimed, on a separate row, displaying benefit item details, status, service date, total claimed, total paid, claimed components, quantity, professional fees, total, payee, Provider number, Provider name, any applicable frequency counts, processing details (document number, registration number, settled date) etc.;
vi. after selecting a row display further details of that entry.

d) **Frequency History –** shows the Client's current frequency counts, limits and the date of benefit eligibility and the Contractor must:

i. display Client identifiers (number, surname, given name, date of birth and gender);
ii. search based on province or territory, procedure code, specialty, Frequency Limit, and/or service date range;
iii. for all benefits except Dental: display item and claim document number, frequency limit in effect, maximum amount allowed, claimed amount including negative balances due to PA overrides, amount remaining, service and settled dates, next date eligible for the item;
iv. for the Dental benefit: display each frequency count including negative balances, on a separate row, displaying PD or claim count, Frequency Limit, tooth code, maximum, period, level, service date, count, total, number available, PD number, and next date eligible for service.

e) **Client Documents** – shows documents attached to the record (Client, PD, CA, etc.) and the Contractor must:

i. display the Client details (number, surname, given name, date of birth and gender);
ii. display each document (most recent first), on a separate row, displaying document name, title, description, type, User ID, and received date;
iii. allow the user to prioritize one or multiple documents so they appears at the top of the list, regardless of its creation date;
iv. allow the HC User to attach a document from the HC User's computer as outlined in SOW Article 3.3.9.7 *Capturing and Retaining Documents*;
v. allow the HC User to remove, rename, view, annotate and print the attached documents.

f) **Alternate Numbers –** show a list of numbers used over time to represent the same Client. Any of the alternative numbers can be used in place of the Client ID.

g) **Clinical Notes -** The Contractor must provide HC Users the ability to record clinical notes including the ability to view related cases marked as special interest, create and attach documents and capture an ongoing textual history of the Client's key clinical information. The Contractor must provide the HC User with the ability to:

i. capture the Client's clinical notes within client details;
ii. view the Client's demographic information (Surname, Given name, Alias Surname, Alias Given name, DOB, Gender, Client ID) while managing the clinical notes;
iii. restrict access to clinical notes to users with a specific role or permission;
iv. create a letter or other type of document using the workflow in SOW Article 3.3.9.6 *Requesting and Receiving Missing Items or Additional Information*;
v. manage documents attached to record using the workflow in SOW Article 3.3.9.7 Capturing and Retaining Documents;
vi. view, edit, save the clinical notes record;
vii. view the Client's dose history for drugs of concern defined by HC including, but not limited to, the date of the entry, the drug, the dose and associated dose conversion unit (MEQ, DEQ, etc.);
viii. record the following client details:
- diagnoses;
- medical conditions;
- current medication allergies and intolerances;

ix. record general comments such as the opioid risk score;
x. view the user's ID and date the clinical note and subsequent progress notes were added;
xi. create an addendum to existing clinical progress note (Contractor must ensure that existing clinical progress notes cannot be edited);
xii. archive a note once it is deemed to no longer be relevant (for examples, erroneous information was imputed or time specific information such as increase dose secondary to fracture that is no longer relevant 5 years after the fact);
xiii. search all sections of the clinical notes, including free text;
xiv. view all clinical notes for a Client on one page with most recent note at the top (reverse chronological order);
xv. link a clinical note to a specific case;
xvi. view list of Client's cases marked as special interest in the clinical note record including basic information including, but not limited to, the following elements:
- case number, case type;
- Client ID;
- Provider ID;
- item # / item group ID, item name / item group name;
- approval record status and date status set;
- request status and date,

- review status;
- settled date;
- dates and Clinical recommendation such as decision, rationale, next steps, comments;

xvii. access the case details for the record selected from the clinical note case list.

3.3.9.2.2 Access to Client Specific information

From the Client Detail results, the Contractor must provide HC User the ability to:

a) access benefit specific workflows including but not limited to:
   i. PA, SA, PD, CR, Appeal, case record;
   ii. Tooth information;

b) search including but not limited to:
   i. claims history;
   ii. frequency history.

3.3.9.2.3 Managing Client Groups

The Contractor must create multiple client management groups based on Client affiliation (see SOW Article 3.3.9.2.1 (a)(v) *Client Details)* such that specific edits could apply to all Clients within that managed group.

3.3.9.3 Searching for a Provider

The Contractor must provide the HC User with the ability to search and view the results for the Provider record in several workflows. Examples include a sub-search in search or to identify the Provider as part of a request workflow. Once the Provider has been identified, the HC User must be able to view certain Provider information.

3.3.9.3.1 The Contractor must provide the HC User with the ability to:

a) search for a Provider using, but not limited to, the following elements individually or in combination:
   i. business name, Provider ID, province, city, phone and f numbers, communication preference, Provider benefit type, Provider specialty;
   ii. enrolment start and end dates;

b) view search results, including, but not limited to:
   i. business name, Provider ID, office ID, province, city, phone, and fax numbers, communication preference,
   ii. enrolment start and end dates;
   iii. other data elements, as specified by the Project Authority;

c) view and edit the Provider details for the record selected from the search results;

d) view the Provider details once the Provider is identified in associated workflow that initiated the search, including, but not limited to:
   i. business name, Provider ID, Province or Territory, Phone and fax numbers, communication preference;
   ii. enrolment start and end dates;

e) display and allow editing of the details regarding the Provider's affiliations - the Contractor must ensure that the HC User has the ability to capture at least 5 distinct affiliation values per Provider, their status and effective period;

f) select the Provider for use in associated workflow that initiated the search;

g) view and edit the provider details once the provider is identified in associated workflow that initiated the search.

3.3.9.4 Viewing Provider Details

The Contractor must provide the HC User with the ability to display supporting Provider information when viewing Provider, PA, PD, SA, CR and Appeal records.

3.3.9.4.1 The Contractor must provide the HC User access to, but not limited to, the following supporting information:

a) Provider details for all benefits must include but not necessarily be limited to:
   i. Provider type;
   ii. Provider regulatory body or professional association;
   iii. Business name, Provider ID, Office ID;
   iv. Provider surname, given name;
   v. Provider practice/group arrangement details;
   vi. mailing address, physical address, phone and fax numbers, email address;
   vii. communication preference by document type;
   viii. language preference;
   ix. Provider enrolment records, including but not limited to, signed agreements, current license or certificate;
   x. enrolment start and end dates;
   xi. termination of enrolment reason;
   xii. If Provider is on the “Do Not Enrol” list;
   xiii. Electronic Funds Transfer details as required by the Provider type;
   xiv. EDI status and details where applicable;
   xv. Provider Claim Verification details as defined in SOW Article 3.3.13.1 *Claim Verification Record;*
   xvi. Provider audit history listing audit date and types;
   xvii. money owed to the NIHB Program;
   xviii. Provider Management indicator, when active, link to Provider Management details.

b) for the Dental benefit:
   i. office ID;
   ii. Provider license number;
   iii. business relationship of Provider to office
   iv. Provider specialty;
   v. Provider regulatory body or professional association;

c) for the Pharmacy benefit:
   i. pricing Schedule provider is associated to;
   ii. agreement signed status;
   iii. Provider regulatory body or professional association
   iv. Provider’s usual and customary fee;
   v. banner store is under, when applicable;

d) for the MSE Benefit:
   i. specialty/professional designation as required by the Project Authority;
   ii. Provider regulatory body or professional association

e) for the Mental Health Counselling Benefit:
   i. Provider type (professional designation)

ii. Provider regulatory body or professional association
iii. Area of expertise;
iv. Provider license number;
v. hourly and group rates;
vi. cultural competency;
vii. education level;
viii. specialty;
ix. membership enrolment (start and end dates);
x. criminal record check;
xi. travel commitment;
xii. auto-identification (i.e. Indigenous);
xiii. Indigenous language competency;

f) for the Vision Care Benefit:

i. Provider license number;
ii. prescriber number;

g) Provider Notepad – displays a chronological history of Provider notes made by users (Contractor and HC) from all benefit areas, and must:

i. display Provider identifiers (business name, Provider ID, province or territory);
ii. display an area to add a new note as freeform text - after entering the new note the interface will automatically populate the User ID and timestamp and place the note at the top of the list of notes;
iii. allow the user to prioritize a note so it appears at the top of the list, regardless of its creation date;
iv. display existing notes in a chronological order with the most recent note at the top and displaying the User ID, date, and note content - a prioritized note must appear at the top of the list and highlighted to distinguish it;
v. allow the user to filter notes created by HC, Contractor, or view all notes, third party coverage and/or the benefit area - the benefit area can be All, Dental, Pharmacy, MSE, Vision Care or Mental Health Counselling (MHC);
vi. allow the user to filter the list by date, User ID or search string within the note's content;
vii. allow the user to select notes and move them to history;

h) Claims History - shows a chronological history of all claims made by the Provider, including those entered today but not adjudicated or processed, and must:

i. display Provider identifiers (business name, Provider ID, Office ID, province);
ii. search based on a combination of service date range, settled date range, benefit, Benefit Item, frequency limit, PA,PD,SA, CR, Appeal Number, doc number, Client number, Claim Number;
iii. allow the user to filter on Settled or All claim lines (settled, rejected, reversed);
iv. display each benefit item claimed displaying Benefit Item details, Claims Status, Status Service Date, Total Claimed, Total Paid, Payee, Provider Number, Provider Name, any applicable Frequency Counts, Processing Details, Settled Date;

i) Alternative Numbers **–** provide access to a list of alternative numbers used over time to identify the same Provider;

j) manage documents attached to the record using the document management workflow in SOW Article 3.3.9.7 *Capturing and Retaining Documents*.

3.3.9.5 Verifying Mandatory Information

The Contractor must provide an interface through which a HC User can review a list of mandatory information (supporting documentation), select those present and request the Contractor automatically send a letter requesting any missing or required additional information for a PD, PA, SA, CR, Appeal

request. The information must be returned electronically, by fax, or by mail in a manner that uniquely identifies the outstanding request.

Examples of mandatory information are BEQs, claim forms, treatment plans, radiographs, photographs, dental models, etc. Not all mandatory information can be submitted electronically, such as certain radiographs and dental models which must be received by mail.

Examples of records with mandatory item lists are PD, PA, CR, SA and Appeal records.

3.3.9.5.1 The Contractor must provide the HC User the ability to:

a) view required mandatory information and mark documents or materials as present;

b) review the remaining list of missing or required additional information and correct the list by adding or removing any additional requirements in free form text or by using additional dropdown selections;

c) maintain the list of mandatory information.

3.3.9.6 Requesting and Receiving Missing Items or Additional Information

The Contractor must provide an interface through which a HC User can request additional supporting material for a PA,PD,SA, CR or Appeal, such as, but not limited to, missing or required additional mandatory items for each benefit type. The items are returned electronically, by fax, or by mail in a manner that uniquely identifies the outstanding request whereby the items are attached to the appropriate record and queues the record for the attention of HC staff.

3.3.9.6.1 The Contractor must provide the HC User with the ability to:

a) select the Missing Items letter or one or more BEQ's letter (per benefit type) to be sent or printed;

b) select the free form letter template to be sent or printed:

   i. select, unselect and remove predefined statements to add to the letter as defined within the letter template;
   ii. add, amend and remove free form text to the letter where allowed within the letter template;

c) view and reprint the content of the letter at any point after it has been saved;

d) select or change the individual or combination of recipients (Provider, prescriber, Client) and the method of delivery or print the letter;

e) automatically send the letter to the recipient(s) using the method selected and store a copy of the letter sent, the method used to send it, the delivery result, the timestamp and User ID and include return instructions and a unique identifier to associate any returned items to the requesting record;

f) resend a document, record the date and reason for resending;

g) view a list of documents printed or sent including but not limited to the name of the document, the date printed or sent, who created the document and what address or fax number it was sent to;

h) receive documents electronically or by Fax where;

   i. If the unique identifier is recognized the documents will be automatically added to the record and queued for the HC User's attention (and notification is sent to HC User);
   ii. Mark the mandatory item as present and update the mandatory item list; or
   iii. If the unique identifier is missing or unreadable the Contractor must automatically queue the electronic document or Fax and send notification to HC User;

i) receive documents by mail and scan, save and remove documents to the record;

j) capture and manage documents (see SOW Article 3.3.9.7 *Capturing and Retaining Documents*);

k) repeat missing or additional item process if applicable.

3.3.9.6.2 The Contractor must automatically:

a) populate the document(s) with information from the PA, PD, SA, CR or Appeal as defined within the document template when the document(s) is/are sent or printed;

b) generate and add to the document a machine readable unique identifier linking it to PA, PD, SA, CR or Appeal.

c) notify HC when a fax or other secure electronic transmission fails to be transmitted, identifying the reason of failure and number of pages that were successful or unsuccessful and provide them with a resend option of all pages or just specific pages;

d) send a reminder to the recipient(s) when missing items have not been received after a defined period;

e) send a final Confirmation Letter indicating the request cannot be reviewed due to lack of response after a defined period.

3.3.9.6.3 The Contractor must provide the HC User with the ability to:

a) define the number of business days, by benefit, before a reminder is sent to the recipients(s) or indicate no reminder to be sent;

b) define the number of business days, by benefit, before the final Confirmation Letter is sent indicating the request cannot be reviewed.

3.3.9.7 Capturing and Retaining Documents

The Contractor must provide an interface through which a HC User can capture and retain documents or images (such as radiographs, photographs, BEQ's, prescriptions, etc.) to support a request or decision. Examples of records with attached documents are Client, Provider, PA, PD, SA, CR or Appeal records.

3.3.9.7.1 The Contractor must provide the HC User with the ability to:

a) capture, name, retain, and remove documents by:

i. for documents with a unique identifier associating them to a record have the document automatically attached to the record;
ii. scanning and saving directly to a record;
iii. attaching, saving or removing a document, such as a pdf, jpg, doc, xls, etc. or a previously scanned document; or
iv. attaching, saving or removing a document from a fax or unattached document queue;

b) remove, rename, view, annotate, save and print the attached documents;

c) identify the document or image type, such as letter, treatment plan, radiograph, photograph, etc.;

d) receive a notification on an incoming fax with a matching unique identifier has been received;

e) view the user ID, source and timestamp when a document is added or modified.

3.3.9.8 Maintaining Document Templates

The Contractor must provide an interface through which a HC User can create document templates such as BEQs, letters and other correspondence to be selected, populated with the information from the specific workflow, and sent or printed as required.

3.3.9.8.1 The Contractor must provide the HC User with the ability to:

a) search for a document template by name with wild card searching, or benefit type items associated to BEQ;

b) view the search results list of document templates including the name in English and French and effective dates;

c) view and edit the document template from the search results;

d) create and amend a document template;

e) record a title or name and description for the template;

f) set the type of document from a predefined list provided by the Project Authority for example, BEQ's and requests for information;

g) define the static text, formatting and layout of the content of the document template using standard word processing functionality;

h) add data elements (e.g. Client details, item, request details) that will populate the document template when it is printed, faxed, or otherwise sent from the system (The Contractor must allow HC Users to add the Client Identifier used by the Client when requesting a benefit. This may be their INAC number, territorial or provincial health card number, or number provided to them by HC);

i) add images to the template (logos, watermarks, etc.);

j) set the default recipient of the document, as identified in request, including but not limited to the following:

   i. Provider;
   ii. Client; or
   iii. prescriber for pharmacy and MSE requests;

k) preview the document template;

l) mark BEQs as public or for DEC use only;

m) create and amend a free form letter template with the following attributes:

   i. allow user to select predefined text from a list to populate the letter;
   ii. allow user to add free text to populate the letter.

3.3.9.8.2 The Contractor must provide the HC User with the ability to:

a) create, amend, and maintain English, French and bilingual code messages such that a message created in one language can be distributed in another.

3.3.9.8.3 The Contractor must automatically:

a) set and display the version number for the document template.

3.3.9.9 Preparing, Amending, and Retaining Standard Letters

The Contractor must provide an interface through which a HC User can create, amend, generate or suppress a Standard Letter and retain the content to support a decision or respond to a request. Examples of Standard Letters are PD Confirmation, Appeal Confirmation, Missing Items or Client Update Letter. Other letters contain a mix of free form and coded message contents.

3.3.9.9.1 The Contractor must provide the HC User with the ability to:

a) prepare Confirmation Letters using the outcome of adjudication, user selected override actions and other user selections such as pre-defined or freeform text;

b) review messages selected based on the adjudication result, the user selected override reason or user selection;

c) prepare letters using both coded messages and free form text;

d) instruct the Contractor to automatically produce and distribute letters by the default or selected distribution method (See Article 3.3.9.10 *Producing and Distributing Confirmation Letters*);

e) suppress, send, or resend to another recipient or view a letter;

f) sign the letter electronically, where applicable.

3.3.9.9.2 The Contractor must provide the HC User with the ability to:

a) maintain predefined letter formats merging data representing Provider and Client benefit lines and coded messages at time of use;

b) create, amend and maintain English, French and bi-lingual letter templates such that a letter created in one language can be distributed in another;

c) create, amend and maintain English, French and bi-lingual code messages such that a letter created in one language can be distributed in another;

d) select and unselect the letter of choice with the interface prefilling merged data fields and allowing the user to add additional free form text or amend information;

e) add and remove external message at each line level from a selection of predefined messages.

3.3.9.9.3 The Contractor must:

a) save copies of the letter attached to their respective PD, PA, SA, CR or Appeal record and make available if requested by the Project Authority.

3.3.9.10 Producing and Distributing Confirmation Letters

The Contractor must produce and distribute Confirmation Letters on behalf of HC.

3.3.9.10.1 When a PA, SA, PD or Appeal is Set or Amended by a HC User, the Contractor must automatically produce and distribute a Confirmation Letter, based on Provider or Client method of communication preference (default bilingual for Clients), through:

a) the mail on the same business day; or

b) by electronic transmission or Fax either immediately or after a delay defined by the Project Authority. If the letter is not delivered electronically or by fax after a number of retries defined by the Project Authority, it must be sent by mail.

The delivery method used, any retries, the timestamp and the outcome must be recorded and accessible by a HC User.

Confirmation Letters must follow a defined content template pre-approved by the Project Authority. The letter must detail the benefit item(s) and fee(s) requested by the Provider along with the NIHB outcome and if applicable, the NIHB maximum fee for the item(s).

When a Confirmation Letter is addressed to a Client less than 18 years of age, the Contractor must automatically address the letter to the Client's parent, legal guardian, or "tuteur".

3.3.9.10.2 The Contractor must produce and distribute a copy of the Confirmation Letter to the recipient(s) selected by the HC User:

a) with the HC User able to select the method of delivery:

   i. recipient's default;

ii. fax to the number on file;
iii. mail;
iv. print (local to the HC User);
v. save as a PDF file; or
vi. fax to a number entered by the HC User;

b) with the HC User able to select the language for each recipient as:

i. recipient's default;
ii. English;
iii. French; or
iv. bilingual (both English and French).

3.3.9.10.3 The Contractor must suppress Confirmation Letters to a Provider or a Client for work performed by HC personnel or a designate in accordance with SOW Article 3.3.10.4 *Capture Benefit Information on Claims for which Payment Is to Be Suppressed*;

3.3.9.10.4 The Contractor must provide the HC User the ability to amend or suspend Confirmation Letters.

3.3.9.11 Viewing PD, PA, SA, CR and Appeal Supporting Information

The Contractor must provide the HC User with the ability to display supporting information when viewing PD, PA, SA, CR and Appeal screens.

3.3.9.11.1 The Contractor must provide the HC User access to the following supporting information:

a) Mandatory Item List – shows a list of mandatory supporting items (documents, radiographs, photographs, models, etc.) required to process a request (PD, Appeal, etc.) and must:

i. display a list based on:
- the combination of procedure codes entered for the PD, CA, etc. with repeated items removed;
- a predefined list of items maintained by HC; or
- a list entered by the HC User;

ii. allow the HC User to mark an item as being present or missing;

b) Internal Notepad – shows a chronological history of notes made to the record and must:

i. display an area to add a new note as freeform text or select from a predefined list of benefit-specific messages after entering the new note the interface will automatically populate the User ID and timestamp and place the note at the top of the list of notes;
ii. display existing notes in a chronological order with the most recent note at the top and displaying the User ID, date, and note;
iii. allow the user to filter the list by date range, user ID or search string within the note's text;
iv. allow the user to select notes and move them to history;

c) General Notepad – shows notes created in response to adjudication and must:

i. generate text based on PD line or Appeal criteria entered using HC maintained English and French phrases that correspond to the codes entered by the HC User;
ii. when the PD line or Appeal criteria is updated the General Notepad must be updated with a history of the previous notes maintained;
iii. be used to produce the PD/Appeal Confirmation Letter;
iv. allow the user to select notes and move them to history;

d) PD, PA, Appeal Documents – shows a list of documents attached to the PD, PA, Appeal and must:

i. display the Client Details (Number, Surname, Given Name, Date of Birth and Gender) and the record reference;
ii. display each document, on a separate row, displaying Document Name, Title, Description, Type, User ID, and Received Date;
iii. display the PD or Appeal line, Procedure Code and Name that the item supports;
iv. attach a document from the HICPS document repository, the HC User's computer or scan directly from a desktop scanner to the current record;
v. ability to remove, rename, view, annotate and print the attached documents.

3.3.9.12 Client Reimbursements

The Client Reimbursement process for the Pharmacy and MSE Benefits is addressed in SOW Article 3.3.9.12.2. The Client Reimbursement process for the following benefits: Dental, Mental Health Counselling, Vision Care is addressed in SOW Article 3.3.9.12.3. Client Reimbursements are submitted directly by Clients to the Contractor either manually by a paper process or electronically via an online form (See SOW Article 3.3.3.3 *Online Forms*). For CRs submitted by paper, the Contractor must enter the CR request details into the HICPS solution. CR requests for Open Benefits with no missing information can be processed automatically by the edits in the HICPS solution. CR requests for which information is missing or that require a PA or PD must be put into a queue by the Contractor for follow-up by HC Users.

3.3.9.12.1 Manage Automated Client Reimbursements

3.3.9.12.1.1 The Contractor must:

a) generate an automated Client Reimbursement request when a claim is submitted to the Contractor and it is missing a valid PD or PA number or a frequency maximum has been reached, or other scenarios as defined by the Project Authority;

b) send to HC in an automated pre-populated (Client, Provider, and Claim line details, attachments where applicable) Client Reimbursement format and placed in a queue for HC review.

3.3.9.12.1.2 The Contractor must provide the HC User with the ability to:

a) retrieve and manage the client reimbursements in accordance with SOW Article 3.3.9.12.2 *Managing Client Reimbursement requests for Pharmacy and MSE, and* SOW Article 3.3.9.12.3 *Client Reimbursements for Dental, Mental Health, and Vision Care*;

b) send the Client Reimbursement request back to the Contractor for processing and payment.

3.3.9.12.2 Managing Client Reimbursement Requests for Pharmacy and MSE

The Contractor must provide an interface through which a user can enter and process a Client Reimbursement (CR) for a Pharmacy or MSE benefit. If the entered CR requires a PA, the interface must automatically populate the PA fields from the CR. The Contractor must provide HC Users with the ability to record the request and approval details for the Client Reimbursement including the ability for the HC Users to validate the request details against HC's Verification Edits. Once the PA is reviewed and adjudicated the interface must transfer the PA result back to the CR. The recipient will receive an Explanation of Benefits (EOB) Letter (also referred to as "Claims Statement") and payment if applicable.

3.3.9.12.2.1 Create a Client Reimbursement Request

The Contractor must provide the HC User the ability to:

a) create, edit, view and save a reimbursement claim request;

b) identify the Client related to the reimbursement through the workflow in SOW Article 3.3.9.1 *Searching for a Client*;

c) identify the Client's parent or guardian for the request through the workflow in SOW Article 3.3.9.1 *Searching for a Client* if applicable;

d) identify payee for claim as Client or other;

e) record other payee's name, organization name, phone and fax, full address;

f) enter item ID or search for each item requested through accessing the workflow in SOW Article 3.3.7.4 *Managing Pharmacy Items* for Pharmacy items or SOW Article 3.3.6.5 *Searching and Viewing MSE Benefit Items* workflow for MSE items;

g) view item details once the item is identified through the search, including but not limited to:

i. Item ID, name, strength and form;
ii. benefit status based on jurisdiction of Provider;

h) capture claim line designation(s) (e.g. Jordan's Principle) as determined by the Project Authority;

i) access the item details specific to the jurisdiction identified in the request where the user is able to view the item details while maintaining their view of the request - information to be displayed includes, but not limited to:

i. operational directives, dose fraction, emergency dispense allowed, frequency limit, short term dispense policy, interchangeability, Dossette eligibility and other NIHB Program policy driven details;

j) record the details for each item requested including but not limited to:

i. date of service;
ii. Provider, including the ability to search and access the Provider details once identified through the workflow in SOW Article 3.3.9.3 *Searching for a Provider*;
iii. prescriber ID;
iv. total quantity;
v. total requested dollar amount to be reimbursed;
vi. private or public Coordination of Benefits;
vii. third party COB amount defined as the balance outstanding after the primary insurer was billed or amount already paid by third party;
viii. PA number;

k) enter at least 5 items within claim without additional user action with the ability to add more items to the claim as needed;

l) add as many items as needed to the request beyond the minimum of 5 items;

m) remove one or more items from Claim once the item has been started.

3.3.9.12.2.2 Search and View Client Reimbursement Requests

The Contractor must provide the HC User the ability to:

a) search for a reimbursement claim request using, but not limited to, the following elements individually or in combination:

i. Client ID including ability to search for a Client through accessing the workflow in SOW Article 3.3.9.1 *Searching for a Client*;
ii. item including ability to search for an item through accessing the item search workflows (see SOW Article 3.3.7.4 *Managing Pharmacy Items* and SOW Article 3.3.6.5 *Managing MSE Items*);
iii. service date;
iv. filed date, or filed by;
v. PA number;
vi. request status (Approved, Denied), date request status set, request status set by;

vii. record status (Filed, Settled, Amended), date record status set, record status set by;
viii. text search of summary and/or comments allowing for search terms used to be in combination;

b) view results based on the search parameters including, but not limited to, the following elements:

i. Client ID;
ii. item ID, Item name;
iii. PA number;
iv. service date;
v. record status and date record status set;
vi. request status and date request status set;
vii. dates such as document received, client notified;

c) view and edit the reimbursement record details for the record selected;

3.3.9.12.2.3 Adjudicate Client Reimbursement Request

3.3.9.12.2.3.1 The Contractor must ensure that HC Users have the ability to:

a) verify Client, Client's parent or guardian, each Provider(s), the item and request details against all applicable eligibility limits, NIHB Program limits and pricing details for the date of service on the receipt as entered by the HC User of the reimbursement request;

b) re-verify the details if information is changed;

c) view warning(s) related to Verification Edits for each item if the edit is not satisfied;

d) view warning(s) for each item at any point after the warning(s) was provided;

e) calculate or recalculate total dollar amounts when any value is added or updated;

f) edit the approval dollar amounts of each item;

g) record or update the request status for each item using one, but not limited to, of the following statuses:

i. Approved;
ii. Approved on History; or
iii. Denied;

h) set the record status for each item to indicate the item has been:

i. Filed;
ii. Settled;
iii. Amended;
iv. Denied; or
v. Canceled;

i) record comments for the reimbursement request;

j) create a letter or other type of document using the workflow in 3.3.9.6 *Requesting and Receiving Missing Item or Additional Information;*

k) manage documents attached to record using the workflow in SOW Article 3.3.9.7 *Capturing and Retaining Documents.*

3.3.9.12.2.3.2 At the completion of the CR Decision workflow, the Contractor must perform the following functions:

a) produce a Claims Statement Letter and cheque if applicable;

b) select recipients to receive Claims Statement Letter;

c) select predefined statements for each item in the request to include on Claims Statement Letter - predefined statements defined in SOW Article 3.3.9.6 *Requesting and Receiving Missing Items or Additional Information;*

d) enter general comments for Claims Statement Letter and confirmation letter;

e) suppress the sending of Claims Statement Letter, if applicable;

f) view a summary of reimbursement request as recorded prior to saving the case when there are items marked ready for payment;

g) return to editing of the record if information presented on summary is incorrect or needs adjustment.

3.3.9.12.2.4 Adjudicate Client Reimbursement Requests

The Contractor must automatically:

a) generate and display a unique claim record ID for the request, which is traceable and searchable by HC Users;

b) use Client's name, address as the default values for payee information when Client is selected as the payee with the ability to edit the values;

c) set and display the allowed item cost, mark up amount, dispense fee based on the Pricing Schedule and category for the date of service on the receipt as entered by the HC User of reimbursement request and calculate the total approval dollar amount given the quantity requested;

d) validate whether COB dollar amount is less than or equal to what the HC total dollar amount covered by the NIHB Program would be had the claim come solely to HC, unless the HC User defines otherwise;

e) reduce or reject the approved dollar amount as prescribed by the program limits for the date of service of the reimbursement request and indicate this to the user;

f) indicate the status of each item on the request (e.g. approved, pending, denied, filed);

g) indicate the approved items have been sent successfully to the Contractor;

h) require the HC User to edit request details in specific situations, defined by the Project Authority, prior to completing the request. Examples include when there is insufficient data or if the amounts are incompatible.

3.3.9.12.3 Client Reimbursements for Dental, Mental Health, and Vision Care

The Contractor must provide an interface through which a user can enter and process a Client Reimbursement (CR) for a Dental, Vision Care, or Mental Health Counselling benefit. If the entered CR requires a PA or PD, the interface must automatically populate the PA or PD fields from the CR. Once the PA or PD is reviewed and adjudicated the interface must transfer the PA or PD result back to the CR. The recipient will receive an Explanation of Benefits (EOB) Letter and payment if applicable.

3.3.9.12.3.1 The Contractor must provide the HC User the ability to, but not limited to:

a) search for a Client and create a CR from the client Screen with the client details populated automatically;

b) search for and enter the Provider details;

c) verify both the Provider and the Client;

d) select and unselect the recipient(s) of the Confirmation letter.

e) add, edit, and delete claim lines for a maximum of 30 lines. The initial number of claim lines displayed and the claim line details vary by benefit, details will be given upon contract award;

f) capture claim line designation(s) (e.g. Jordan's Principle) as determined by the Project Authority;

g) enter private or public coordination of benefit details and amounts;

h) view the current Client details from the Client Record, with the ability to update if necessary;

i) enter a payee with the Client selected by default;

j) record the Client representative's name, organization name, full address, phone, fax, and email; Verifying against previous entries of authorized Client representatives to ensure consistent data entry for reporting;

k) create a PA or PD and transfer the Client, Provider and any marked "require a PA or PD" lines to auto-populate the PA or PD. Once reviewed and adjudicated the PA or PD result can be transferred back to the CR with the appropriate claim lines adjusted (PA or PD number added or claim line deleted);

l) adjudicate the Claim and verify that no claim line requires a PA or PD;

m) file, set(tle), cancel and delete, amend (including partially paid) a CR;

n) display the new balance on a partially CR by line;

o) save, supress, resend, print a CR Confirmation Letter to the Client or authorized Client representative;

p) view, print, resend the Claim Statement;

q) view claims history and update the Client Notepad and information;

r) get explanations and help on coded information used on the screen such as, but not limited to: error codes, item details, etc.;

s) override dates set by the system, as defined by the Project Authority.

3.3.9.12.3.2 The Contractor must automatically:

a) suppress the Provider's Confirmation Letter when the PA or PD is a result of a CR request;

b) produce and distribute an EOB Letter to the checked recipients (see SOW Article 3.3.9.10 *Producing and Distributing Confirmation Letters*).

3.3.9.13 Maintaining Pre-defined Lists

The Contractor must provide an interface through which a HC User can maintain and keep current predefined lists used by the HC Users when entering or updating data elements.

3.3.9.13.1 The *Status Verification System (SVS)* feeds provide the Band Numbers for Clients, which are used to look up and display the Band Name. The SVS does not provide the Band Names for Clients. The Contractor must provide the HC User with the ability to:

a) view a table of all Band Numbers and enter and update the Band Name;

b) select a First Nations Band for special handling and enter a reason (in English and French) for the special handling (for example: where HC may need to back date the eligibility date for that Band);

c) easily view the special handling when viewing a Client from a Band marked for special handling.

3.3.9.13.2 The Contractor must use lists of values defined by the Project Authority in the interface. The Contractor must provide the HC User with the ability to:

a) add, edit and hide (delete) values in a list - for reporting purposes values in a list must be hidden rather than deleted;

b) enter predefined lists in English, French and bilingual alphanumerical phrases for each member of a list.

The pre-defined lists and values will be determined after Contract Award.

3.3.9.14 Efficient and Consistent User Interface

The Contractor must provide an interface through which users will experience an efficient and consistent user interface.

3.3.9.14.1 The Contractor must provide the users with the ability to, including but not limited to:

a) use menus and/or button groups grouped by benefit and function and optimized for the user role;

b) access one or more benefits in a single login based on user role;

c) view screens in English and French:

   i. based on the user's default upon login;
   ii. switchable to another language after login;

d) change or recover passwords by the Contractor sending a password reset link to the user's email address;

e) distinguish information that is presented for display (and cannot be changed) from information fields that can be entered or changed;

f) take advantage of the screen dimensions when displaying records or lists of records;

g) use keyboard, logical tabbing, navigation or data entry assistance aids, including but not limited to copy and paste functions, to speed up data entry;

h) use keyboard shortcuts defined by the Project Authority;

i) specify the number of records to be displayed on the screen;

j) search multiple criteria, with wild card searching;

k) filter records to narrow down a selection;

l) filter table columns by field values with reference to the entire dataset and the search criteria in play;

m) select multiple (non-consecutive) records to indicate records to be acted upon;

n) sort table columns in ascending or descending order with reference to the entire dataset, subject to any search/filter criteria (not the rows currently displayed on the screen). Default sort is the most recent records first;

o) print the records displayed on the screen with selection criteria and header row - with the user ID, date, page number and marked "PROTECTED B" repeated on each page;

p) print multiple selected records, even if they span multiple screens;

q) export multiple selected records, even if they span multiple screens, to a file (in csv format);

r) view expanded details of a record from a list view;

s) suppress the display of old data in list views (For example: Display only the current and 3 other records per search match);

t) use a "Clear" function that returns the fields to an initial state;

u) have more than one session for the same logged-in user - for example, while working on entering data for a Client A the user is asked to query Client B the user must not lose the partially entered data for the Client A.

3.3.9.14.2 The Contractor must:

a) indicate for multi-page views the current page and the number of total pages with a navigation aid to go to first or last; go to next or previous; and go to a specific page;

b) have error messages indicate the error and the field it applies to;

c) ensure that mandatory fields must be completed before allowing an updating action;

d) ask for confirmation when changing data associated with an existing data record;

e) not delete data used for reporting and audit purposes but have an effective start date and end date;

f) enforce user access such that any action must be based on the user's profile;

g) easily view and recognize key information used in decision making.

3.3.9.15 Data Record Management

Managing the Effective Date

3.3.9.15.1 The Contractor must provide HC Users with the ability to:

a) set the start and end of the effective period for the information within a record;

b) amend the start and end dates of the effective period;

c) create a version of the record that will take effect at a future date, maintaining the unique record ID referenced within other workflows, where applicable;

d) edit details of the record with a future effective date up to the start of the effective period.

3.3.9.15.2 The Contractor must:

a) indicate the record is not in effect when its effective period has not started;

b) enforce the rules, where necessary, on the start date of the effective period, ensuring that records do not contradict each other based on their effective dates;

c) prevent edits to records where the start date of the effective period has passed.

Maintaining and View Record History

3.3.9.15.3 The Contractor must provide HC Users the ability to:

a) access and view the entire change history for a record as required by the Project Authority - records include, but are not limited to: the item, client or provider details, request record;

b) view the change history of information within the context of the complete record the information is associated to as required by the Project Authority - the change must be clearly identified to the HC User.

3.3.9.16 Managing Client Appeals

3.3.9.16.1 Managing Appeals

The Contractor must provide an interface through which HC User can generate Appeals, store and record decisions supporting material and communicate the outcomes with the Clients and Providers. The following benefits follow the same Appeal process: (a) Dental; (b) Mental Health Counselling; (c) Vision Care. The Appeal process for the Pharmacy and MSE is addressed SOW Article 3.3.9.16.3 *Appeal Process for Pharmacy and MSE Benefits*.

3.3.9.16.2 Appeal Process and Services for All Benefits; excluding Pharmacy and MSE

3.3.9.16.2.1 The Contractor must capture relevant data, level of appeal and link to the cases when processing Client Appeal for all benefits, excluding Pharmacy and MSE. The Contractor must provide the HC User with the ability to:

a) initiate, from the PD or PA being appealed, an Appeal where the Appeal is auto filled with the Client details, Provider details, and the PD or PA reference - then set the Appeal Level to “1”, and add the Appeal reference to the PD or PA;

b) add on a subsequent Appeal, Level 2 and 3 appeal data to the Client’s original Level 1 appeal record, such that all the Appeal levels are in one Appeal record;

c) enter benefit appealed;

d) enter the Client and a minimum of 3 contact details of their representative, if any, with their language preference;

e) view a Mandatory Item List and request any missing items required to support the appeal (see SOW Article 3.3.9.5 *Verifying Mandatory Information*);

f) attach, annotate, name, rename, and delete documents and associate then with the Appeal or a specific procedure code (see SOW Article 3.3.9.7 *Capturing and Retaining Documents*);

g) view claims history, PD or PA history, Appeal history, frequency history and update Client Information, notepads, and other information;

h) select the recipient of the Appeal Confirmation Letter;

i) select the recipients of a copy (i.e. CC) of the Appeal Confirmation Letter;

j) select an appeal status from a HC predefined list;

k) file, set, amend, cancel and delete an Appeal;

l) assign the Appeal to a health professional ID from a list of health professionals and placed in a queue for their review;

m) agree to a health professional attestation statement;

n) enter the health professional’s recommendation using the Appeal Criteria list;

o) enter additional messages to include in the letter using free form text;

p) print an Appeal Response Letter to a HC printer local to the HC User;

q) scan signed Appeal Response Letter into the Appeal.

3.3.9.16.2.2 The Contractor must provide HC Users with the ability to:

a) create, update any lists used by the interface with codes and messages in English and French including, but not limited to:

   i. Client Representative Role List;
   ii. Appeal Status List;
   iii. Appeal Criteria list;

b) create, update any groups used by the interface, but not limited to:

   i. Professional Support;
   ii. Professional Advisor;

iii. Health Professional.

3.3.9.16.2.3 The Contractor must:

a) automatically generate a PD Appeal Confirmation Letter and Appeal response letter to the recipients selected based on current Appeal Level, Appeal Criteria selected and any free-form text entered.

3.3.9.16.3 Appeal Process for Pharmacy and MSE Benefit

The Contractor must be able to verify mandatory items and capture relevant data (See SOW Article 3.3.9.6 *Requesting and Receiving Missing Items or Additional Information*), level of appeal and where applicable link to the denied case when processing Appeal for a Pharmacy or MSE Benefit.

Appeal Request Specifics

3.3.9.16.3.1 The Contractor must provide the HC User with the ability to:

a) create, edit, view and save an appeal request case including all the information outlined in SOW Article 3.3.7.14 *Managing Requests for PAs, SAs, Appeals* or 3.3.6.11 *Managing Requests for Approval*;

b) select who initiated the appeal from a pre-defined list of Client representatives, as defined by the Project Authority, which includes a free form text option;

c) record contact details for up to at least 5 selected Client representatives including but not limited to:

i. name;
ii. phone number;
iii. fax number;
iv. e-mail address;
v. their language preference;
vi. contact type;
vii. city;
viii. province;
ix. postal code;

d) enter the level of the appeal as level 1, 2 or 3;

e) add one to many activities by selecting a specific activity from a predefined editable list as defined by the Project Authority;

f) enter comments related to the activity when specific activities defined by the Project Authority are selected;

g) enter a start and end date for each activity.

3.3.9.16.3.2 The Contractor must ensure that the Appeal case record defaults to blank for the province field, but be mandatory and editable.

3.3.9.17 Real-time Operational Reporting (ROR)

The Contractor must provide Real-time Operational Reporting for each benefit area such that an HC User can report on staff productivity, turn-around time, and delays to processing, etc. for, but not limited to, PA, PD, SA, CR, and Appeal request processing.

The Contractor must provide the authorised HC user the ability to:

a) view hourly, daily, weekly, monthly, quarterly and annual reports for the benefit area and office (NHQ or FNIHB region);

b) view user productivity and activity reports;

c) define periods of working time for that benefit and location to take account of hours worked in a day, work days in a week and to define public holiday and vacation time for staff;

d) define operational quality metrics, such as turn-around-time;

e) view exceptions to operational quality metrics (such as turn-around time);

f) save, print, and download in formats provided by the Project Authority;

g) view start, end and duration of operational tasks using dates and actions provided by the Project Authority. Operational tasks include, but are not limited to:

i. initial receipt of request;
ii. data entry of request;
iii. assessing request;
iv. on-hold waiting further details from Provider;
v. recommendation by advisor;
vi. adjudication of request;
vii. amendment to a request;
viii. reconsideration of a request;
ix. appeal of a request.

For example show (i) the date of the initial receipt of a request; (ii) the start, end and duration of request data entry; (iii) the start, end and duration of Adjudication; (iv) the start, end and duration of the entire request as well as for the individual lines; (v) the start, end and duration for "on-hold", waiting for additional information from a provider; and (vi) start, end and duration for an amendment to an existing request. Showing the User ID, start, end, duration and location for users interacting with the system at each stage.

3.3.9.18 Integration with Interactive Voice Response (IVR) Telephony System

The Contractor must integrate the data from HC's Interactive Voice Response telephony system into the necessary workflows to allow users to leverage this information.

3.3.9.18.1 The Contractor must populate request workflows as required by the Project Authority with the case ID, Client, Provider IDs and/or item ID from IVR telephony system when a caller provides one to all of the elements.

3.3.10 Claims Processing Services

3.3.10.1 Capture and Retain Records for NIHB Claims and Claim Reversals

Claims can be submitted to the Contractor via mail, fax, or electronic forms. Electronic forms may be submitted through point of sale (POS) EDI methods and Internet submission methods developed by the Contractor and acceptable to the Project Authority. Consistent claims capture and processing procedures must be used consistently across the country and for all benefit areas such that common functions can be handled in the same manner within each benefit area.

3.3.10.1.1 The Contractor must capture all the data contained in HICPS benefit claims and claim reversals submitted by Providers, Client, or HC Users on behalf of Clients. The Contractor must develop and implement control procedures to ensure the accuracy and completeness of the data captured. For electronic and manual claims, the Contractor must provide the ability to accept PD's,

PA's, SA's , Client Reimbursements, for services per Claim for each benefit type as per SOW Articles 3.3.4.3 *Managing Predeterminations, Post-determinations, Automated Post-determinations*, 3.3.5.6 *Managing Prior Approvals, Post Approvals* 3.3.6.11 *Managing Requests for Approval,* 3.3.7.14 *Managing Requests for PAs*, SAs, Appeals, 3.3.8.8 *Managing Prior Approvals, Post Approvals, Automated Post Approvals, 3.3.9.12 Client Reimbursements*. The initial number of claim line entries displayed will vary by benefit.

3.3.10.1.2 The Contractor must ensure that data communication mechanisms with Providers are based on EDI requirements currently in place. EDI and Internet submission methods must allow adjudication results to be automatically returned to the sender. The Contractor must support EDI and Internet submission functionality as follows:

a) be available to all enrolled Providers who wish to use the service in accordance with the service standards detailed below, except for any scheduled system downtime;

b) be based on and updated as the following standards evolve:

   i. the current Canadian Dental Association (CDAnet), Denturists Association of Canada (DACnet), Canadian Dental Hygienist Association (CDHAnet), and the Association des chirurgiens dentists du Québec (Réseau ACDQ) claim standards for dental benefits;
   ii. the current Canadian Pharmaceutical Association (CPhA) claim standard for drugs and MSE benefits;
   iii. Contractor or claims processing industry standards, subject to review and approval by the Project Authority;
   iv. professional association claim standards when new or existing professionals (or their associations) are licensed to operate in provinces and territories, subject to the Project Authority's review and approval;

c) have the capacity to support HL7 messaging standards as they evolve;

d) meet the automated claims verification requirements;

e) meet the requirements for the administration of PAs, SAs and PDs;

f) allow Providers to reverse and re-key claims or to request that the claim be reversed through the HICPS Call Centre, while maintaining a real-time record of the reversal transaction;

g) comply with all established Government of Canada security requirements.

3.3.10.1.3 The Contractor must capture and process all Claims submitted on paper claim forms by Providers and Clients. The Contractor must:

a) be based on NIHB benefit claim or request forms or equivalent professional association benefit claim or request forms;

b) support a Contractor notes field for:

   i. the entire claim or request;
   ii. each claim line;

c) support adjudication and review of errors after data entry;

d) support reversals by claim line (without impacting other claim lines within the same request) for, including, but not limited to:

   i. recoveries;
   ii. corrections (HC user, or Providers);
   iii. adjustments;

e) retain and electronically forward, the Project Authority, the information on claims for the following situations:

   i. as over frequency;
   ii. as missing a required authorization number; or
   iii. another rejection reason requested by the Contractor or the Project Authority and agreed to by the Project Authority;

f) accept claims, updated and returned from the Project Authority, for processing and payment by the Contractor;

g) suppress claim statement and payment at processing for each claim line for NIHB services that have been delivered by HC personnel or designates (see SOW Article 3.3.10.4 *Capture Benefit Information on Claims for which Payment Is to Be Suppressed*);

h) suppress claim information from reports at processing for each claim line for NIHB services that have been delivered by HC personnel or designates (see SOW Article 3.3.10.4 *Capture Benefit Information on Claims for which Payment Is to Be Suppressed*).

3.3.10.1.4 When paper claims lacking sufficient information to be processed (for example, claims with illegible or missing information) are received, the Contractor must return a form to the requestor with an explanation of the reason for the claim not being processed and how to resubmit the missing information to allow the claim to be processed. The Contractor must retain the original incomplete form.

The Contractor must send a form when a claim is illegible, unclear or is missing one or more of the following, including, but not limited to:

a) Client’s secondary identifier, such as surname, given name and birth date;

b) Client’s complete address (where applicable, i.e. Client Reimbursement, Dental);

c) Provider ID number and Provider name;

d) Provider’s signature or stamp;

e) No response to the "Coordination of benefits" question;

f) Missing payee information (i.e. Provider submits for reimbursement to Client).

3.3.10.1.5 The Contractor must contact and enrol the Provider before rejecting a claim for which the Provider number (and office ID in Dental) cannot be verified. If the Provider cannot be enrolled, or chooses not to be enrolled the claim must be rejected.

3.3.10.1.6 Although Clients will be directed to forward paper-based Client Reimbursement claims to the Contractor, the Contractor must also provide the ability for a HC User to electronically capture Client Reimbursements from Client submitted paper-based claims and forward to the Contractor for processing and payment. In cases when the HC User is entering the Client Reimbursement claim, the HC User is responsible for reviewing and ensuring that Client claim forms are complete and accurate before submitting them to the Contractor for processing. (See SOW Article 3.3.9.12, *Client Reimbursements*).

3.3.10.1.7 Service Standards:

a) When paper claims are received that lack information required for processing, the Contractor must send a form to the requestor within 3 business days of receipt, 98 percent of the time, as measured through monthly HICPS Operational Reports (See Appendix H *Summary of Status HICPS Operational Reports*).

b) Paper claims must be entered and adjudicated within 3 business days of receipt, 98 percent of the time as measured through monthly HICPS Operational Reports (See Appendix H *Summary of Status HICPS Operational Reports*).

3.3.10.1.8 Managing Claims Processing Management Reports

3.3.10.1.8.1 The Contractor must produce and submit Claims Processing Management Reports that include:

a) the Claim processing statistics that must include monthly and year-to-date reports by each benefit area (Pharmacy, Medical Supplies & Equipment, Dental, Vision Care, and Mental Health Counselling) identifying claims settled (includes paid, rejected, reversed, adjusted etc.) and statistics showing number of claim items, claim items as percent of total, dollars claimed, and dollars paid (if applicable) for all claim lines that were settled during the current period;

b) Statistics on the number of settled claims associated with PA's and PD's during the current period for individual items.

3.3.10.2 Electronic Adjudication and Verification of Claims and Claim Reversals

The Contractor must electronically process claims submissions against NIHB Program benefits, policies and prices (in Canadian dollars) in effect at the time services were rendered. The Contractor must support the reversal and resubmission of claim information and ensure that verification parameters are set back to the values that existed before the claim was processed. This includes claim history, tooth history and frequency history counters as well as the claimed against portion of any PA, PD, or SA records.

3.3.10.2.1 The Contractor must use *NIHB Program Verification Edits* detailed in Appendix C of this SOW to process claims that result in claims being:

a) accepted for payment as billed;

b) paid but adjusted to comply with NIHB pricing rules;

c) rejected due to ineligibility;

d) reversed.

3.3.10.2.2 The Contractor must communicate the detailed results of the claims processing through EDI and on Claim Statements and stored for future reference. The explanatory messages provided through EDI are based on the codes accepted by each EDI submission network, whereas the codes reported on statements are based on NIHB explanatory messages.

3.3.10.2.3 The Contractor must analyse annually the cause of claim rejections and propose solutions, for the Project Authority's approval, to reduce the rejection rate. The Contractor must apply solutions, approved by the Project Authority, aimed at reducing the claim rejection rate.

3.3.10.2.4 The Contractor must process NIHB claims (EDI, other electronic, and manual) against the solution edits which are based on NIHB policies. The following is a non-exhaustive list of adjudication edits (Refer to Appendix C for a detailed description of these edits):

a) *General Verification Edits* (SOW Appendix C, Article 1) verify that:

i. all information required has been submitted;
ii. the Claim is not a duplicate;

iii. the Claim has been submitted within 1 year from the date of service.

b) *Provider Verification Edits* (SOW Appendix C, Article 2) verify that:

i. the Provider is enrolled with the NIHB Program;
ii. the Provider is authorized to provide the products or services claimed based on his or her area of specialization;
iii. the date of service falls within the Provider's effective period of being enrolled.

c) *Client Verification Edits* (SOW Appendix C, Article 3), verify that:

i. the client identification number is registered with the NIHB Program for the claimed benefit program;
ii. the date of service is within the client eligibility coverage period;
iii. the Client is not covered under another program (i.e. land claim, transfer programs) for the benefit type claimed, e.g.: Drug, MSE, Dental, etc.

d) *Benefit Verification Edits* (SOW Appendix C, Article 4), verify that:

i. the services meet the NIHB Program benefit rules;
ii. claims for a Provider and/or Provider office under Provider Management are verified according to the services and actions listed for that Provider or office;
iii. claims that require a PA, PD, SA or post-determination have the required PA/PD number;
iv. claims that exceed a Frequency Limitation have the necessary authorization to be adjudicated and paid;
v. that the services meet the specific benefit edits relating to tooth conditions, conflicts, surfaces, etc., including providing and maintaining a Drug Utilization Review (DUR) or Drug Interaction capability that provides standard drug interactions and duplicate therapy warnings as Claims are processed and transmits this information to Providers at the point of sale.

The Contractor must, for claims submitted with a PA or PD number, adjudicate the benefit and pricing against the information provided in the corresponding PA or PD record.

e) *HC Approved Claim Verification Edits* (SOW Appendix C, Article 5), verify that the:

i. PA or PD number has been identified;
ii. PA or PD number is a valid number;
iii. claim matches the terms of the PA or PD;
iv. PA or PD is still within its effective period;
v. PA or PD has not been used in a previous claim (where applicable);

f) *Cost Verification Edits* (SOW Appendix C, Article 6 "Title"),6), verify that:

i. claims are paid at the lower of the amount claimed or the amount allowed under NIHB pricing rules in effect on the date that the item or service was provided, or according to the PA or PD amount if specified;
ii. claims are paid on a retroactive basis when agreements with Provider associations include retroactive provisions;
iii. GST and PST are not paid, unless specified by the Project Authority.

g) *Third Party Verification Edits* (SOW Appendix C, Article 7), verify that

payment for services or products covered under provincial or territorial plans, Worker's Compensation or private coverage is adjusted to reflect the amount of the balance (paid by the other party) of the claim that meets NIHB benefit criteria.

3.3.10.2.5 During the adjudication process, the Contractor must:

a) update the Client's claims history and Provider claims history;

b) update any frequency counters;

c) update the tooth history – including when teeth are extracted;

d) adjust Client and Provider Claims history, frequency counters and tooth history when a claim line is reversed;

e) update Client address contact information;

f) update coordination of benefits with other coverage information;

g) capture claim line designation(s) (e.g. Jordan's Principle) as determined by the Project Authority, based on the PA, SA, PD authorization.

3.3.10.2.6 The Contractor must support adjudication edits in a visible manner. All parameters of a business rule, representing an aspect of an edit, should be:

a) accessible by HC Users in real-time;

b) visible against affected benefit items.

3.3.10.2.7 The Contractor must, upon request by the Project Authority, access and edit in real-time all aspects of verification edits and business rules. The Contractor must:

a) ensure that the solution associates a descriptive alphanumeric text string (in English and French) with a business rule, representing an aspect of an edit;

   i. the descriptive text string must be displayed alongside other rules/edits associated with a benefit item so that a reader can fully comprehend ALL the rules affecting that item.

b) apply modifications to verification edits described or additional verification edits may be requested by the Project Authority.

3.3.10.2.8 The Contractor must have the ability to assign an effective start and end date to a business rule, representing an aspect of an edit. For example, an NIHB Program policy statement that resulted in an edit may no longer be needed or it may not go into effect immediately.

3.3.10.3 Provide and Maintain a Tracking System for Submitted Claims

The Contractor must develop the processes and services to track and report on NIHB claims through each stage of the claim's processing.

3.3.10.3.1 The Contractor, at a minimum, must ensure that the solution can track a claim through the following milestones in the process:

a) the date when a paper or electronic claim is received by the Contractor and any dates that the claim has been resubmitted;

b) the date a form is sent to the requestor with an explanation (reasons) why the claim is not being processed;

c) the date the claim was processed, the result of adjudication and if rejected, the reason(s) why;

d) the dates the claim was put on hold and re-submitted for adjudication;

e) the dates the claim was paid, its amount, and the date the payment was sent and the statement mailed;

f) the date the claim line(s) was reversed and the reason(s) why;

g) the date a Claim Statement and cheque was sent;

h) the date a Claim Statement was sent and the date an EFT was transmitted;

i) record any and all electronic tracking numbers for statements, payments made, payments received, payments cashed.

A reference to date infers both the calendar date and the time of day. For any HC or Contractor User action, the User ID and location must also be recorded.

3.3.10.3.2 The Contractor must provide secure access to HC Users and HICPS Call Centre staff to view the status of requests and claims in real time, including milestones in SOW Article 3.3.10.3, *Provide and Maintain a Tracking System for Submitted Claims.*

3.3.10.4 Capture Benefit Information on Claims for which Payment Is to Be Suppressed

To maintain a complete history of benefits received by Clients, the Contractor must capture claim information for NIHB services that have been delivered by HC personnel or designates (Contracted Providers). For example, HC may hire and pay a dentist to provide services in remote communities. The work performed by these HC contracted providers will be adjudicated in HICPS, follow the normal adjudication edits, and count towards the Client's claims history and frequency limits. The payment and the Claims Statement, however, must both be suppressed. Furthermore, these claim lines must be able to be either counted or excluded in the statement of proposed disbursement and claims expenditure summary file and report.

3.3.10.4.1 Service Standard: The Contractor must post a validation report summarizing the results of the data capture to the DRR within 5 business days of receipt of data.

3.3.11 Claims Settlement

Claims Settlement is the process by which Providers and Clients receive the summarized results of adjudication (Claim Statement); payment is made based on the NIHB Program policies and rules; and the information has been stored for future reference.

The Contractor must ensure that Providers and Clients receive payment in their selected method of payment (cheque or Direct Deposit) and receive the Claims Statement in their selected method of communication (electronic or mail).

3.3.11.1 Claim Statements

The Claim Statement is a document intended to be distributed by the Contractor to Providers and Clients to summarize the results of adjudication for each of the claims processed during the bi-weekly period. In addition, Claim Statements may be used to communicate relevant NIHB Program information.

The Contractor must produce these Claim Statements that must include, but not necessarily be limited to, the Client and Benefit information for the Provider's claim reconciliation. The Contractor must provide HC with explanatory messages for each claim line.

The Contractor must:

a) produce and distribute the Claim Statements in the official language of the Provider's choice;

b) produce and distribute the Claim Statements in both official languages for Clients;

c) produce and distribute the Claim Statements by the recipient's selected method of communication (electronic or mail);

d) ensure that the Claim Statements list all claim payments and claim settlements and with appropriate messaging, if required, including any messages from the Project Authority communicating relevant NIHB program information;

e) produce and distribute at no additional cost, duplicate Claim Statements upon request by HC, the Provider, the Client;

f) suppress a Claims Statement to a Provider or a Client for work performed by HC personnel or a designate in accordance with SOW Article 3.3.10.4 *Capture Benefit Information on Claims for which Payment Is to Be Suppressed*;

g) produce for the Project Authority's approval:

   i. Claim Statement formats;
   ii. all changes to the Claim Statements;

h) produce for the Project Authority's approval:

   i. all messages in both official languages that could appear on a Claim Statement;
   ii. all changes to Claim Statements;

i) provide HC Users ability to access statements;

j) provide the information to HC, upon request by HC, on the tracking of when a statement was printed and distributed;

k) document the procedures for producing and distributing Claim Statements, and must make this information available to HC upon the Project Authority's request.

3.3.11.2 Payments and Settlements

The Settlement is the conclusion of the business operation or transaction by payment of the adjudicated claims.

The Contractor must ensure that:

a) Claim Statements accompany all claim payments and claim settlements – via the recipients preferred method of communication such as, but not necessarily limited to: mail, fax, and electronically;

b) settled claims for the payment period are included in one payment for each Provider and Client;

c) Electronic Funds Transfers (EFT) are completed on the payment date;

d) cheques are mailed with the corresponding Claim Statements;

e) payments to Providers and Clients are made bi-weekly;

f) payments to Providers and Clients are made within 1 business day of receipt of the deposits from HC;

g) payments can be re-issued by a new cheque or EFT, as required;

h) payments can be suppressed to a Provider, upon Project Authority request;

i) issuance of payments can be made electronically or by paper cheque to Clients (or their representative) and Providers;

j) identify all requests for re-issuing of payments that were originally made and dated prior to the Implementation Date and must obtain the Project Authority's approval prior to making any of these payments;

k) amounts being recovered from a previous claim are clearly indicated (Client, service, date of service, paid vs. recovery) on the Claim Statement so that Providers can reconcile their books with HICPS payments;

l) upon request of the Project Authority, special handling of payments outside the normal payment schedule must be actioned within 5 business days of the request, at no additional cost to Canada.

3.3.11.3 Cancelation and Re-Issuance of Payment

The Contractor must be able to trace a payment to a Provider, Client, or Client Representative and, if applicable, cancel it and re-issue a new payment by cheque or EFT, as required and by approval of the Project Authority, at the Contractor's expense.

3.3.12 Financial Operations

3.3.12.1 Claims Funding Requests - Bi-weekly Request for Funds from HC to cover the NIHB Claims Payments

By 12:00 (noon) ET, two business days prior to the bi-weekly Contractor payment date, as determined by the Project Authority upon Contract Award, the Contractor must request funds from HC to cover the NIHB Claims Payment period, by posting to the DRR, a Claims Funding Request which must:

a) Include a signed summary sorted by payment type and the following types of benefit claims:

i. Dental;
ii. Pharmacy:
- prescription drugs;
- over the counter drugs;

iii. Medical Supplies and Equipment:
- medical supplies;
- medical equipment;

iv. Mental Health Counselling;
v. Vision Care
- Ophthalmologist
- Optometrist
- Optician

b) Include a report detailing the amount payable to individual Providers, individual Clients and approved Third Parties for the payment period, by Provider number and office ID sorted by the types of benefit claims as listed in SOW article 3.3.12.1(a).

c) Include a report of all manual adjustments, in a format to be confirmed by the Project Authority that will affect the HICPS Claims Funding Request. This report must include a list of adjustments and recoveries resulting from Provider Verifications, sorted by Provider number and office ID, to be offset against claims settled in the payment period. Other manual adjustments could include detailed information regarding the re-issuance of claim adjustments, and the return or re-issuance of personal cheques or EFT rejections.

d) Separate/segregate by HC's fiscal year all Claims Expenditure files for Claims Funding Requests that cross HC's fiscal years.

3.3.12.2 Claims Funding Request Payment

a) HC will verify the Claims Funding Request. The Contractor must answer and resolve any questions asked by the Project Authority the same business day the Claims Funding Request is submitted. No funds will be transferred until all outstanding issues are resolved to the Project Authority's satisfaction. The Claims Funding Request amount must be reduced to

account for all credits due to recoveries and any other adjustments, including reductions due to benefit price effective date and Provider end date errors.

b) HC will transfer the funding directly to the Contractor's HICPS Account when the payment verification process is completed (refer to SOW Article 3.3.12.3 *HICPS Account* requirements). Payments to Providers, Clients, and approved Third Parties must be made by the Contractor within one business day of receipt of the deposit from HC.

3.3.12.3 HICPS Account - Establish, Manage and Report on Disbursement and Collection of Funds

The Contractor must establish, manage and report on the disbursement and collection of funds through a dedicated account with a Canadian Financial Institution.

a) The Contractor must establish and maintain, in its name, one interest-earning account to be called the HICPS Account. The HICPS Account must be established with a Canadian Financial Institution that is a member of the Canadian Payments Association. The HICPS Account is for the payment of all NIHB Program claims and claim reimbursements to Providers Clients and authorized Client representatives and for any other activity related to this Contract, as approved by the Project Authority. All fees and charges by the Financial Institution must be borne by the Contractor. All interest accrued in the HICPS Account must be returned to the Receiver General of Canada via HC within 10 business days following month end.

b) The Contractor must also establish a payment service with the Financial Institution such that cheques and EFT payments cleared must be matched by the Financial Institution against the issued cheque and EFT records.

c) The Contractor must provide the Project Authority with a copy of the Financial Institution's monthly statements of the HICPS Account within 10 business days of month end. The Contractor must reconcile all financial statements against the HICPS Claims Funding payment prior to sending to the Project Authority. Any errors noted by HC must be corrected within two business days of notification and the financial statements resubmitted to the Project Authority.

d) The Contractor must track amounts related to stale-dated cheques (cheques not cashed within 6 months from the cheque issue date). If a cheque is not cashed within 6 months of the cheque issue date, the full amount of this cheque must be returned to Canada on the first Claims Funding Request after the end of the 6 month period.

    i. Between 4 to 6 months after the cheque issue date, the Contractor must attempt to contact the Provider or Client to resolve the issue of the un-cashed cheque(s) and maintain a log of all communication attempts that must document at a minimum, name, home and business address, phone number if available, and outcome of the attempt(s) to be posted on the DRR on a quarterly basis.

    ii. If a request to reissue a payment from a Provider, Client, or authorized Client representatives is received 6 months after the date of issue, the Contractor must forward the request and supporting documentation to the Project Authority for approval to reissue the cheque. Upon approval by the Project Authority, the Contractor must reissue the cheque.

e) The Contractor must maintain a record and actively recover amounts receivable from Providers, Clients as a result of claim verifications, claims errors, corrections, amounts assigned to HC from the former Contractor at the termination of the previous contract, or other adjustments by:

    i. reviewing all debts and complete a checklist (approved by the Project Authority) that will record, at a minimum, any home/business address information obtained, details of internet searches performed (including screenshots), names dates and phone numbers of individuals contacted;

ii. accept all forms of payment from Providers including, but not limited to, making bill payments online;

iii. remitting to Canada all monies collected as part of recoveries as a result of claim verifications, claims errors, corrections, or other adjustments through the next Claims Funding Request in accordance with SOW article 3.3.12.1 *Claims Funding Request*;

iv. maintaining a Carry Forward Balance for the Provider;

v. preparing bi-weekly reports to HC detailing the type and reason for recovery, amounts recovered, and amounts outstanding and posting to the DRR at the time of the next Claims Funding Request;

vi. preparing a monthly debt recovery report package for HC that will describe the specific steps and activities taken to recover amounts and posting to the DRR within five business days of month end. The report package must include:

- A Carry Forward Balance Report which lists the activities by benefit and at a payee level by indicating the opening balance from the prior payment run, changes taking place during the current payment period, and the closing balance after the current payment run.

vii. A separate listing the same activities described above but only for recoveries related to the Provider Claims Verification Program.

f) All other monies received by the Contractor and Subcontractors in relation to the administration of the program, such as rebates, will be reported separately, and returned to Canada on the next Claims Funding Request.

g) The Contractor must provide the Project Authority with the following additional monthly financial reports within 10 business days of month end (see SOW Appendix H *Summary of Static HICPS Operational Reports*):

i. a report on stale-dated and un-cashed cheques;
ii. a report on payments stopped or cancelled.

3.3.12.4 HICPS Claims Expenditure Data File and Report

a) The Contractor must provide a HICPS Claims Expenditure Data File and Report in support of the HICPS Claims Funding Request (see Appendix H *Summary of Static HICPS Operational Reports*).

i. In support of the HICPS Claims Funding Request, the Contractor must provide a HICPS Claims Expenditures Data File by payment period according to the file layout and format type specifications detailed in Appendix E. The Expenditure Data File must be posted, for retrieval by the Project Authority, on the DRR. The Contractor must provide this file no later than two business days prior to the Contractor payment date.

ii. The Contractor must provide a report of the HICPS Claims Expenditure Data File for each payment period, at the same time the HICPS claims expenditure data file is provided to the Project Authority. This report must detail expenditures by Client/claim details as determined by the Project Authority (e.g. band, benefit type, region, program, client group, client affiliation). The Expenditure Data File and Claims Expenditure Report must balance against the HICPS Claims Funding Request for the same period. The Contractor must post this report on the DRR.

3.3.12.5 Financial Controls and Practices

The Contractor must apply financial controls and practices to support HICPS financial operations.

a) The Contractor must develop, document and implement the financial controls and procedures to support the HICPS financial operations and to interface with the HC financial system. These procedures must be documented in the HICPS Administrative Procedures Manual (see SOW Article 3.6.1.2 *Administrative Procedures Manual (APM)*) and must be updated by the Contractor. The financial controls and procedures and subsequent changes thereto must be approved by the Project Authority and must include at a minimum:

   i. Financial management planning and control processes and procedures that will be used to ensure efficient budgeting, cash flow planning and financial management, financial data integrity, accuracy and probity, including a description and timing of any anticipated reports;

   ii. An accurate, efficient and secure payment service to Providers, Clients and approved Third Parties for verified claims;

   iii. A methodology for consolidating claim lines per Provider, per Client, per client group, per client affiliation, per approved Third Party, per benefit area, per band, per province and territory and per FNIHB region;

   iv. Methods for detection and correction of financial errors or abuse of responsibility;

   v. The procedures to be used for recovery, processing, and remittance to HC of amounts due as a result of Provider claim verifications, stale-dated cheques, interest earned on the HICPS Claims Account, etc.;

   vi. Error free reconciliations of the HICPS Account, HICPS Claims Expenditure Data File and Report and NIHB Claims Funding Request;

b) These financial controls and procedures are subject to audits described in SOW Article 3.3.12.6 *External Audits and Corrective Measures*.

3.3.12.6 External Audits and Corrective Measures

The Contractor must participate in all external audits and implement any required corrective measures.

a) The Contractor's controls will be subject to an annual audit by an external auditor, with the audit report extending to controls placed on operations and tests of the operating effectiveness of controls, in accordance with CSAE 3416 of the Handbook of the Canadian Institute of Chartered Accountants (CICA). The Contractor must ensure all Work is performed in a manner that permits and facilitates a CSAE 3416 audit. If the Contractor sub-contracts activities relating to controls covered by the audit, the Subcontractor will also be subject to audit. CSAE 3416 audits are required and will be conducted annually, commencing in the first government fiscal year of operations of the Contract and must extend to any activities performed by the Contractor's Subcontractors. The Contractor must ensure the same audit access to Subcontractors as audit access to the Contractor. The Contractor is solely responsible for all costs associated with the audit. If the audit opinion includes a reservation or denial of opinion, the Contractor (Subcontractors) must disclose the planned corrective action relating to the reservation to the Project Authority for its concurrence. The Contractor is solely responsible for costs associated with any corrective actions taken to address issues that are identified pursuant to a CSAE 3416 audit.

b) The Contractor will be subject to an annual audit by an external auditor who will perform an audit in accordance with CAS 805 of the Handbook of the Canadian Institute of Chartered Accountants (CICA). The Contractor must ensure all Work is performed in a manner that permits and facilitates a CAS 805 audit. If the Contractor sub-contracts activities relating to areas covered by this audit, the Subcontractors will be also be subject to audit. The Contractor must ensure the same audit access to Subcontractors as audit access to the Contractor. CAS 805 audits are required and must be conducted annually, commencing in the first government fiscal year of operations of the Contract and will extend to any activities

performed by the Contractor's Subcontractors. If the audit opinion includes a reservation or denial of opinion, the Contractor (Subcontractors) must disclose the planned corrective action relating to the reservation to the Project Authority for concurrence. In the event of a denial of opinion, the contract may be terminated or other remedial action may be taken. Canada will pay for the services of the external auditor to conduct the CS 805 audits (of both the Contractor and any Subcontractors) through the Task Authorization process. The Contractor must secure the contract for the independent auditor, with the Project Authority's participation and approval. The Contractor is solely responsible for all other costs associated with the audit, including participating in the audit and those costs associated with any corrective actions taken to address issues that are identified pursuant to a CAS 805 audit. The Project Authority will prescribe the scope of the audit.

c) The Contractor's and any Subcontractor's records and invoices related to all financial operations of the Contract must be subject to an audit by an external auditor at least once per fiscal year. Audits of records related to the post account verification process of the claims payment needed to support the *Financial Administration Act* may be required on a monthly basis. The Contractor must ensure the same audit access to Subcontractors as audit access to the prime Contractor. The Contractor will ensure all Work is done in a manner that permits and facilitates such audits and must keep all invoices, receipts and vouchers relating thereto. The Contractor must provide all facilities for such audits and inspections. Any amounts found to be owing to Canada must be paid back to Canada. The Project Authority will prescribe the scope of the audit. The Contractor must develop and seek the Project Authority's approval to implement corrective measures to address any audit findings, observations and recommendations. The Project Authority will pay for the services of the external auditor through the Task Authorization process. The Contractor must secure the contract for the independent auditor, with the Project Authority's participation and approval. The Contractor is solely responsible for all other costs associated with the audit. In the event of any corrective measures, the Contract may be terminated or other remedial actions may be taken to address issues.

3.3.12.7 Service Standard

The service standard for SOW Article 3.3.12 Financial Operations is 100 percent adherence to all specified timelines. The Contractor must report monthly to the Project Authority any incidences where a timeline requirement is not fully met. In the absence of Contractor notification, the Project Authority reserves the right to determine if a requirement is not fully met.

.

3.3.13 Provider Claim Verification Program

3.3.13.1 Claim Verification Record - Capturing Provider Claim Verification Program Data

The Contractor must provide the HC User with the ability to manage the NIHB Claim Verification Program components for all benefit types through the HC HICPS interface and to track verification activities by verification type. The Contractor must include the ability to view the assessment details and associated documentation.

Search for Claim Verification Details

3.3.13.1.1 The Contractor must ensure that HC Users have the ability to:

a) access and manage the following information through the HICPS interface:

i. claim verification records;
ii. claim verification sample queries;
iii. electronic copies of, but not limited to, reports, letters and documents;

b) search for a claim verification record by, but not limited to:

i. claim verification record ID;
ii. claim verification type;
iii. date range;
iv. Provider ID including the ability to search for a Provider by accessing the workflow in SOW Article 3.3.9.3 *Searching for a Provider*;
v. recovery code;

c) view search results including, but not limited to:

i. claim verification record ID;
ii. date of claim verification;
iii. verification type;
iv. number of claim lines verified;
v. amount adjusted, reversed, withheld or recovered;

d) access the claim verification details for record selected in the search results.

3.3.13.1.2 The Contractor must provide the HC User with the ability to:

a) view Daily Claim Verification Program (see SOW Article 3.3.13.3 *Implementation of a Daily Claim Verification Program*) or Client Confirmation Program (see SOW Article 3.3.13.6 *Implementation of a Client Confirmation Program*) claim verification details for each benefit area including, but not limited to, the following:

i. claim verification record details including but not limited to record ID, date of claim verification, type of claim verification;
ii. Provider details including but not limited to provider ID and name;
iii. Client details including but not limited to client ID, name, date of birth and gender;
iv. benefit specific claim information including but not limited to benefit name, item procedure code or service and name, claim dollar amount and service date;
v. assessment details including, but not limited to, assessment criteria, date of request, date of response, response documents included and date of review;
vi. reversal or adjustment details including, but not limited to, amount paid, amount reversed or adjusted and predefined recovery reason;
vii. appeal details including, but not limited to, appeal receipt date, decision date, supporting documentation;
viii. electronic copies of reports, letters, and documents attached to each claim verified, including the ability to view the document;

b) view on-site and desk claim verification details for each benefit area including, but not limited to, the following:

i. claim verification record details including, but not limited to, record ID, date of claim verification, type of claim verification;
ii. Provider details including, but not limited to, provider ID, name;
iii. Client details including, but not limited to, client ID, name, date of birth and gender;
iv. benefit specific claim information including, but not limited to, benefit name, item or procedure name, claim dollar amount and service date;
v. assessment details including, but not limited to, assessment criteria, date of request, date of response, response documents included and date of review;
vi. Initial recovery details including, but not limited to, amount recovered and predefined recovery reason;
vii. final recovery details including, but not limited to, amount recovered and predefined recovery reason;
viii. amendment details including, but not limited to, if recovery was amended, amendment amount and associated dates;

ix. electronic copies of reports, letters, and documents specific attached to the claim verification record;

c) control access to claim verification record based on user's permission.

View Claim Verification Record Details in Claim History

3.3.13.1.3 The Contractor must provide the HC User the ability to view the claim verification assessment details within a client's benefit area specific claim details including, but not limited to, the following:

a) Indication of non-payment, payment, adjustment or repayment from appeal and associated dollar amount related to Daily Claim Verification and Client Confirmation Program assessments;

b) Indication of non-recovery, recovery, adjustment or repayment from appeal and associated dollar amount related to Desk and On-site Claim Verification assessments;

c) Predefined recovery reason for non-payment or adjustment identified in Administrative Procedure Manual (APM).

3.3.13.2 Managing the Administrative Procedures Manual (APM)

The Contractor must implement and maintain the *Provider Claim Verification Program* according to the benefit-specific APM. The APM will be developed by the Contractor in consultation with the Project Authority. The Project Authority has final approval of the document.

The Contractor must execute the detailed processes outlined within each benefit-specific APM including, but not necessarily limited to, the claim verification assessment methodology, quality assurance standards, program reporting and communication templates as approved by the Project Authority.

3.3.13.2.1 The Contractor must:

a) adhere to the approved APM for each benefit area;

b) implement changes to the execution of each program including but not limited to training staff identified in Appendix F, updating communication templates and program reports as the APM is updated;

c) provide all claim verification specialists access to expert advice from professionals including, but not limited to, dentists and pharmacists (all professionals as identified in Appendix F *Task Authorization Labour Categories*) through hiring of professionals as employees and consultants;

d) provide claim verification coordination services described in Appendix F *Task Authorization Labour Categories*;

e) provide services, requests, reports and all communication in either English or French for all benefit areas based on the Provider's language preference particularly with the execution of desk and on-site claim verifications;

f) use templates for written communication approved by the Project Authority prior to use;

g) adhere to APM service standard:

i. the Contractor must update the APM with the approved changes within five business days;
ii. the Contractor must implement process changes as documented in the APM within five business days of documented Project Authority approval.

3.3.13.3 Implementation of a Daily Claim Verification Program

The Contractor must deliver a Daily Claim Verification (DCV) Program for each program benefit whereby the Contractor verifies claims for administrative errors daily using the methodology described in the APM (refer to SOW Article 3.3.13.2 *Managing the Administrative Procedures Manual (APM)*).

3.3.13.3.1 The Contractor must:

a) execute 12,000 claim line investigations across all program benefits per year including:

   i. claims using the predefined criteria;
   ii. claims on an *ad hoc* basis *in lieu of* claims identified using the predefined criteria. *Ad hoc* claims are defined as targeted assessments prescribed by the Project Authority.

3.3.13.4 Management of Daily Claim Verification Program

The Contractor must provide the HC User with the ability to manage DCV assessments through describing the sample of claims to be verified and related guidelines for the administrative validation of the claim submission.

3.3.13.4.1 The Contractor must adjust the DCV procedures and sampling criteria for each benefit area as required by the Project Authority and update the APM accordingly.

3.3.13.4.2 The Contractor must provide the HC User with the ability to:

a) preview the DCV sampling criteria results using existing claims data at any point;

b) generate and view reports on existing assessment results captured through DCV activities via the BI Reporting Tool in accordance with SOW Article 3.3.14 *Reporting Services*.

3.3.13.5 Execution of Baseline Daily Claim Verifications

The Contractor must execute the DCV Program as described by the Project Authority for each program benefit including creating a sample of claims, requesting information related to the claims, assessing the claim for administrative errors and taking the appropriate action.

3.3.13.5.1 Setup of DCV samples

The Contractor must:

a) create and maintain samples of claims to populate the claim verification record based on criteria approved by the Project Authority;

b) identify each sample uniquely using a naming convention that clearly describes the sample;

c) implement criteria to populate samples based on program needs -DCV samples to be based on, but not limited to, the following individual criteria or a combination of criteria:

   i. stratified sampling based on provider volume;
   ii. clustering Providers by geographic area;
   iii. claims processed the previous day;
   iv. claims processed from other defined points in time as needed;
   v. including or excluding one to many items or procedures;
   vi. including or excluding one to many Providers based on claim verification frequency, claim verification performance or other factors;
   vii. including random selection of claims regardless of item or procedure;
   viii. including any item or procedure handled by benefit program currently or in the future;

d) create and manage list of uniquely named criteria as required by the Project Authority and make these values available for use in the claim verification record;

e) execute *ad hoc* DCV claim assessments, as described and requested by the Project Authority;

f) identify *ad hoc* assessments within the claim verification record with a uniquely named criteria.

3.3.13.5.2 Execution of Daily Claim Verifications

The Contractor must:

a) initiate assessment on a daily basis by creating a unique claim verification record and populating the claim verification record with the appropriate sample of claims for each benefit area as required by the Project Authority (refer to SOW Article 3.3.13.1 *Claim Verification Record* for data requirements);

b) hold payment for any claims identified upon initiation of the assessment that have not yet been released for payment by means other than reversing a paid claim:

   i. only until the claim is appropriately validated with Provider's records will the claim be paid at the next available payment interval;

c) request documentation from Providers based on claims identified in daily sample using a timely and confidential means of written communication to determine if the documentation supports the billing for each claim assessed;

d) record in the claim verification record:

   i. the date of request for information for each Provider;
   ii. if the Provider responded to each the claim assessed and date of the response;
   iii. if documentation was received and the date received;
   iv. comments related to assessment when appropriate;

e) capture and manage documents returned from Providers against each claim assessed in the claim verification record;

f) review and analyze the information provided for each claim using requirements set out by the Project Authority to determine if the documentation supports the billing for each claim assessed;

g) adjust or close the claim without payment, prior to the payment being processed, as supported by the evidence found in documentation and record the date of the transaction;

h) adjust or reverse the claim, after the payment has been processed, as supported by the evidence and record the date of the transaction;

i) adjust or close claim without payment after 21 calendar days when no response is received or documentation supplied is insufficient to support the claim;

j) accept appeals from Providers within one year of benefit service date based on HC policy

k) analyze data provided as part of an appeal and process or adjust payment based on supporting evidence found in documentation for each claim appealed;

l) record result of appeal assessment, adjusted payment amount and the date of repayment when necessary;

m) record in the claim verification record, but not limited to, the following:

   i. result of assessment including indication of non-payment, payment, adjustment or repayment from appeal and associated amount;
   ii. predefined recovery reason for non-payment or adjustment identified in APM;

n) provide appropriate communication to Provider regarding each non-payment, adjustment to claim or repayment using a timely and confidential means of communication and date of communication;

o) update provider record to exclude specific or all provider billings from future DCV assessments for a set period of time (6, 12, 18 or 24 months), as deemed by the Project Authority;

p) generate a report on the results of the DCV Program (see SOW Article 3.3.13.17 *Reporting Requirements for the Provider Claim Verification Program*);

q) service Standard - DCV Program:

i. claims must be processed within one business day of the Provider submission for all assessments;
ii. appeals must be processed within one business day of submission by the Provider;
iii. *ad hoc* DCV requests must be initiated within one business day of receipt of Provider submission.

3.3.13.6 Implementation of Client Confirmation Program

The Contractor must deliver a Client Confirmation Program (CCP) for each benefit type whereby the Contractor verifies claims for administrative errors based on Client responses using the methodology described in the benefit-specific APM (refer to SOW Article 3.3.13.2 *Managing the Administrative Procedures Manual (APM)*).

3.3.13.6.1 The Contractor must:

a) execute 1,800 CCP written communication investigations with certain exclusions for all NIHB Program benefits per fiscal year including:

i. claims using the predefined criteria;
ii. claims on *an ad* hoc basis *in lieu of* claims identified using the predefined criteria.

3.3.13.7 Management of Client Confirmation Program

The Contractor must provide the HC User with the ability to manage CCP assessments through describing the sample of claims to be verified for the administrative validation of the claim submission.

3.3.13.7.1 The Contractor must adjust the CCP procedures and sampling criteria for each benefit area on a routine and on an as needed basis as required by the Project Authority.

3.3.13.7.2 The Contractor must provide the HC User with the ability to:

a) preview the CCP sampling criteria results using existing claims data at any point;

b) generate and view reports on existing assessment results captured through CCP activities via the BI Reporting Tool in accordance with SOW Article 3.3.14 *Reporting Services*.

3.3.13.8 Execution of Client Confirmation Program

The Contractor must execute the CCP as described by the Project Authority for each benefit type including creating a sample of claims, requesting information related to the claims, assessing the claim for administrative errors and taking the appropriate action.

3.3.13.8.1 Setup of CCP samples

The Contractor must:

a) create and maintain samples of claims to populate claim verification record based on criteria provided or approved by the Project Authority;

b) identify each sample uniquely using a naming convention that clearly describes the sample;

c) implement a random sample of Clients by province/territory based on HC methodology including the following criteria:

i. including or excluding one to many items or procedures;
ii. include or exclude one to many Clients based upon residency information (e.g. known or suspected fictitious residential address) Clients currently identified as residing at an alternate address for those letters that are non-deliverable, or known long term residential care facilities as drugs may not be sent to the Client, rather to the nursing staff to provide to the Client);

d) populate samples in addition to criteria outlined in SOW Article 3.3.13.8.1(c) based on PCVP needs - samples may be based on but not limited to the following individual criteria or a combination of criteria:

i. stratified sampling based on provider volume;
ii. clustering Providers by geographic area;
iii. clustering Clients by geographic area;
iv. Clients receiving benefits from the previous month;
v. Clients receiving benefits from other defined points in time as needed;
vi. including or excluding one to many items or procedures;
vii. including random selection of claims regardless of item or procedure;
viii. including any item, procedure or service currently or in future handled by benefit program;
ix. include or exclude one to many Clients based upon residency information (e.g. known or suspected fictitious residential address – clients currently identified as residing at an alternate address for those letters that are non-deliverable, or known long term residential care facilities - as drugs may not be sent to the client, rather to the nursing staff to provide to the client on a daily basis.);

e) execute *ad hoc* CCP assessments, as described and requested by the Project Authority;

f) identify *ad hoc* assessments within the claim verification record with a uniquely named criteria.

3.3.13.8.2 Execution of Client Confirmation Verifications

The Contractor must:

a) initiate CCP assessment on a monthly basis by creating a unique claim verification record and populating the claim verification record with the appropriate sample of claims for each benefit area as required by the Project Authority (refer to SOW Article 3.3.13.1 *Claim Verification Record* for data requirements);

b) request information from Clients identified in sample in a timely and confidential manner of written communication in order to confirm whether the benefit or benefits claimed and paid on their behalf were in fact received by them:

i. letter-based communication must obscure the client's ID sufficiently to prevent unauthorized third parties from being able to use the ID;
ii. envelopes for letter-based communication to be stamped "Confidential" or marked with another term to indicate letter is intended to be read only by the intended recipient;

c) include postage paid return envelope when means of communication is through letter mail;

d) record in the claim verification record:

i. the date of request for information for each Client;
ii. Client's response if benefit received as either "yes", "no" or no response and reason for no response when available (example, failed to deliver or change of address);
iii. if documentation received and the date received;
iv. comments related to assessment when appropriate;

e) capture and manage documents returned from Clients against each claim assessed in the claim verification record;

f) update Client's address based on Client's response or remove address if letter mail was returned or otherwise was failed to be delivered;

g) review and analyze the information provided for each claim using HC requirements to determine if the documentation supports the billing for each claim assessed;

h) notify the Project Authority of any negative responses, comments, comments related to a change of name, complaints or significant unresolved issues via email or other confidential means identifying the claim ID within one business day of response;

i) request documentation, on Project Authority approval, from the Provider and record the date of the request when a discrepancy is reported and/or the Client indicates benefit was not supplied or received;

j) adjust or reverse the claim, after the payment has been processed, as supported by the evidence found in documentation and record the date of the transaction;

k) adjust or reverse the claim after 21 calendar days when no response is received or documentation supplied is insufficient to support the claim;

l) capture and manage documents returned from Providers against each claim assessed in the claim verification record;

m) accept appeals from Providers within one year of benefit service date based on HC policy;

n) analyze data provided as part of an appeal and process or adjust payment based on supporting evidence found in documentation for each claim appealed;

o) record result of appeal assessment, adjusted payment amount and the date of repayment when necessary;

p) record in the claim verification record:

   i. result of assessment including indication of non-payment, payment, adjustment or repayment from appeal and associated amount;
   ii. predefined recovery reason for non-payment or adjustment identified in APM;

q) provide appropriate communication to Provider regarding non-payment, adjustment to claim or repayment using a timely and confidential means of communication and date of communication;

r) generate a report on the results of the CCP (see SOW Article 3.3.13.16 *Review of the Claim Verification Program with the Contractor*); for details;

s) service standard - CCP:

   i. responses received from CCP must be assessed by the Contractor within two business days of receipt;
   ii. responses received by the Contractor from Provider must be assessed within two business days of being submitted by the Provider and sent to the Project Authority for action/approval;
   iii. appeals must be assessed within one business day upon Provider submission;
   iv. *ad hoc* CCP request must be initiated within one business day of receiving request from the Project Authority.

3.3.13.9 Implementation and Management of Provider Desk and On-Site Claim Verification Programs

The Contractor must implement and manage Provider Desk Claim Verification and On-Site Claim Verification Programs as described by the Project Authority for each program benefit.

3.3.13.9.1 The Contractor must:

a) Execute 50 Provider verifications through a combination of desk and on-site claim verification processes outlined in the APM per year. A Task Authorization will assign the program benefit to be verified.

   i. Note: Claims for the Pharmacy benefit include prescription refills - generally, these are not considered as part of the original claim sample but rather a straight recovery action in a secondary sample - this is subject to a change in definition in certain jurisdictions where sample sizes are predefined by a legal agreement with provider groups such as the AQPP in the province of Quebec where claim line counts are a transaction count and not separated by status of first fill or refill.
   ii. Note: *ad hoc* desk and on-site claim verifications upon the Project Authority's request above the stated annual amount through a Task Authorization process.

b) provide claim verification coordination services:

   i. ensure timely delivery of reports to the Project Authority on a weekly and monthly basis;
   ii. scheduling activities for all claim verifications;
   iii. providing updates to the Project Authority;
   iv. management of Resources;
   v. program management and consulting.

3.3.13.10 Provider Desk Claim Verifications Program

Contractor must execute a desk claim verification program as described by the Project Authority for each benefit type including the assessment of Provider's claims through an administrative review of documentation received from the Provider.

3.3.13.10.1 The Contractor must:

a) adjust the Desk Verification procedures and sampling criteria for each benefit area as required by the Project Authority and update the APM accordingly.

3.3.13.10.2 Setup of Provider Desk Verification Samples

The Contractor must:

a) generate a sample of claims for single provider based on criteria provided by the Project Authority within claim verification record (refer to SOW Article 3.3.13.1 *Claim Verification Record* for data requirements);

b) implement criteria to populate desk claim verification samples based on program needs. Desk Claim verification samples may be based on, but not limited to, the following individual criteria or a combination of criteria:

   i. including or excluding claims within a specific date range;
   ii. including or excluding one to many items or procedures;
   iii. including random selection of claims regardless of item or procedure;
   iv. including any item or procedure handled by benefit program currently or in future.

3.3.13.10.3 Execution of Desk Verifications

The Contractor must:

a) Provide the HC User with the ability to:

   i. review the initial claims sample within the claim verification record;
   ii. request adjustments be made to the sample as needed;
   iii. approve the sample prior to execution;

b) submit initial claim verification report package to HC for review and approval;

c) send, upon the Project Authority's approval, the initial claim verification report package consisting of the claim verification report and claim verification letter requesting a response with supporting documentation using a timely and confidential means of written communication;

d) record the date the initial claim verification report package is sent in the claim verification record;

e) follow-up with provider after 21 calendar days if no response received;

f) capture and manage documents returned from providers against each claim assessed in the claim verification record;

g) review and analyze the information provided for each claim using the Project Authority's requirements to determine if the documentation supports the payment for each claim assessed;

h) record in the claim verification record, but not limited to, the following:

i. indication that result is non-recovery, recovery, adjustment or repayment from appeal;
ii. associated dollar amount to non-recovery, recovery, adjustment or repayment from appeal;
iii. predefined recovery reason for non-payment or adjustment identified in APM;

i) expand claim sample and analysis of claims of the same type (e.g. same procedure code, item or item type) that are found through the initial assessment to have been claimed in error within the defined sample period - for example, the item is not a benefit but is billed under an eligible benefit code - all like claims are to be listed in recovery report;

j) generate the summary report providing statistical information on claim lines and recovery rates and describes the desk claim verification in narrative form including but not limited to:

i. an overview of the claim verification;
ii. a narrative of the risks identified and reviewed;
iii. summary of the number of claims, dollar value, error rate, value to be recovered, recovery rate;
iv. issues identified and recommendations to the Project Authority.

3.3.13.10.4 Reporting on the Results
The Contractor must:

a) submit final claim verification report package consisting of the claim verification report, claim verification letter and summary report to the Project Authority for review and approval 30 calendar days following receipt from Provider's response;

b) send Provider the final claim verification report package within 2 business days upon the Project Authority's approval using a timely and confidential means:

i. including a written request that the recovery amount be paid within 30 calendar days;
ii. see SOW Article 3.3.13.14 *Recovery of Funds related to the Provider Claim Verification Program* requirements for managing the receipt of the cheque;

c) record the date the final claim verification report package is sent to the provider in the claim verification record;

d) accept, review and document the provider's appeal, if received, for each claim line in the claim verification record where applicable;

e) review and analyze submitted documents to determine if claim is supported and record the associated reason;

f) create an amended final report package as needed updating the claim verification record, claim verification letter and summary report;

g) submit amended final claim verification report package consisting of the claim verification report, claim verification letter and summary report to the Project Authority for review and approval;

h) send Provider, upon the Project Authority's approval, the amended final claim verification report package and request that the recovery amount be paid within 30 calendar days using a timely and confidential means of written communication as needed and record the date of communication, see SOW Article 3.3.13.14 *Recovery of Funds related to the Provider Claim Verification Program* requirements for managing the recovery of funds;

i) record the date the amended final claim verification report package is sent in the claim verification record;

j) withhold funds, upon the Project Authority's approval, if Provider has not responded with payment in 30 calendar days;

k) record if the Provider's billings are to be monitored in the provider record for a defined period of time, for example 3, 6, 9 or 12 months;

l) record the recommended date by which the next Provider Claim Verification should be performed and the type of claim verification to be executed in the provider record;

m) generate program reports on the results of the desk claim verification program (see SOW Article 3.13.16 *Review of the Claim Verification Program with the Contractor* for details);

n) provide the Project Authority with the ability to view the following attached to the claim verification record:

   i. signed electronic copies of the initial, final and amended claim verification reports within the claims processing system;
   ii. all additional communications (for example, requests for response extension and legal letters);

o) adhere to the service Standard – Provider Desk Claim Verification Program:

   i. adhere to delivery dates stated within individual requirements 100% of the time.

3.3.13.11 Financial Recovery Program

Contractor must deliver a Financial Recovery Program as described by the Project Authority for each NIHB Program benefit type.

3.3.13.11.1 The Contractor must:

a) provide HC User with the ability to generate list of claims for single Provider within claim verification record (refer to SOW Article 3.3.13.1 *Claim Verification Record* for data requirements);

b) generate list of claims for single Provider based on criteria provided by the Project Authority within claim verification record (refer to SOW Article 3.3.13.1 *Claim Verification Record* for data requirements);

c) implement recovery claim verification records based on the Project Authority's request - financial recovery claim verification records may be based on but not limited to:

   i. including or excluding claims within a specific date range;
   ii. including or excluding one to many items or procedures;
   iii. including random selection of claims regardless of item or procedure;
   iv. including any item or procedure handled by benefit program currently or in future;

d) provide HC Users the ability to review the claim verification record, require adjustments be made to the sample as needed and approve record prior to execution;

e) document the recovery or adjustment amount for each claim within the claim verification record and the date of the transaction;

f) produce the summary report providing statistical information on claim lines and recovery rates (see SOW Article 3.3.13.17 *Reporting Requirements for the Provider Claim Verification Program* for details);

g) submit recovery report package consisting of the claim verification report, claim verification letter and summary report to HC for review and approval;

h) capture and store electronically in the claim verification record the communication and or documentation returned from Providers;

i) send Provider the recovery report package within two business days upon the Project Authority's approval using a timely and confidential means:

   i. including a written request that the recovery amount be paid within 30 calendar days;
   ii. see SOW Article 3.3.13.14 *Recovery of Funds related to the Provider Claim Verification Program* requirements for managing the recovery of funds;

j) record the date the recovery report package is sent to the Provider in the claim verification record;

k) withhold funds, upon the Project Authority's approval, if Provider has not responded with payment in 30 calendar days;

l) notify and submit to the Project Authority the Provider's appeal, if received;

m) amend the recovery report package as needed updating the claim verification record, claim verification letter and summary report based on direction from the Project Authority;

n) generate the Financial Recovery Summary Report that summarizes and identifies the findings of an financial recovery including:

   i. an overview of the claim verification;
   ii. summary of the number of claims, dollar value, error rate, value to be recovered, recovery rate;

o) adhere to the service Standard - Financial Recovery Program:

   i. Adhere to delivery dates stated within individual requirements 100% of the time.

3.3.13.12 On-site Claim Verification Program

The Contractor must execute an on-site claim verification program as described by the Project Authority for each NIHB Program benefit including the assessment of Provider's provider claims through an administrative review of documentation at the Provider's place of business.

3.3.13.12.1 The Contractor must adjust the on-site verification procedures and sampling criteria for each benefit area as required by the Project Authority and update the APM accordingly.

3.3.13.12.2 Setup of On-site Verification samples
The Contractor must:

a) prepare for on-site claim verification by conducting a review of the Provider's information including:

   i. review of the key risk criteria identified in the Task Authorization by the Project Authority and build a claims sample reflective of current provider profile defined by provider claims history results;
   ii. review regional association agreement and specific claim verification process;
   iii. past Claim Verification Program assessment results;

b) generate sample of claims for single Provider based on risk criteria provided by the Project Authority within claim verification record:

i. the sample to be based on claim verification representative extensive experience and knowledge of the subject matter - an in-depth knowledge of HC benefit policies and guidelines, provider practices and types of inappropriate billing are pre-requisites to conducting on-site claim verifications - it is expected the individual will be able to identify claims within the risk criteria that properly assess the Provider's habit relative to the benefit guidelines (Refer to Appendix F for details on education and work experience requirements for a claim verification representative);

c) implement criteria to populate on-site claim verification samples based on program needs - on-site claim verification samples may be based on, but not limited to, the following individual criteria or a combination of criteria:

i. including or excluding claims within a specific date range;
ii. including or excluding one to many items or procedures;
iii. including random selection of claims regardless of item or procedure;
iv. including any item or procedure currently or in future handled by benefit program;

d) have consulting specialty sign-off on sample and submit to the Project Authority (see Appendix F *Task Authorization Labour Categories* for details on consulting specialty).

3.3.13.12.3 Execution of On-site Verifications

The Contractor must:

a) provide the HC User with the ability to:

i. review the initial claims sample within the claim verification record;
ii. request adjustments be made to the sample as needed;
iii. approve the sample prior to execution;

b) schedule claim verification with Provider three weeks before scheduled on-site date to a maximum of three months prior;

c) travel to and conduct an on-site claim verification at Provider's place of business anywhere in Canada, including remote and isolated communities, using the method of claim verification defined by the Project Authority;

d) send Client Confirmation Letters (volume determined as the situation demands) using the CCP templates and associated requirements as described in SOW Article 3.3.13.8 *Execution of the Client Confirmation Program*;

e) review and analyze CCP Client responses, according to CCP process and procedures as described in SOW Article 3.3.13.8 *Execution of the Client Confirmation Program* upon Project Authority approval;

f) capture and store electronically in the claim verification record the documentation provided for each claim assessed;

g) record in the claim verification record, but not limited to, the following:

i. indication that result is non-recovery, recovery, adjustment or repayment from appeal;
ii. associated dollar amount to non-recovery, recovery, adjustment or repayment from appeal;

h) create a secondary sample of Pharmacy claims where a claim error is and subsequently applies to refills or repeat instances - the same recovery applied to initial sample must be applied to secondary sample;

i) expand claim sample and analysis of claims of the same type (e.g. same procedure code, item or item type) that are found through the initial assessment to have been claimed in error within the defined sample period - for example, the item is not a benefit but is billed under an

eligible benefit code - all like claims are to be listed in recovery report (i.e. if one is detected, analysis must be conducted on all similar claims to determine recovery action);

j) generate the summary report providing statistical information on claim lines and recovery rates and describes the on-site claim verification in narrative form including but not limited to:

i. an overview of the claim verification;
ii. a narrative of the risks identified and reviewed;
iii. summary of the number of claims, dollar value, error rate, value to be recovered, recovery rate;
iv. issues identified and recommendations to HC.

3.3.13.12.4 Managing the Initial Report Package

The Contractor must:

a) submit initial claim verification report package consisting of the claim verification report, claim verification letter and summary report to the Project Authority for review and approval within 45 calendar days from on-site visit;

b) send Provider the initial claim verification report package that has been approved by the Project Authority within 60 calendar days from the on-site visit using a timely and confidential means;

c) record the date the initial claim verification report package is sent to Provider in the claim verification record.

3.3.13.12.5 Managing the Final Report Package

The Contractor must:

a) accept, review and document the Provider's response, if received, for each claim line in the claim verification report where applicable;

b) review and analyze submitted documents to determine if claim is supported and record the associated reason;

c) create a final claim verification report package updating the claim verification report, claim verification letter and summary report;

d) submit final claim verification report package consisting of the claim verification report, claim verification letter and summary report to the Project Authority for review and approval within 45 calendar days following receipt of Provider's response;

e) send the Provider the final claim verification report package that has been approved by the Project Authority within 60 calendar days following receipt of Provider's response using a timely and confidential means:

i. including a written request that the recovery amount be paid within 30 calendar days;
ii. see SOW Article 3.3.13.14 *Recovery of Funds related to the Provider Claim Verification Program* requirements for managing the recovery of funds;

f) record the date the final claim verification report package is sent to provider in the claim verification record.

3.3.13.12.6 Managing the Amended Final Report Package

The Contractor must:

a) accept, review and document the Provider's appeal for each claim line in the claim verification record where applicable;

b) review and analyze if response is accepted or not accepted and record the associated reason;

c) create an amended final report package as needed updating the claim verification record, claim verification letter and summary report;

d) submit amended final claim verification report package consisting of claim verification report, claim verification letter and summary report to the Project Authority for review and approval;

e) using a timely and confidential means, send the Provider the amended final claim verification report package that was approved by the Project Authority:

   i. including a written request that the recovery amount be paid within 30 calendar days;
   ii. see SOW Article 3.3.13.14 *Recovery of Funds related to the Provider Claim Verification Program* requirements for managing the recovery of funds;

f) record the date the amended final claim verification report package is sent to Provider in the claim verification record.

3.3.13.12.7 Completing the Verification

The Contractor must:

a) withhold funds, upon the Project Authority's approval, if Provider has not responded with payment in 30 calendar days;

b) record if the Provider's billings are to be monitored in the provider record for a defined period of time, for example 3, 6, 9 or 12 months;

c) record the recommended date by which the next claim verification should be performed and the type of claim verification to be executed in the Provider's record;

d) generate program reports on the results of the Provider On-Site Claim Verification Program (see SOW Article 3.3.13.17 *Reporting Requirements for the Provider Claim Verification Program* for details);

e) provide HC Users the ability to view the following attached to the claim verification record:

   i. signed electronic copies of the initial, final and amended claim verification reports within the claims processing system;
   ii. all additional communications (for example, requests for response extension and legal letters);

f) adhere to the service Standard – Provider On-Site Claim Verification Program:

   i. adhere to delivery dates stated within individual requirements 100% of the time.

3.3.13.13 Provider Claim Verification Quality Assurance

The Contractor must deliver a Quality Assurance program to maintain the quality of the Provider Claim Verification Program's data, reports and documentation created for and on behalf of the Project Authority.

3.3.13.13.1 The Contractor must:

a) review, analyze, and validate DCV claims that have been identified are based on risk based criteria;

b) review the justification provided for DCV claim reversals or adjustments for a sampling of assessments within claim verification records to ensure the appropriate action was taken within the assessment;

c) ensure the accuracy of DCV reports;

d) review, analyze, and validate CCP claims that have been identified are based on sampling criteria;

e) review the justification provided for CCP claim reversals or adjustments for a sampling of assessments within claim verification records to ensure the appropriate action was taken within the assessment;

f) ensure the accuracy of CCP reports;

g) verify on-site and desk claim Desk Claim verification reports during the initial and final review stages to ensure they are accurate and adhere to the APM, ensuring timely submission to the Project Authority for approval;

h) have the consulting specialty review analysis of claim verification;

i) ensure that all milestones for each desk and on-site claim verification are met and monitor the status of all claim verifications on an ongoing basis;

j) prepare a Claim verification Quality Assurance Sign-off Form for each report sent to the Project Authority for review;

k) complete and sign a Claim Verification Quality Assurance Sign-off Form for each draft report sent to the Project Authority for review ensuring any corrections noted on the form have been completed;

l) prepare and make available on request quality assurance reports (SOW Article 3.3.13.17 *Reporting Requirements for the Provider Claim Verification Program*) by benefit area including but not limited to, claim verification log - high level view report.

3.3.13.14 Recovery of Funds related to the Provider Claim Verification Program

The Contractor must recover monies owed under the Provider Claim Verification Program and to track and report the recoveries to the Project Authority.

3.3.13.14.1 The Contractor must:

a) recover monies owed as per SOW Article 3.3.12.3(e) *HICPS Account*;

b) review all debts and complete a checklist (approved by the Project Authority) that will record, at a minimum, any home/business address information obtained, details of internet searches performed (including screenshots), names dates and phone numbers of individuals contacted;

c) track separately by Provider, name, benefit, region, claim verification type (on-site or desk), and by Provider claim verification showing monies collected and monies outstanding:

   i. reports must be submitted to the Project Authority monthly, within 10 business days of month end;
   ii. an annual summary report must be submitted to the Project Authority within 10 business days following the end of the fiscal year;

d) notify the Project Authority of any reimbursement required as the Provider either over paid or the Contractor withheld monies over and above the identified recovery amount;

e) notify the Project Authority when an account has been deemed uncollectible at which point it will become the Project Authority's responsibility through the Assignment of Rights.

3.3.13.15 Provider Claim Verification Program Liaison

The Contractor must provide the Project Authority with a contact for liaising on the Provider Claim Verification Program. The contact must be a manager with the following qualifications:

Manager

Manager - Role to oversee Pharmacy

Qualifications:

- Minimum five years' relevant business experience listed below
- Experience identifying trends, process gaps, analyzing information, recommending, developing and implementing creative and effective solutions and providing strategic input
- Good knowledge of provider practice regulations, familiarity with Pharmacy provider software systems and an understanding of the health insurance business

Tasks:

- Provide Claim Verification Coordination services including:
- Delivery of reports to HC in specified delivery dates
- Scheduling activities for the on-site claim verifications
- Providing updates to HC
- Management of Resources;
- Program Management and Consulting
- Other management and coordination services as required

Manager - Role to oversee Dental

Qualifications:

- Minimum five years' relevant business experience listed below
- Experience identifying trends, process gaps, analyzing information, recommending, developing and implementing creative and effective solutions and providing strategic input
- Good knowledge of provider practice regulations, familiarity with Dental provider software systems and an understanding of the dental insurance business

Tasks:

- Provide Claim Verification Coordination services including:
- Delivery of reports to HC in specified delivery dates
- Scheduling activities for the on-site claim verifications
- Providing updates to HC
- Management of Resources;
- Program Management and Consulting
- Other management and coordination services as required

Manager - Role to oversee MSE, MH, and Vision

Qualifications:

- Minimum five years' relevant business experience listed below
- Experience identifying trends, process gaps, analyzing information, recommending, developing and implementing creative and effective solutions and providing strategic input
- Good knowledge of provider practice regulations, familiarity with provider software systems and an understanding of the health insurance business

Tasks:

- Provide Claim Verification Coordination services including:
- Delivery of reports to HC in specified delivery dates
- Scheduling activities for the on-site claim verifications
- Providing updates to HC
- Management of Resources;
- Program Management and Consulting
- Other management and coordination services as required

3.3.13.16 Review of the Claim Verification Program with Contractor

The Contractor must meet with the Project Authority, as required, to discuss activities and outcomes for each of the components of the Provider Claim Verification Program.

3.3.13.16.1 The Contractor must:

a) lead a *Joint Provider Claim Verification Review Committee to*:

i. lead review of all Provider Claim Verification Program components for all benefit areas and identify procedures documentation updates required;
ii. present a summary report and recommendations for each benefit area to the Project Authority on a quarterly basis highlighting the activities and outcomes for each of the components of the Provider Claim Verification Program;
iii. provide recommendations for changes to the Provider Claims Verification Program;
iv. share industry trend analysis as it relates to the NIHB Program;

Note: This committee meets quarterly with an annual comprehensive review. The estimated time commitment for committee members is approximately five to six business days per year. Meetings are generally held by teleconference with a face-to-face at year end;

b) participate in a *Joint Provider Review Committee*:

i. The mandate for the Joint Provider Review Committee is to review the results of claim verification activities and review the subsequent on-site and desk claim verification reports (initial, final and if necessary amended final). The Contractor must present the claim verification findings to the Project Authority in a clear manner, case-by-case, describing the findings and the risks they present to the Project Authority so that informed decisions may be made on the recoveries presented.
ii. This committee meets as required per desk or on-site claim verification unless deemed not required by the Project Authority.

c) participate, as required by the Project Authority, in presentations and meetings with Providers and professional representatives.

3.3.13.17 Reporting Requirements for the Provider Claim Verification Program

The Contractor must create and maintain the Provider Claim Verification Program (PCVP) reports.

3.3.13.17.1 Contractor must:

a) produce static reports for the PCVP components for all five benefit areas;

b) create PCVP reports on a monthly, quarterly, or annual basis as required by the Project Authority;

c) post the reports on the DRR no later than 10 business days from the required period (monthly, quarterly, or annual).

3.3.13.17.2 Acceptable Formats

The Contractor must provide HC User with the ability to view, print and export all reports to a format acceptable to the Project Authority (e.g. Excel), that allows the User to manipulate the report information as needed.

3.3.13.17.3 Service Standard – PCVP Reports:

a) The Contractor must post all reports to the DRR within 10 business days of the reporting period (monthly or quarterly or fiscal year end).

3.3.13.17.4 List of PCVP Reports

The Contractor must provide the Project Authority with the following reports, (this is not an exhaustive list):

a) daily claim verification service standard reports as required by the Project Authority;

b) daily claim verification program reports including, but not limited to:

   i. claims adjustments and reversals reports;
   ii. a summary by province and territory, provider, and criteria;

c) Client confirmation program service standard reports as required by the Project Authority;

d) Client confirmation program reports including, but not limited to:

   i. a summary by province or territory;
   ii. number of letters, claims lines investigated and recoveries;

e) Client confirmation on-site or desk claim verification reports including, but not limited to:

   i. summary by province or territory and provider;
   ii. number of letters, claim lines investigated and recoveries;

f) on-site and desk claim verification results including, but not limited to:

   i. number of claim lines and recoveries;
   ii. number of verification by type;
   iii. summary by province or territory and provider;

g) Client and Provider or prescriber confirmation mail-out summary reports;

h) Claim verification recoveries reports including, but not limited to:

   i. summary of claim verification recoveries and savings;
   ii. summary by province or territory;
   iii. number of letters, claim lines investigated, and recoveries;

i) daily claim verification recoveries reports templates including, but not limited to:

   i. itemized cheques received and withholds as they occur;

j) claim verification summary report for all NIHB Benefits including, but not limited to:

   i. summarize provider claim verification result history.

3.3.14 Reporting Services

The Contractor must provide reporting services that include but are not necessarily limited to:

a) **BI Reporting Tool:** Business intelligence (BI) reporting tool, containing all HICPS data elements as specified by the Project Authority to allow HC Users to manipulate and explore data through queries and analysis and enabling them to build reports to answer business questions.

b) **Static Reports:** Program Management and Operational reports that the Contractor must produce on a fixed schedule and post to a secured repository, the DRR (see SOW Article 2.6 *Documentation and Reporting Repository*), that must be made accessible to HC Users.

3.3.14.1 BI Reporting Tool Requirements

The Contractor must provide a Business Intelligence (BI) reporting tool that contains all HICPS data elements as specified by the Project Authority to allow HC Users to manipulate and explore the data through queries and analysis as well as enabling them to build reports to answer business questions.

3.3.14.1.1 BI Reporting Tool: General

The Contractor must provide and maintain, throughout the life of the contract, a BI reporting tool interface to meet the reporting and analytic needs of the Project Authority.

3.3.14.1.2 BI Reporting Tool: Permissions

The Contractor must ensure the HICPS tables and data elements are accessible from the BI reporting tool by HC Users in accordance with the privileges granted to them by the Project Authority. The Contractor must:

a) provide and maintain user access controls to the BI reporting tool data elements in accordance with privileges granted by the Project Authority including but not limited to:
    i. user specific;
    ii. user-benefit specific;
    iii. user-benefit-table specific;
    iv. user-benefit-table-field specific (both field access and limiting to specific values);
    v. enable the use of consistently de-identified values for data elements as identified and approved by the Project Authority.

3.3.14.1.3 BI Reporting Tool Configuration

3.3.14.1.3.1 The Contractor must:

a) ensure that the BI Reporting Tool accurately reflects all HICPS data;

b) ensure that table names, column names, and field values are translated into NIHB business terms within the BI Reporting Tool;

c) provide the ability for HC Users to access and report on the data tables located in the HICPS Test/Training environment, and production environment;

d) report on an annual basis proposed BI Reporting Tool modifications to improve functionality and performance.

3.3.14.1.3.2 The Contractor must ensure that changes to the HICPS Solution, including the addition or modification of data elements impacting the BI reporting tool, are implemented in the tool.

3.3.14.1.4 BI Reporting Tool: Building Queries

The Contractor must provide HC Users with the ability to build queries by selecting tables and fields, joining tables, applying conditions, calculating additional fields and applying groupings and sorting.

3.3.14.1.4.1 The Contractor must provide HC Users with the ability to:

a) develop, run, store, and share queries;

b) run single benefit and cross-benefit queries using default joins between tables;

c) import external data (outside the HICPS Solution) in the BI Reporting Tool to generate queries based on combined HICPS and external data (see SOW Article 3.4.2.1 (c) *Storage Capacity* for storage of external data):
    i. external data formats able to be imported into the BI Reporting Tool must include csv, text files, and Excel

d) generate and store reference tables that can be incorporated into a report or query;

e) define the joins between the reference table and BI Reporting Tool tables;

f) generate complex reports based on nested queries (result of sub-query into main query);

g) report on both historical details and the current details including, but not limited to, the ability to query data based on current benefit status or historical benefit status;

h) include conditions in queries to filter results, apply conditions including, but not limited to, mathematical comparisons, IN, BETWEEN and using calculated values;

i) filter using advanced filters (AND/OR) and nested filters;

j) create prompts and parameters for queries entered at run-time;

k) create detail-level calculations using data values and/or other calculations;

l) create aggregate-level calculations, including, but not limited to, sum, mean, mode, median, count and count distinct;

m) create semi-aggregate-level calculations including, but not limited to, lag, lead, rank, and percentile;

n) specify columns in aggregate queries to group by, and order by;

o) specify columns to sort by, including ascending vs descending;

p) group & sort by both selected fields and/or calculated fields.

3.3.14.1.4.2 The Contractor must define default joins between HICPS tables with the Project Authority's approval.The Contractor will work with HC Users to define data exclusions to suppress information in HICPS that is not relevant to day-to-day reporting such as client groups outside of NIHB or others as identified by the Project Authority.

3.3.14.1.4.3 The Contactor must provide HC Users with the ability to define their own joins between tables to enable advanced reporting activities.

3.3.14.1.5 BI Reporting Tool: Formatting Queries

The Contractor must provide HC Users with the ability to:

a) format data including, but not limited to, fonts and numeric formats;

b) apply conditional formatting of data including, but not limited to, traffic-lighting;

c) format and rename column headers;

d) format report layouts including, but not limited to, titles.

3.3.14.1.6 Tool BI Reporting: Visualizations

The Contractor must provide HC Users with the ability to view visual representations of query results including, but not limited to, graphs and charts.

3.3.14.1.7 Saving and Sharing Queries

The Contractor must provide HC Users with the ability to:

a) save queries with a user specified name;

b) share queries with other HC Users.

3.3.14.1.8 BI Reporting Tool: Running Queries

The Contractor must:

a) provide HC Users with the ability to run queries and reports;

b) allow multiple Users to run the same report or query simultaneously using the same or different parameters;

c) provide HC Users with the ability to schedule queries and reports to be executed at a time in the future in accordance with the HC User's specified parameters.

3.3.14.1.9 BI Reporting Tool: Outputting Results

The Contractor must provide HC Users with the ability to:

a) print and save query and report outputs;

b) export outputs in formats (at minimum, Excel, csv, text files, and PDF) and other formats acceptable to the Project Authority.

3.3.14.1.10 BI Reporting Tool: Support and Service Standards

The Contractor must maintain adequate performance for the BI Reporting tool. The service standards stated herein are not intended to be an exhaustive list. The Contractor must:

a) work with the Project Authority to address and resolve issues or concerns identified within the BI reporting environment in a timely fashion;

b) monitor the system and take appropriate actions to ensure stable system performance;

c) measure and report on all service standards and make available the service standard reports to the Project Authority for review as requested;

d) provide quarterly statistics on how many users log in to the BI Reporting Tool and their duration of use posted to the DRR quarterly within 5 business days of quarter’s end;

e) ensure that the BI tool is able to return:

   i. query results using any combination of tables across benefits for a period of 60 months within 15 minutes for 25 users simultaneously;
   ii. specific client claims history query results over the entire database history in less than 30 seconds;
   iii. ensure that users are able to retrieve any records in any table within the BI Reporting tool in under 2 minutes using any field or combination of fields;

f) ensure users be able to run queries approximately 400 times a day;

g) provide support to HC Users in the optimal use of the BI reporting tool;

h) work with HC Users to optimize multiple table queries to reduce result time;

i) provide performance optimization of the BI Reporting Tool in collaboration with the Project Authority.

3.3.14.2 Database Design & Documentation

For the BI Reporting Tool the Contractor must maintain and provide the current designs for all tables, columns, fields, indexes, data, and table relationships including, but not limited to:

a) BI environment database dictionary (comprehensive data definitions);

b) entity relationship diagrams.

When design changes are made to the database, updates to the above documents must be posted to the DRR within five business days.

3.3.14.3 Static Reports

3.3.14.3.1 The Contractor must develop and maintain static (program management, and operational) reports. NIHB program management and operational reports are used by HC staff to administer the Program. These reports are national, provincial/territorial, regional and jurisdictional in scope. NIHB Program management and operational reports must be produced in both official languages, and be posted to the DRR by the Contractor within five business days from the month's end (or quarter's end, where applicable).

3.3.14.3.2 The Contractor must develop and maintain static management and operational reports (see Appendix H). These reports are produced by the Contractor and posted to the DRR for the Project Authority's review. Reporting on activities includes, but is not limited to:

a) reporting on service standards;

b) the status of activities;

c) various claim processing activities;

d) system lifecycle management activities;

e) interface transaction results (SVS and financial system);

f) testing (system, user and security) results;

g) financial operations and reconciliations;

h) provider claims verification system reports;

i) disaster recovery (DR), business continuity (BC) incidences, and backup and tracking activities;

j) system availability and performance;

k) HC User support services;

l) quality assurance (i.e. non-system issues and resolutions);

m) incident and change management reports (i.e. system tickets for fix/enhancement);

n) end-users' activity logs, with details on frequency and specification to be provided by the Project Authority.

o) Provide BI Reporting tool quarterly statistics on how many users log on and their duration of use

3.3.14.4 Report Specifications

The Contractor must document all HICPS report design standards, specifications and layouts. Static reports must:

a) be either PDF, MS Word, Excel, CSV, or formats approved by the Project Authority;

b) have a standardized naming convention, be version controlled and dated;

c) have a consistent layout;

d) use NIHB Program terminology.

3.3.15 Records Management

The following outlines the requirements, information, and service standards, where applicable, for the management of records.

3.3.15.1 For All Paper Based HICPS Documentation and NIHB Claim Forms

a) The Contractor must retain and store all paper based documentation and records related to HICPS at the Contractor's expense. Such documentation may include, but is not limited to: claim forms and associated records, communication materials, manuals, financial records, Provider agreements and enrolment documentation, and Provider claim verification records.

b) The Contractor must label, file, and store documents and records in a logical and organized manner that will enable an effective and efficient transfer of documents upon completion of the contract.

c) The Contractor must handle completed claim forms and their associated records in accordance with PROTECTED B documentation safeguarding procedures. The Contractor must retain all paper claims and related documents at the Contractor's site for two years from the date of adjudication. At the end of this period, the Contractor must transport, store and maintain completed NIHB claim forms and associated records. The Contractor must complete this at its cost and in accordance with the transportation, storage, and retention requirements listed below.

d) The Contractor must transport, store, and retain all documentation in accordance with MGI, the Industrial Security Manual (http://iss-ssi.pwgsc-tpsgc.gc.ca/msi-ism/index-eng.html) and the RCMP standard for the Transport and Transmittal of Protected and Classified Information (G1-009) (see also SOW Article 3.4.6.2 *Policy Compliance*).

e) The Contractor must not sell, donate, auction, or discard any documentation or records. The Contractor must not destroy any documentation or records without the express written consent of the Project Authority obtained through the Task Authorization process.

   i. TAs associated with the destruction of documentation and records which result from a request initiated by the Contractor will be considered "No cost TAs" as the cost is included in the cost of the Contract and there will be no additional costs associated with them. These TAs serve only to provide the Contractor with written consent to proceed.

f) The Project Authority has the right to access all paper based records pertaining to the HICPS Solution provided by the Contractor and its Subcontractors, including, but not limited to, all adjudication rules, client information, payments made to Providers and Clients, claims and input documents, Provider claim verification information and financial records.

g) Unless otherwise indicated, the Contractor must make available all HICPS documentation within 5 business days of the Project Authority's request for documentation from the prior 24 months; within 10 business days for documentation from the prior 25 to 60 months; and within 20 business days of request by the Project Authority for requests relating to documentation for periods prior to the last 60 months.

3.3.15.2 For All Electronic HICPS Records

a) The Contractor must retain and store all electronic HICPS-related records in a format acceptable to the Project Authority for the period of the Contract. The Contractor must store and transport all HICPS electronic records in accordance with MGI, the Industrial Security Manual (http://iss-ssi.pwgsc-tpsgc.gc.ca/msi-ism/index-eng.html) and the RCMP standard for the Transport and Transmittal of Protected and Classified Information (G1-009) (http://www.rcmp-grc.gc.ca/physec-secmat/res-lim/pubs/g1-009-eng.htm) (see also SOW Article 3.4.6.2 Policy Compliance) at the Contractor's cost. The Contractor must back up all electronic data and records in accordance with the requirements outlined in SOW Article 3.4.6.25 *System Backups*. The Contractor must not destroy any electronic records without the express written consent of the Project Authority obtained through the Task Authorization process.

   i. TAs associated with the destruction of documentation and records which result from a request initiated by the Contractor will be considered "No cost TAs" as the cost is included in the cost of the Contract and there will be no additional costs associated with them. These TAs serve only to provide the Contractor with written consent to proceed.

b) The Project Authority has the right to access all electronic HICPS-related records provided by the Contractor and its Subcontractors, including, but not limited to, all adjudication rules, Client information, payments made to Providers and Clients, claims and input documents, Provider claim verification information and financial records.

c) Unless otherwise indicated, the Contractor must make available all HICPS electronic records through SFTP or the DRR within 5 business days of the Project Authority 's request for requests relating to electronic records from the prior 24 months, within 10 business days of request by the Project Authority for requests relating to electronic records from the prior 25 to 60 months and within 20 business days of request by the Project Authority for requests relating to electronic records for periods prior to the last 60 months.

3.4 Technical Specifications

3.4.1 HICPS Solution Requirements (includes the BI Reporting Tool)

3.4.1.1 Business Continuity, Availability and Service Standards

The Contractor must ensure the availability of the Solution.

a) Where the lack of availability will result in a moderate reduction in capability, restoration within 24 hours is acceptable.

b) The availability service standard for the solution and infrastructure that support all of the HICPS services is a minimum average of 99.700 percent. The performance service standard of the applications and applications infrastructure is a maximum average of 2 seconds as measured in user response time.

c) The availability service standard for the HICPS Website is a minimum average of 99.400 percent. The performance service standard of this Website is a maximum average of 3 second response time per request.

d) The BI Reporting Tool must be available, at minimum, between 5am to 12am (Eastern Standard Time – EST) Monday to Sunday; any scheduled outages must be planned outside of this window.

e) The availability service standard for the network infrastructure that supports all of the HICPS services that are under the control of the Contractor, excluding the HC network, the EDI network, and the Internet is a minimum average of 99.700 percent. The performance service standard of this network infrastructure is a maximum average of 200 milliseconds required for a packet to travel across a network path from a sender to a receiver.

f) The Contractor must measure and report all service standards to the Project Authority on a monthly basis using standard infrastructure and application monitoring tools provided by the Contractor. The Contractor must deliver this report to the Project Authority within 5 business days of the end of each month and post it to the DRR.

3.4.1.2 Expected Lifespan

The Contractor must provide a solution that is capable of being fully functional with the same network performance, application performance, database performance, and report performance for the life of the contract.

3.4.2 Information Management, Capacity, and Performance Requirements

3.4.2.1 Storage Capacity

The Contractor must deliver a solution that provides the adequate storage capacity needs.

a) The Contractor must deliver a solution capable of processing an initial 36 Million Claim Lines per year.

b) The Contractor must deliver a solution that accepts attachments for each claim and Client, including, but not limited to, radiographs.

c) The Contractor must provide storage capacity of two terabytes to support the requirement identified in SOW Article 3.3.14.1.4.1(c) *BI Reporting Tool: Building Queries*.

3.4.2.2 Data Archiving

The Contractor must ensure that all data is available for Client history review purposes; therefore, there is no requirement for data archiving.

3.4.2.3 Performance

The Contractor must ensure adequate performance of the Solution as stated in the service standard section (see SOW Article 3.4.1.1 *Business Continuity, Availability, and Service Standards*).

a) The Contractor must deliver a solution that supports a user base of approximately 425 users expected at any one time during the day, with a peak in the afternoon.

b) The BI reporting function will experience peak usage in the weeks following the beginning of the fiscal year.

c) The majority of users do a combination of data retrieval and data entry.

d) Approximate user distribution per region is:

Yukon: 26
Atlantic: 38
Québec: 32
Ontario*: 240
Manitoba: 31
Saskatchewan: 25
Alberta: 33

* *Ontario includes Regional users in Ontario region and National users at HQ*

3.4.2.4 Maintainability

a) The Contractor must deliver a solution that accommodates all information required to support HICPS Services. The Contractor must provide a flexible data management function that allows for future additions of data tables and field elements. All records and transactions must have a reference number, date/time stamp, and user ID to facilitate tracking, reporting, and auditing in all systems used by the Contractor in the delivery of HICPS.

b) The Contractor must ensure that the BI reporting tool holds information that is at most 24 hrs out-of-date. Data updates more frequently than once a day are highly desirable.

c) The Contractor must update the Solution in response to changes in NIHB Program eligibility and pricing rules, and external to NIHB changes (e.g. provincial/territorial insurance, claims processing industry, EDI software). The Contractor must implement these changes on the basis of ITIL Best Practices and must follow the change management process as detailed below in SOW Article 3.5.1, *Change Management*. Both the Project Authority and the Contractor will be responsible for the quality of data that they input on behalf of the claims services, but the Contractor, through system logic and data validations, must ensure data integrity, audit tracking, and archiving of changed data elements. Where the Contractor is responsible for updating data, update costs will be the responsibility of the Contractor.

d) The Contractor must ensure that historical concordance of information is maintained in the system data, the BI tool data, and in reports produced by the Contractor. The Contractor must maintain the data with an effective start and end date. The Contractor must document all changes to coding and message standards to ensure that historical concordance is maintained and report the data changes from the solution or the BI tool. In addition, the Contractor must ensure that claims history follows the Provider and Client even when Provider or Client numbers change.

3.4.3 System Access – Remote or Mobile

3.4.3.1 Remote Access

a) All remote access will be managed by Health Canada and use Health Canada's infrastructure and hardware.

3.4.4 Usability and User Interface

3.4.4.1 User Interface Language

The Contractor must apply HC screen development standards to all screens used by HC Users. The Contractor must design the screen applications to:

a) all screens, reports, documentation and solution outputs developed for HC Users and Providers must be available in both official languages (unless otherwise noted);

b) all screens and documentation developed for Clients must be bilingual (unless otherwise noted);

c) have the same functionality in both official languages;

d) default to a User's preferred official language, but allow the option to select either official language at sign in time – users should be able to change a screen's language directly from the screen;

e) provide graphical user interfaces;

f) provide consistent layout and functionality across all screens;

g) limit entry errors via field edits where appropriate;

h) be intuitive and user-friendly;

i) for external public facing user interfaces, provide the ability to increase or decrease font size while maintaining the page layout.

j) For HICPS (excluding the BI Reporting Tool) ensure titles, headings, field names and messages are based on NIHB Program terminology, any truncation or abbreviations to accommodate field size must be approved by the Project Authority.

3.4.4.2 Mandatory Fields

The Contractor must consistently indicate mandatory fields on all data input screens.

3.4.4.3 Session Management

HICPS users are often required to lookup various information while performing a task without interrupting the task itself. This could be looking up a Client's past claim history while assessing a new claim, or a Client's profile information, etc. The Contractor must deliver a solution that allows HC Users to access multiple instances of the Solution, either by way of allowing more than two sessions, or by other means. The Project Authority prefers a multi-session approach versus a tabbed interface because information must often be copied and pasted between instances.

3.4.4.4 System Messages

The Contactor must:

a) consistently display all interface messages on the same screen as the one on which the data was inputted;

b) ensure that messages are explanative and provide clear directions on how to fix the issued reported;

c) ensure that all messages are displayed with a unique identifier for that message to facilitate defect reporting and technical support;

d) ensure that after a message is displayed, the cursor should be placed where most appropriate to optimize navigation and user input.

3.4.4.5 Browser and Operating System Compatibility

The Contractor must ensure that the following requirements are met:

a) for Internet based user interfaces for HC Users, all user interfaces must be compatible with the standard HC Internet browser at the time the solution is deployed to production and be kept current with subsequent versions when HC upgrades to a new standard Internet browser, at no additional cost;

b) for public facing Internet sites, all user interfaces must be compatible with the latest minus 2 versions of the most popular Internet browsers - “Popular Internet browsers” is defined as those that have captured at least 5% of the WWW usage share at the time the solution is deployed to production;

c) for desktop applications, all user interfaces must be compatible with the standard HC desktop operating system at the time the solution is deployed to production and be kept current with subsequent versions when HC upgrades to a new standard operating system version, at no additional cost.

3.4.5 Hardware Infrastructure

The following outlines the requirements, information, and service standards for hardware and infrastructure.

3.4.5.1 Robustness - The Contractor must use a robust network architecture with no single point of failure and capable of supporting the high availability required.

3.4.5.2 Data Centre

The Contractor must provide access to a data centre and enable communication between:

a) Providers and the Contractor, e.g. real-time point-of-sale claims processing arrangements based on standard professional software, including but not limited to CPhA, CDAnet and Réseau ACDQ standards;

b) HC and the Contractor (including data communications arrangements for on-line HC access to the Contractor's system). All connectivity and/or desktop services must be compatible with HC infrastructure, must receive prior approval by the Project Authority, and anything which must be installed on HC’s infrastructure must not negatively impact upon the HC network or its operations;

c) Providers, Contractors, HC, and any Subcontractors.

3.4.5.3 Data Communication

a) The Contractor must base all data communication mechanisms with HC on secure Internet technologies. No direct connections to HC are required.

b) The Contractor's data communications technology must be compatible with and capable of integrating with HC's data communications network (see Appendix B *HC Technical Environment)* taking into account HC's personal computer hardware and software standards which will be communicated to the Contractor during the pre-implementation phase, and the application volumetric (such as frequency of transactions, size of data sets, etc.) to ensure the appropriate bandwidth is provided.

3.4.6 Security Requirements

3.4.6.1 Target risk level

The target level of risk for HICPS is “Low”, thereby establishing that the risk of a security breach must be kept to a minimum. Upon Contract Award, the Project Authority will provide a Statement of Sensitivity (SOS) for the Solution, which specifies an overall rating of at least “Moderate” for availability. The Contractor must ensure that all elements and environments of the claims processing service and its processes meet these target levels of risk, availability ratings and compliance with security requirements stated herein. This includes the production, testing, development, training, backup and off-site facilities for DRP, BCP and media storage and Contractor systems where ‘PROTECTED B’ information is handled or stored.

3.4.6.2 Policy Compliance

The Contractor must ensure that all data systems, connectivity and telecommunication methods, data transfers, reports, physical locations and individuals with access to systems and/or data, and handling of all ‘PROTECTED B’ information meets the following security policies and legislation:

a) Policy on Government Security;

b) Management of Information Technology Security;

c) RCMP G1-009 - *Transport and Transmittal of Protected and Classified Information* and other applicable Federal/Provincial/Territorial privacy and security legislation / regulations.

The Project Authority will monitor that the *Health Information and Claims Processing Services* will comply with the Government of Canada laws, regulations, policies, and standards on information management, IT security, privacy, and access to information; as well as those related to data collection, use, retention, and disposal.

3.4.6.3 TRA Requirement and Additional IT Security Safeguards

The Contractor must apply security measures above baseline levels when justified by a Threat and Risk Assessment. The Project Authority engages a contracted third party to perform the TRA in accordance with SOW Article 2.2.4(a) *Security*. The steps of a Threat and Risk Assessment are to:

a) identify and categorize information and related assets according to their sensitivity;

b) assess the threats and system vulnerabilities that could affect the delivery of HICPS;

c) determine the level of risk, based on current safeguards and system vulnerabilities;

d) recommend safeguards that will mitigate risk to an acceptable level.

3.4.6.4 Canadian Location Requirement

The Contractor must not provide services from locations outside of Canada. Please refer to the requirements in the Model Contract, Section 7.14.7 Location of Records.

3.4.6.5 Security Integrity of the HICPS Processing Environment

The Contractor must ensure that each of its network device(s) and its server(s) are secure and subject to configuration control, while also ensuring that there are no backdoor connections with access to the system. Wireless network devices or remote access connections cannot interface with the claims processing system without the express written consent of the Project Authority.

3.4.6.6 Malware

The Contractor must ensure that all workstations used by its staff (or the staff of its Subcontractors) to access the HICPS Solution are under configuration control and have been configured with up-to-date anti-virus and anti-spyware software. If the workstations are not within a protected network, the Contractor must install hardware or software firewalls to safeguard these workstations.

3.4.6.7 Data Separation

The Contractor must ensure that all data centres, data management systems, inquiry centres, operations centres and records and information storage (electronic and hard copy) used in the delivery of HICPS are logically independent and separate from all other Contractor data or data systems.

3.4.6.8 Facilities

The Contractor must ensure that all environments and facilities, including backup facilities, where PROTECTED information is handled and stored, adhere to the security requirements defined in the Contract, including the SOW.

3.4.6.9 Encrypted Communications

The Contractor must protect the confidentiality and integrity of data transmitted across public carrier or Internet networks with government approved cryptography technology.

The Contractor must enable encryption on all network communications protocols using Transport Layer Security or the cryptographic features of the protocol.

3.4.6.10 Encrypted Storage

The Contractor must protect the confidentiality of data throughout its lifecycle by implementing cryptography for all storage, temporary storage, data processing, and data backup locations.

3.4.6.11 Security Zones

The Contractor must identify and delineate the physical and logical security boundaries through the implementation of physical and logical security zones. Each zone must be isolated and defended from the other locations by its own perimeter defence and network security safeguards. Each facility must comply with the facility security requirements defined in the Security Requirements Checklist. The Contractor must segregate networks into IT security zones and implement perimeter defence and network security safeguards. The use of IT security zones by the Contractor ensures a consistent, minimum level of protection of its data communication networks. The Contractor must strictly control all Public Zone interfaces, including all external uncontrolled networks such as the Internet, at a defined security perimeter. The Contractor must use perimeter defence safeguards (e.g., firewalls, routers) to mediate all traffic and to protect servers that are accessible from the Internet.

3.4.6.12 Least Functionality

The Contractor must configure its information systems used to deliver HICPS to provide only essential capabilities and specifically prohibit or restrict the use of high risk functions, ports, protocols, and/or services.

3.4.6.13 Systems Documentation & Configuration Management

The Contractor must develop, document and maintain an inventory of its information system components and configurations that:

a) accurately reflects the current information system;

b) is consistent with the authorization boundary of the information system;

c) is at the level of granularity deemed necessary for tracking and reporting;

d) is available for review and audit by designated the Project Authority, CISD and CSO organizational officials.

The Contractor must update the inventory of its information system components as an integral part of component installations, removals, and information system updates.

3.4.6.14 Vulnerability Assessment

The Contractor must perform, at its own cost, through an independent Third Party security firm, at minimum once per calendar year vulnerability assessments throughout the life of the Contract to verify the security configuration of the claims processing system network perimeter, servers, and its systems and to remedy any identified limitations. The Contractor must also perform such assessments whenever there are significant changes to its system or whenever network security incidents occur. The Contractor must report on the results of these assessments and propose solutions and timeframes for resolving identified limitations at the Contractor’s expense. The Contractor must report the results to the Project Authority within 20 business days of the completion of the assessment.

The Contractor must complete automated code vulnerability assessments against application programming code that implements custom features of the HICPS Solution.

3.4.6.15 Security Monitoring

The Contractor must monitor all its systems, environments, and facilities for compliance with security requirements and ensure that all upgrades, replacements, patches and all operational functions maintain the security requirements.

The Contractor must ensure that its underlying system services (e.g., trusted time, event logging) are provided to support security services. Based on a trusted time source, the Contractor must provide an accurate time and date throughout its systems and networks. Trusted time is particularly important in activities such as electronic financial transactions and digital signatures, and for audit and investigations.

3.4.6.16 Incident Detection & Response

The Contractor must prevent, detect, respond, and restore from electronic data processing errors and omissions, technical failures, sabotage, and cyber-attacks. The Contractor must use layered security, which must include at a minimum, a Firewall and an Intrusion Detection System (IDS) with appropriate rules, port filtering, and monitoring to defend against attacks and to alert the Contractor to unauthorized network traffic.

To detect incidents, the Contractor may use firewalls and routers, audit logs, virus and malicious code detection software, system performance tools, health-monitoring tools, integrity checkers, and host- and network-based intrusion detection systems. The rigor and extent of detection will depend on the level of risk, including the sensitivity (in terms of confidentiality, availability, and integrity) and the HICPS solution

exposure. To protect information and ensure service delivery the Contractor, in conjunction with Health Canada, must continuously monitor the HICPS solution performance to rapidly detect:

a) attempts (failed or successful) to gain unauthorized access to HICPS, or to bypass security mechanisms;

b) unauthorized probes or scans to identify system vulnerabilities;

c) unplanned disruption of systems or services;

d) denial-of-service attacks;

e) unauthorized changes to system hardware, firmware, or software;

f) solution performance anomalies;

g) known attack signatures.

At a minimum, the Contractor must include a security audit log function in the HICPS Solution. The Contractor must incorporate automated, real-time, incident detection tools in the HICPS Solution.

3.4.6.17 Incident Detection & Response - Security Breach

In the event of a breach in security, the Contractor must inform the Project Authority immediately. The Contractor must assume financial responsibility for all impacts and restitution resulting from a breach in the Contractor's security.

3.4.6.18 Project Security Documentation Requirements

a) The Contractor must develop an Application Security Architecture document, which will be the blueprint for the overall security implementation. It shall encompass policy, architecture, compliance with standards and process definitions pertaining to the security of HICPS. The Project Authority will approve this document and it will be used for the TRA.

b) The Contractor must develop a Security Component Design document, which will be an extension of the security models and policies defined in the Application Security Architecture Document to the application layer. The document ensures that the IT security policy is considered during the coding of modules of the application and is reflected in the module design. It also includes best practices such as the Open Internet Application Security Policy (OWAP) to avoid security vulnerabilities as the solution is developed.

c) The Contractor must develop a Security Service Operations document, which will describe the processes and safeguards that are in place to prevent, detect, respond, and recover from security incidents. It defines the security staff roles and responsibilities and how they will interact with HC. The document must identify two security roles: The Information System Security Officer who is responsible for overseeing the management, implementation, and operation of the HICPS security services and to liaise with HC as the prime point of contact on security related matters; and the Company Security Officer who is responsible for personnel and physical security. The Security Service Operations document must describe how the security of the HICPS solution will be certified and accredited (authorized), managed, monitored, and maintained.

d) The Contractor must develop a Security Test Plan (STP), which will describe how the technical and non-technical security controls will be verified and validated. Technical controls include configurations and features designed within the solution such as identification and authorization, audit and operating system security policies. Non-technical controls include management and operational security controls such as rules of behaviour, configuration management plans, contingency/disaster recovery plans, interface control documents, physical security controls, and/or interconnection agreements. The STP must assess the technical implementation of the security design, ensures that the security controls have been implemented as described in the SOW, and ensures that the features perform as planned.

i. The STP must clearly define the process and procedures that will be employed during the test and evaluation phases as well as during any future change to the Contractor's system or the service functionality. The plan must address each of the security requirements for the Contractor's system, validate that they are functioning correctly, and clearly demonstrate the level of residual risk that exists.
ii. The STP must validate the correct implementation of the security controls. The plan must provide high-level guidance on security testing, identify the security safeguards to be tested, and provide detailed information on the test items. The plan must evaluate and test all HICPS services including network, the Contractor's critical systems, and services, and supporting components for compliance with security requirements. It must also include a description of the test environment, identify the tests to be performed, provide a schedule of test activities, and describe the test cases, preparations, and procedures used.

e) The contractor must develop a Security Test Results document, which will describe the results of the testing performed according to the Security Test Plan. It must provide a description of the actual testing regime, how each test performed against the expected results, and any actions performed subsequent to any failed tests. This document must provide important security evidence for the security authorization process and demonstrates that the services tested meet the security requirements.

3.4.6.19 Access Control & Account Management

a) The Contractor must implement role-based access controls for all HICPS, where each role is assigned capabilities and access according to the least privilege required for that role, and a need-to-know. The Contractor must document the access controls implemented.

b) The Project Authority may define user roles for each HC User, including but not limited to, limiting an HC User's ability to view and/or edit HICPS information, override rules, or view information or process requests for Clients outside of a specified Client Affiliation.

c) The Contractor must provide a function to manage user access and profiles and maintain and document the function at all times as users and/or access levels change or are updated. Any change to a user account must be accompanied by an audit record indicating what was changed, which user account made the change and on what date and time.

d) The Contractor must explicitly authorize access to security functions (deployed in hardware, software, and firmware) and security-relevant information.

e) The Contractor must implement a two factor authentication for HC users of the HICPS solution PROTECTED B data. The first authentication factor must be a username/password combination while the second authentication factor must be a software token. A certificate approach is considered appropriate as well as leveraging the existing MyKEY infrastructure already in place at Health Canada.

f) The Contractor must ensure Contractor and Subcontractor user access and controls are kept current with all changes or updates to Contractor and Subcontractor staff.

g) The Contractor must provide a mechanism for Users to change their own password in a self-server fashion.

h) The Contractor must apply changes to user access profiles within one business day of receipt of information.

i) The Contractor must provide an administrative interface to HC Users that provides the Project Authority the ability to create User accounts, deactivate User accounts, and add to or change the roles assigned to a User account.

j) The Project Authority will manage HC User accounts and the Contractor must develop a Static HICPS Operational report that lists all active and inactive user accounts and the various roles

assigned to them. The Contractor must post this report, within 5 business days of month end, to DRR.

k) The HICPS solution must notify users, upon successful logon, of the date and time of the last logon.

3.4.6.20 Auditable Events, Analysis & Reporting

a) The Contractor must maintain an audit trail for each user granted access to the HICPS Solution to ensure accountability on the part of the users.

b) Any change on HICPS by a user must be accompanied by an audit record indicating what the change was, which user made the change, and on what date and time and be viewable by HC Users on the interface, where specified by the Project Authority. Execution of privileged functions must be included in the list of events to be audited.

c) The Contractor must produce audit records that contain sufficient information to, at a minimum, establish what type of event, which is anything that changed and includes but is not limited to Create, Add, Update, Delete, occurred, when (date and time) the event occurred, where the event occurred, the source of the event, the outcome (success or failure) of the event, and the identity of any user and/or subject associated with the event.

d) The Contractor must allocate appropriate record storage capacity and configure auditing to retain audit records for two years to provide support for after-the-fact investigations of security incidents and to meet regulatory and organizational information retention requirements.

e) The Contractor must authorize access to management of audit functionality to only a limited subset of privileged users.

3.4.6.21 Archiving & Media Sanitization

a) The Contractor must sanitize HICPS information media, both digital, and non-digital, prior to disposal, release out of organizational control, or release for reuse. The Contractor must sanitize all media containing sensitive information in accordance with applicable GC policies, standards, and procedures.

b) The Contractor must provide offsite storage services for backup media that must be set up and maintained in accordance with the Industrial Security Manual published by PWGSC.

3.4.6.22 Security of Electronic Data Interchange

a) The Contractor must ensure that HICPS claims submitted via EDI and the Internet comply with all established GOC security requirements.

b) Contractor computer facilities must facilitate secure transmission of information between and among Providers, Clients, and the Contractor (e.g., real-time point-of-sale claims processing arrangements based on standard professional software, including but not limited to CPhA, CDAnet and Réseau ACDQ standards, and drug utilization review edits) and among HC and the Contractor (including data communications arrangements for on-line HC access to the Contractor's system) and among Providers, Clients, the Contractor, HC, and any Subcontractors.

c) The Contractor must safeguard the integrity and authenticity of personal and financial data from corruption and inadvertent or malicious changes by employing hashing, digital certificates, or similar technology. All such data must be securely hashed to ensure their integrity as they are transmitted from one location to another.

d) The Contractor must ensure that technical security services are implemented as contractually required to defend against unauthorized disclosure and modification of PROTECTED B

information and to defend against the forgery of financial data used in the preparation of direct deposit transfers and/or cheque printing.

e) The Contractor must ensure that security and privacy of information is maintained throughout any data conversion or loading exercise.

3.4.6.23 Labelling Protected Info – Screens

The Contractor should clearly label all data screens and printouts with their data classification – 'PROTECTED B' where applicable.

3.4.6.24 Labelling Protected Info – Output

The Contractor must label any reports that are produced by HICPS with the "PROTECTED B" label where applicable.

3.4.6.25 System Backups

a) The Contractor must:

i. perform daily, weekly, monthly and yearly solution back-ups, including all data and program software source code, in accordance with the best practices described below for the backing-up of protected data;

ii. store all back-up media off-site, at a minimum distance of five kilometres from the main site and in secure, fire and flood protected storage cabinets. Refer to SOW Article 3.3.15 *Records Management* for further information regarding the retention, storage, and transportation of electronic files;

iii. store daily back-up media for a minimum of 14 calendar days;

iv. store weekly backup media for a minimum of 3 months;

v. store monthly backups for a minimum of 24 months;

vi. store yearly back-ups for a minimum of 7 years;

vii. once the required retention period for the applicable media has expired, the Contractor may reuse the media for new backups, but this media may only be used to backup information from the HICPS solution;

viii. assess the viability of whether media can be reused and the Contractor remains subject to the requirements of this SOW Article 3.4.6.25 *System Backups*;

ix. the Contractor may reuse media at its own risk;

x. perform random back-up media restore tests on a quarterly basis, at least once per quarter;

xi. deliver a quarterly Back-up and Restore Report for the Project Authority's review;

xii. post the report to the DRR within 5 business days of quarter end;

xiii. deliver to the Project Authority an analysis of the cause of the failure, as well as an action plan to mitigate future failures where the quarterly Back-up and Restore Report identifies the failure of one or more back-up media - should these random back-up media restore tests demonstrate deterioration in the condition or quality of the reused media in comparison with new media, the Project Authority reserves the right to direct the Contractor to end the practice of reusing the media;

xiv. maintain all back-up media in an industry standard format that allows them to be read and restored by other back-up infrastructures or systems, if required;

xv. not destroy any data without the written consent of the Project Authority obtained through the Task Authorization process. All data stored on back-up media is the property of Canada;

xvi. erase all back-up media and render the data contained therein unrecoverable prior to destruction;

xvii. never sell, auction, donate, or discard media that have contained PROTECTED B data;

xviii. TAs associated with the destruction of data stored on back-up media which result from a request initiated by the Contractor are considered "No cost TAs" as the cost is included in the cost of the contract and there must be no additional costs associated with them. These TAs serve only to provide the Contractor with written consent to proceed.

3.4.6.26 Data Extracts

Health Canada requires periodic extracts of HICPS source tables (including HICPS data from the previous contractor) to support business needs.

The Contractor must provide to the Project Authority within five (5) business days of a request, in an industry-standard format suitable for import into a relational database management system, which at a minimum includes csv and tab delimited. Data extracts must be provided to Health Canada via the DRR or a Contractor hosted SFTP. Data extracts may include but are not limited to the following:

a) Ad hoc extracts from any HICPS and supporting tables specified by the Project Authority, including:

   i. complete extracts of all tables;
   ii. extracts for specified time frames;
   iii. deltas from previous extracts;

b) scheduled extracts from any HICPS and supporting tables (content and frequency to be specified by the Project Authority) including:

   i. complete extracts of all tables;
   ii. extracts for specified time frames;
   iii. deltas from previous extracts;

c) scheduled or ad hoc extracts from any HICPS and supporting tables for specific client group data or condition defined data as specified by the Project Authority, including:

   i. extracts of all relevant tables relating to the specified group or condition;
   ii. deltas from previous extracts.

3.4.7 Integration with Third Party Information or Submission Systems

The Contractor must ensure that the HICPS Solution will integrate with external sources of information or submission and will support bi-directional communication to support future workflows. An example of this integration is Canada Health Infoway's PrescribeIT initiative where a drug information system will support the flow of information between prescribers, pharmacies, and insurers to increase information sharing and collaboration. Another example is an industry standard method for the electronic transmission of dental predetermination requests with supporting documents such as x-rays.

The Contractor must:

a) ensure that the current and any future HICPS solution will integrate seamlessly with Canada's Electronic Prescription Service (currently named PrescribeIT) through the exposed public API or service;

b) ensure that the current and any future HICPS solution will integrate seamlessly an industry standard method for the submission of dental predetermination requests with supporting documents such as x-rays, as approved by the Project Authority;

c) ensure that the HICPS solution adheres to all security requirements of the future external information system or electronic method of submitting dental predetermination requests, including the transactional auditing of all activities;

d) implement any integration at a future date, with any additional costs negotiated and authorized through the TA process.

3.5 Operational Support

3.5.1 Change Management

The Contractor must manage and maintain the HICPS Solution based on ITIL best practices. Change Management involves both the Solution's management and its maintenance.

Based on ITIL, the goal of HICPS Change Management is to ensure the efficient and prompt handling all changes to HICPS through the use of standardized methods and procedures. It includes all aspects to the HICPS solution management and maintenance, including the BI Reporting Tool. The overall Change Management Plan includes but is not limited to:

a) problem and incident management;

b) work plans;

c) release, and configuration management.

HICPS ITIL change types include:

a) Emergency and Expedited Changes

   i. emergency changes are in response to incidents or problems requiring immediate actions to restore service or prevent service disruption;
   ii. expedited changes is a normal change that does fit the normal process schedule but for technical or business reasons, it must be processed in a faster manner that usual;

b) Standard Changes

   i. a preapproved change that is low in risk, common, and follows a well-documented procedure
   ii. standard changes are generally logged and tracked and must be integrated with service management processes (e.g. incident management system);

c) Normal Changes

   i. are not an emergency or standard change;
   ii. are an addition, modification, or removal of anything related to the HICPS;
   iii. follow the ITIL Change Management Process of assessment, authorization, Change Authorization Board (CAB) approval, scheduling before implementation;
   iv. are based on the scope, complexity and impact and can be further categorised into major, significant and minor.

The Contractor must be able to measure the impact of services changes within HICPS and to minimize the impact of changes to the quality of service delivery.

3.5.1.1 Change Management Solution

The Contractor must:

a) provide and manage a Change Management solution based on ITIL;

b) provide analysis services to support the management of change (emergency, standard or normal changes) as required by the Project Authority

c) include both Contractor and Project Authority representatives on the Change Authorization Board (CAB);

d) be accountable for the management of the change processes and Project Authority approved changes as well any testing and implementation resulting from an approved change;

e) use the Change Management function to manage all Task Authorizations;

f) manage and report on the process from initial incident or problem to resolution;

g) make the Change Management function available to all Users;

h) maintain a log of all changes and deliver a change management report to the Project Authority monthly;

i) deliver the report to the Project Authority within five business days of month end;

j) the Project Authority will prioritize all change requests and define the timelines for implementation.

3.5.1.2 Incident Log and Reports

The Contractor must provide HC Users with the ability to:

a) access the tool and problem log in real time. Designated HC Users would be part of the user support team and could have incident tickets assigned to them for resolution;

b) create, edit and close an incident, problem or change including attaching documents;

c) generate reports from the Change Management Solution.

3.5.1.3 HICPS Solution Maintenance

The Contractor must:

a) implement and maintain all solutions, services, websites, interfaces, screens, electronic forms, functionality, etc. developed in the Pre-Implementation Phase and any subsequent phases;

b) ensure the HICPS Solution functions are available at all times in accordance with the defined requirements and service standards, in accordance with SOW Article 3.4.1.1 *Business Continuity, Availability, and Service Standards*, except for Project Authority approved downtimes required for solution maintenance;

c) monitor the entire solution and inform the Project Authority of any issues or outages;

d) inform Providers of downtimes for solution maintenance at least 24 hours in advance of the approved maintenance;

e) schedule downtimes for regular solution maintenance, such as maintenance windows or annual maintenance events, upon the prior approval of the Project Authority (see SOW Article 3.4.1.1 *Business Continuity, Availability, and Service Standards*);

f) inform the Project Authority, in writing, of planned maintenance downtimes at least 7 calendar days prior to the requested date;

i. Inform the Project Authority of unplanned downtimes or unexpected shutdowns resulting from circumstances outside the Contractor's control as soon as the Contractor becomes aware of the issue requiring an emergency fix such as viruses that could compromise the systems supporting HICPS (See SOW Article 3.5.1.6 *Emergency or Expedited Changes*);

g) maintain an annual release schedule and must post it to the DRR by December 1st for the next calendar year.

3.5.1.4 Problem and incidence management

Problems and incidence management are considered standard changes.

The Contractor must:

a) provide an incident management function and manage the process of opening an incident ticket, assigning it to a user support team member, and closing it upon resolution;

b) log problems as they occur or are reported into an incident management tool;

c) define and submit for the Project Authority's review and approval service standards for assessing, resolving or escalating incidents and/or problems;

d) Deliver a monthly incident management report to the Project Authority that HC and the Contractor will use to identify trends that point to opportunities for service improvement no later than 5 business days after month end;

e) notify the Project Authority and advise them of an Estimated Time to Repair (ETR) or a Problem Resolved Explanation (PRE), as appropriate once a problem has been identified;

f) perform this notification within 4 hours of problem identification, and provide daily updates if the problem has not been resolved by the ETR;

g) update the ETR upon further problem analysis;

h) issue a Problem Resolved Explanation (PRE) to the Project Authority upon resolution of the problem.

3.5.1.5 Incident Resolution

The Contractor must provide HC Users with the ability to:

a) access the tool and problem log in real time - designated HC Users would be part of the user support team and could have incident tickets assigned to them for resolution;

b) open, edit, monitor and close an incident upon resolution including attached documents.

c) generate reports from the Incident Resolution Solution

3.5.1.6 Emergency or Expedited Changes

Emergency and Expedited changes are critical HICPS problems, issues or security problems impeding service delivery for which there is no reasonable system or manual work around including but not limited to:

a) a risk to Client health or safety;

b) changes to program costs;

c) compromises Client, financial and/or Provider data integrity;

d) impedes access and/or functionality to HICPS to 5+ users or one entire office/region;

e) compromises solution or system security, or personal information;

f) where a problem prevents processing of claims, predeterminations, or prior approvals.

The Contractor must for emergency or expedited changes:

a) assess critical problems and notify the Project Authority within 30 minutes of problem identification;

b) provide updates to the Project Authority every 30 minutes thereafter - The notification must include an Estimated Time to Repair (ETR) or a Problem Resolved Explanation (PRE), as appropriate – The Contractor may update the ETR upon further problem analysis;

c) enact the appropriate BCP provisions should the critical problem result in a lack of service availability as defined by the service standards detailed in SOW Article 3.1.4 *Disaster Recovery Plan and Business Continuity Plan*;

d) log the incident and immediately notify the Project Authority of the incident identification (refer to SOW Article 3.4.6.17 *Incident Detection and Response – Security Breach*) in the event of a security breach incident.

3.5.1.7 Defect fixes and Solution Enhancements

Defect fixes and Solution enhancements are normal ITIL change types.

The Contractor must:

a) ensure that all fixes and enhancements are tested and pass prior to release;

b) apply the testing methodology in accordance with SOW Article 2.2.3 *Standards* throughout the course of the Contract;

c) create and maintain test scripts including:

i. produce test scenarios/scripts and provide to the Project Authority;
ii. keep test scripts updated and current as system changes are implemented;
iii. apply version control;
iv. all changes must be tested and receive final approval by the Project Authority prior to being released in the production environment;

d) post the Contractor testing results report to the DRR within 1 business day of testing completion;

e) include a report for all Contractor testing runs that includes outcomes and corrective action plans and be posted to the DRR within 3 business days of a Contractor user acceptance testing run;

f) resolve all errors resulting from fixes or changes prior to release, or sooner as an off-cycle release if urgent or high-risk and requested by the Project Authority;

g) adhere to the security testing requirements detailed in the Security Test Plan in accordance with SOW Article 3.4.6.18 *Project Security Documentation Requirements* throughout the life of the Contract;

h) ensure all changes to the EDI interface are tested with Providers and claims submission software vendors prior to release;

i) liaise with the Providers and claims submission software vendors, as required, to test changes to EDI interfaces;

j) report to the Project Authority on the results of the testing against third party software employed by the HICPS Solution, within 5 business days following the testing.

3.5.1.8 Release/Configuration Management

Release and Configuration Management are normal ITIL change types

The Contractor must:

a) provide and manage release and configuration management functions and processes based on ITIL best practices;

b) maintain a release log of all changes between releases;

c) update the configuration information of the current release;

d) make available release and configuration management processes and reports to HC Users and post them to the DRR;

e) make release notes available at least 15 business days in advance of any release;

f) deliver to the Project Authority a release work plan two weeks before each release and a post mortem report no more than 15 business days after each release;

g) address and release all other solution changes, fixes and patches on a quarterly basis, with the exception of security related patches or fixes, which the Contractor must apply immediately. The Project Authority may choose to release these updates on a more frequent basis depending upon business needs and requirements;

h) obtain the Project Authority's approval of the release prior to the release date;

i) notify the Project Authority of solution changes and changes to the Contractor's system initiated by the Contractor that do not impact HC and HC's use of the solution at least 7 business days prior to the release;

j) ensure that all processes described in this SOW Article 3.5.1.8 are delivered in both official languages;

k) deliver all reports in accordance with the reporting standards in accordance with SOW Article 3.3.14.4 *Report Specifications*;

l) post all reports to the DRR.

3.5.1.9 HC Support, User Acceptance Testing, and the Training, Production, and Testing Environments

The Contractor must provide HC Users with the ability to:

a) perform User Acceptance Testing activities for fixes and changes made to the Solution prior to release;

b) User Acceptance Testing includes but is not limited to:

i. executing the test plan and recording results;
ii. identifying defects for the Contractor to fix;
iii. prioritizing the defects;
iv. summarizing the results in the test report;

c) review the results recorded and the testing errors/defects opened during testing;

d) train staff on the new release prior to the implementation of the release;

e) support front line staff using a replica of the production solution to troubleshoot issues and train new staff on existing functionality;

f) support the testing of new HC configuration of coverage rules such as a new frequency limit or data change;

g) perform each activity independently of the other whereby one does not compromise the ability to perform another;

h) as part of its solution, the Contractor must ensure that HC Users have access to the testing, training and production environments.

3.5.1.10 Training, Production, and Testing Environments

The Contractor must:

a) ensure that each dedicated testing and/or training environment mirrors the architecture and configuration of the production environment;

b) ensure the testing and training facilities and data conform to the same security and privacy standards, policies and legislation as the production environment;

c) provide the testing and training environments in both official languages;

d) ensure that only tested, virus-free, licensed and authorized software is used in all environments;

e) provide the different user roles and scenarios that will be tested;

f) ensure production data copied from the production environment to the testing or training environment be anonymized based on HC consultation so that the results are the same values each time the data is generated;

g) refresh the testing or training environment prior to the Project Authority's UAT testing as required by the Project Authority;

h) provide a testing and/or training environment that provides the ability to run queries and perform updates on the testing data.

3.6 HICPS Manuals

The following outlines the major requirements, related requirements and information, and service standards, where applicable, for HICPS manuals.

3.6.1 HICPS Development, Management and Support Manuals

The Contractor must develop and maintain manuals to support the development, management and maintenance of HICPS. The Contractor must provide documentation services, and must develop, revise, maintain, reproduce, and distribute information in hard copy and electronic formats for HICPS manuals as detailed below. Quality of the documentation must be based on the standards detailed in SOW Article 3.2 *Quality Assurance*.

3.6.1.1 General and Detailed Design System Manual

The Contractor must develop and maintain a HICPS General and Detail Design System Manual that must be structured as a usable, accessible, searchable, web-based tool and printable PDF in English that must encompass:

a) HICPS architecture;

b) hardware, software, and data communications specifications;

c) input, output, and interface specifications;

d) data management system design and file layouts, data dictionary, and data flow diagrams;

e) screen and report specifications;

f) all verification logic specifications (claims, clients, approvals) and system processes;

g) security mechanisms (security management and organization, security architecture, component design and service operations safeguards);

h) all other requirements detailed in General and Detail Design Documents.

3.6.1.1.1 Service Standard

a) The Contractor must make available at all times a current electronic non-editable version of the HICPS General and Detail Design System Manual in a searchable format on the DRR.

b) The Detail Design Documents (DDD) must reflect the current solution and systems. During any change that may affect the DDD, a draft updated DDD must be provided to the Project Authority for review 25 business days prior to the change being implemented in the system.

3.6.1.2 Administrative Procedures Manual (APM)

The Contractor must develop and maintain a HICPS Administrative Procedures Manual in English that must be structured as a usable, accessible, searchable, web-based tool and printable PDF. The APM must have received the Project Authority's approval before making it available to HC Users through the DRR. It must encompass:

a) a detailed description of all procedures and processes required to manage the interactions between the Contractor and HC. This includes (not limited to), service and system change control procedures, protocols and procedures for communications with clients, providers and HC, and the financial procedures for requesting claims expenditure payment from HC.

3.6.1.2.1 Service Standard - The Contractor must make the HICPS Administrative Procedures Manual available on-line to HC Users through the DRR as of the Implementation Date (see SOW Article 2.2.6 *Documentation*). The Contractor is responsible for ensuring that the version on the DRR is kept current and that any changes agreed to by the Project Authority and the Contractor are posted within 5 business days.

3.6.1.3 HC Users' Manual

The Contractor must develop and maintain a HC User Manual in English and French that must have been approved by the Project Authority and must be structured as a usable, accessible, searchable, web-based tool and printable PDF that encompasses:

a) instructions on how to use each component of the Health Information and claims processing solution available to NIHB staff. This includes, but is not limited to, general navigation and data entry screens.

3.6.1.3.1 Service Standard - The Contractor must post a current non-editable searchable electronic copy in each official language to the DRR and within the Help section of the claims processing solution available to HICPS users. The HC User manual is subject to the Project Authority's approval and must be updated and posted to the DRR at least 15 business days prior to a release and be available within the Help section on the day of the release.

3.7 HICPS User Training and Support

The following outline the requirements, information, and service standards, where applicable, for HICPS User Training and Support.

3.7.1 HC User Training

The Contractor must train designated HC Users on system features and functionality, as requested by the Project Authority.

3.7.1.1 Train-the-Trainer Format

The Contractor must prepare and deliver training sessions (or equivalent training materials, such as release notes, to explain changes in each release to users) based on a train the trainer approach, in English and French, prior to release of any system changes and at any other time upon request of the Project Authority through a “no cost TA”.

The Contractor must:

a) obtain approval from the Project Authority on:
   i. the format of the training, whether it is a training session, structured as self-teaching tools or equivalent training materials;
   ii. how the training is delivered, such as on site at HC, through video-conferencing, or web-based;

b) ensure the training materials are clear, concise, bilingual, relevant, current, and delivered according to the timelines requested by the Project Authority;

c) post the training materials to the DRR.

d) The Contractor must assume all costs associated with developing and delivering all training, including but not limited to the provision of all relevant training material and any Contractor travel and living expenses.

3.7.1.1.1 Service Standard

a) Training sessions and associated training material must be provided in both official languages 30 business days prior to a release.

b) Training sessions and associated training material must be provided in both official languages within 30 business days of receipt of a training request from the Project Authority not related to a release.

3.7.1.2 Training Environment

The Contractor must ensure that the training environment is a stand-alone environment and duplicates all aspects of the production system, including EDI interfaces and data from the HICPS Solution. Throughout the term of the Contract, the Contractor must ensure that:

a) the training environment is fully synchronized with all changes and enhancements that are applied to systems and processes in the production environment;

b) the training environment is available to HC Users during regular business hours, with no downtimes;

c) refreshing of the training environment is done outside of regular business hours.

3.7.1.3 Privacy

The Contractor must maintain any data used in training sessions in accordance with the privacy standards of the Contract.

3.7.2 HICPS User Support

The Contractor must provide HICPS User Support throughout the lifetime of the Contract.

3.7.2.1 Technical Support

The Contractor must provide technical support to HC Users, respond to questions, and resolve problems/ incidences.

3.7.2.2 Issues Log

The Contractor must log all problems, incidences and their resolutions.

4.0 Contract Phase-Out

Phase-Out is the period that commences upon formal written notification from Canada to the Contractor and extends to and includes the Contract Expiration Date, whether the subsequent contract is with the incumbent or a new contractor. This Phase includes activities that will be undertaken by the Contractor, in addition to Operations Phase activities, to ensure the smooth, efficient and complete transition to a new contract. Article 4.2 *Major Requirements* of the SOW describes the requirements in detail.

4.1 Roles and Responsibilities

During the Contract Phase-Out, the Contractor must deliver the services detailed below, in addition to maintaining and delivering all services detailed in SOW Article 3.0 *Operations Phase*.

The Project Authority will verify the completion of all contractual requirements and will review all data and documentation returned by the Contractor. The Contractor must return all data and documentation to the location and at the time specified by the Project Authority.

4.2 Major Requirements

4.2.1 – Business Continuity During Phase-Out

The Contractor must ensure continuity in services during the Phase-Out Period of the Contract. The Contractor must complete, at a minimum, the following tasks through a Phase-Out Task Authorization. The Phase-Out Task Authorization will incorporate the Phase-Out Plan and may include additional Work.

4.2.1.1 The Contractor must maintain computer, data communications, and Provider and Client communications functions and allow HC Users to access the Solution for inquiry purposes for 90 calendar days following the Final Claim Day.

4.2.1.2 As-and-when requested, the Contractor must deliver to the Project Authority an electronic record of the complete claims history file, including all pending prior approvals, pre-verifications, and special authorizations, in a form and layout approved by the Project Authority; the complete Provider and Client documentation and history file; the complete prescriber history; and the complete copy of all tables. The Contractor must submit a description of the form and layout to the Project Authority when required. The Contractor must deliver the records in an industry-recognized format, suitable for importing into the data management system of the subsequent Contractor.

4.2.1.3 The Contractor must deliver to the Project Authority, upon their request, a copy of all files and tables required to interpret the above claims history file including benefit codes, Client information, Provider information, and prescriber information.

4.2.1.4 On the business day following the Final Claim Day, the Contractor must deliver to the Project Authority an update to the claims history file and on Online DBL.

4.2.1.5 The Contractor must deliver to the Project Authority a copy of the DRR contents as well as the contents of the HICPS Website application(s) that contain problem, change, release, and configuration management information and logs at no additional cost to HC.

4.2.2 Transition

The Contractor must cooperate with the Subsequent Contractor or the Project Authority, as applicable, on the development of a Contract Phase-Out Plan (the Transition Plan for the Subsequent Contractor), approved by the Project Authority, to ensure the smooth transition of functions and responsibilities.

4.2.2.1 The Phase-Out Plan must include a strategy to transfer all SOW activities from the Contractor to the Subsequent Contractor or HC as determined by the Project Authority, without service disruptions to Providers and Clients, HC and its stakeholders in the NIHB Program. The Contractor must submit the Phase-Out Plan to the Project Authority for approval within 90 calendar days of Canada's notification of the commencement of the Phase-Out Period. The Contractor must cooperate with the Subsequent Contractor to develop and execute the Plan.

4.2.2.2 This Phase-out Plan must address, at a minimum, the following items:

a) how claims unsettled as of the Final Claim Day will be resolved;

b) knowledge transfer, including to any future Contractors;

c) complete records transfer (volumes, formats), including financial records and the addressing of any data conversion issues;

d) transition activities schedule;

e) approach to how information related to data structures, data domains and data- related processes will be delivered;

f) how the Contractor will continue the same level and quality of service to Clients and Providers and continue to deliver service until the day when the Subsequent Contractor assumes the service;

g) how the Contractor will maintain communications with the Program, maintain computer facilities, and allow access to such facilities to HC Users for enquiry purposes until the Contract termination date or the Contract Expiry Date, as the case may be, or the date the Subsequent Contractor begins to process claims, whichever date is earlier;

h) how the Contractor will provide systems consulting to the Subsequent Contractor at the request of the Project Authority, to negotiate file layouts, explain data fields, explain codes, along with general consulting to explain specific administrative procedures and practices, which are not proprietary to the Contractor, to ensure continuity of service after the expiry date or the termination date of the Contract.

4.2.2.3 The Contractor must report to the Project Authority on components of the plan for which it is responsible.

4.2.3 Responding to Queries

The Contractor must respond to queries regarding Phase-Out activities and progress.

4.2.3.1 The Contractor must log all queries with time of receipt, response, and resolution. The Contractor must deliver to the Project Authority a summary report of queries received.

4.2.3.2 The Contractor must forward all queries from Providers that cannot be answered by the Contractor to the Project Authority or their representative in writing by letter or e-mail within one business days of receipt.

4.2.4 Phase-Out Coordination Meetings

The Contractor must attend monthly Coordination Meetings chaired by the Project Authority.

4.2.4.1 Coordination Meetings will take place at the Project Authority's offices. The purpose of these meetings is to ensure the Contractor has all necessary and up-to-date information to carry out the Work described in this SOW and to ensure effective communications with HC.

4.2.4.2 The duration of each Coordination Meeting is expected to be one full day and meetings are expected to occur at least once a month during the Contract Phase-Out.

4.2.4.3 The Contractor must provide data and information as requested by the Project Authority in accordance with their request at least 5 business days in advance of the Coordination Meeting.

4.2.5 Migration

The Contractor must return all HICPS electronic and hard copy materials (including archived), electronic back-up media, hardware where applicable, and documentation to the Project Authority, including the contents of the DRR**.**

4.2.5.1 The Contractor must clearly label all material and file them in boxes to facilitate unpacking at the destination.

4.2.5.2 The Contractor must deliver all materials, such as all HICPS electronic and hard copy materials, electronic back-up media and documentation (hard and soft copies) to the Project Authority, including the contents of the HICPS, in formats acceptable to the Project Authority and at the location and timelines designated by the Project Authority at no additional cost to Canada.

4.2.5.3 The Contractor must deliver all materials to the Project Authority within 30 calendar days of their written request at no additional cost to Canada. Examples of materials include, but are not limited to, information sources, paper claims, manuals, contents of the problem, change, release and configuration management functions, DRR, HICPS Website; reports and queries; data and databases including Provider enrolment; and any other information or data created as a result of the Contract.

4.2.6 Financial Operations During Phase-Out and Reports

The Contractor must deliver to the Project Authority all NIHB Program Management Financial reports on the management and disbursements of all funds. The Contractor must return any and all funds owing to the Receiver General of Canada.

4.2.6.1 The Contractor must deliver to the Project Authority all reports on the management and disbursements of all funds no more than 10 business days following the Final Claim Day in addition to a hard copy of the Financial Institution's final statement of account for the HICPS Account(s). The Contractor must update all financial monthly reports (e.g. stale dated cheques, un-cashed cheques, audit recoveries amounts etc.) at the closing of the accounts and must reconcile the reports to balance the amounts remitted to HC. The Contractor must close all HICPS Accounts and transfer their balances directly to the Receiver General of Canada by way of the Project Authority, or according to written instructions from the Project Authority. The Contractor must deliver these reports in accordance with the timelines designated by the Project Authority.

Appendix A. Historical Volumetrics

Volumetric Data

The HICPS historical business and transactional volume data in Appendix A has been provided to Bidders to assist them in preparing their bids. The inclusion of this data in this bid solicitation does not represent a commitment by Canada that Canada's future usage of the service identified in this bid solicitation will be consistent with this data. It is provided purely for information purposes. Canada accepts no liability for any discrepancies or variation between the estimates provided and the actual resource requirements, decisions and/or claims to be processed under the contract.

1. Actual Volumes of Claim Activity by Benefit Area

Fiscal Year	Drug Benefit Claim Lines	MSE Benefit Claim Lines	Dental Benefit Claim Lines	Vision Care	Mental Health Counseling	Total
2009/2010	16,046,391	309,442	2,645,539	111,116	104,300	19,216,788
2010/2011	17,386,775	311,038	2,867,576	116,876	100,692	20,782,957
2011/2012	18,605,059	327,012	2,888,488	119,120	107,800	22,047,479
2012/2013	19,804,295	338,291	2,955,076	128,668	119,475	23,345,805
2013/2014	20,834,191	359,167	3,065,001	134,683	123,541	24,516,583
2014/2015	22,104,682	363,239	3,171,349	140,979	127,745	25,907,994
2015/2016	23,783,069	394,574	3,300,531	147,569	132,093	27,757,836

2. Drug Benefit Claims Volumes

Fiscal Year	PAID	PAID REVERSED	REJECTED	REVERSED	Total	Paid Claims*
2009/2010	12,715,626	818,581	1,693,509	818,675	16,046,391	$ 377,063,479.41
2010/2011	13,702,841	940,065	1,806,544	937,325	17,386,775	$ 386,284,914.69
2011/2012	14,796,710	979,670	1,844,349	984,330	18,605,059	$ 401,591,034.36
2012/2013	15,751,837	1,060,634	1,931,950	1,059,874	19,804,295	$ 405,509,795.31
2013/2014	16,477,072	1,141,210	2,072,733	1,143,176	20,834,191	$ 411,540,960.32
2014/2015	17,527,781	1,221,342	2,109,947	1,245,612	22,104,682	$ 443,915,043.22
2015/2016	18,825,931	1,259,546	2,348,067	1,349,525	23,783,069	$ 504,724,140.60

**Sum of paid claims through HICPS system, not indicative of total program expenditures*

3. Drug Prior Approvals*

Fiscal Year	AMD		CAN		DEL		FIL		SET		Total Claim Lines	Total PA's
	Claim Lines	PA's	Claim Lines	PA's	Claim Lines	PA's	Claim Lines	PA's	Claim Lines	PA's		
2009/2010	19,467	17,040	18,289	17,193			140	129	106,064	99,422	143,960	133,784
2010/2011	16,233	13,867	14,855	13,798	3	2	13	12	85,979	79,951	117,083	107,630
2011/2012	16,206	13,544	15,376	14,190			32	31	85,369	78,992	116,983	106,757

2012/2013	16,961	14,049	16,037	14,736	2	1	157	142	83,254	77,005	116,411	105,933
2013/2014	17,234	12,771	14,367	12,976			306	281	64,058	57,519	95,965	83,547
2014/2015	18,590	13,307	13,767	12,304			370	338	64,885	56,458	97,612	82,407
2015/2016	20,544	15,261	14,558	13,143			290	255	65,827	59,436	101,219	88,095

**Reflects active claim records, not versions of or historic records*

MSE Benefit Claims Volumes

Fiscal Year	PAID	PAID REVERSED	REJECTED	REVERSED	Total	Paid Claims*
2009/2010	209,124	21,755	56,804	21,759	309,442	$26,040,690.75
2010/2011	213,705	21,476	54,348	21,509	311,038	$27,106,222.70
2011/2012	226,971	22,254	55,514	22,273	327,012	$29,199,245.91
2012/2013	231,625	24,043	58,614	24,009	338,291	$30,810,788.66
2013/2014	248,347	25,103	60,783	24,934	359,167	$33,845,820.60
2014/2015	255,142	23,846	59,425	24,826	363,239	$33,842,884.38
2015/2016	275,520	24,829	66,554	27,671	394,574	$36,970,397.31

**Sum of paid claims through HICPS system, not indicative of total program expenditures*

4. MSE Prior Approvals**

Fiscal Year	AMD		CAN		FIL		SET		Total Claim Lines	Total PA's
	Claim Lines	PA's	Claim Lines	PA's	Claim Lines	PA's	Claim Lines	PA's		
2009/2010	11,209	6,271	3,375	2,249	783	537	83,977	59,333	99,344	68,390
2010/2011	14,845	6,964	3,476	2,222	439	253	84,276	57,140	103,036	66,579
2011/2012	16,035	7,296	3,888	2,261	709	412	91,568	61,186	112,200	71,155
2012/2013	15,138	7,005	4,216	2,403	752	442	100,845	65,769	120,951	75,619
2013/2014	17,544	7,944	5,174	3,012	779	419	102,423	66,393	125,920	77,768
2014/2015	18,670	8,681	4,199	2,392	1,291	741	108,001	70,251	132,161	82,065
2015/2016	19,064	8,609	3,273	1,839	1,203	658	119,013	76,237	142,553	87,343

*** Reflects active claim records, not versions of or historic records*

5. Dental Benefit Claims Volumes

Fiscal Year	PAID	PAID REVERSED	REJECTED	REVERSED	Total	Paid Claims*
2009/2010	2,064,198	49,429	485,412	48,314	2,647,353	$169,113,655.03
2010/2011	2,207,491	60,813	539,833	61,737	2,869,874	$188,715,397.86
2011/2012	2,187,258	61,640	575,557	66,236	2,890,691	$194,801,431.82
2012/2013	2,248,763	44,690	601,308	62,334	2,957,095	$201,221,322.06
2013/2014	2,327,377	41,179	635,877	63,077	3,067,510	$208,574,067.13
2014/2015	2,388,931	40,768	676,474	67,515	3,173,688	$217,841,517.81
2015/2016	2,491,708	45,727	695,251	69,954	3,302,640	$235,762,126.99

**Sum of paid claims through HICPS system, not indicative of total program expenditures*

6. Dental Predeterminations**

Fiscal Year	AMD		CAN		FIL		SET		Total Claim Lines	Total PD's
	Claim Lines	PD's	Claim Lines	PD's	Claim Lines	PD's	Claim Lines	PD's		
2009/2010	85303	32419	5808	2731	6917	4627	273459	129274	371,487	169,051
2010/2011	86709	32591	4932	2275	9112	6699	273147	129642	373,900	171,207
2011/2012	80826	29325	4124	1861	2483	1314	261824	123332	349,257	155,832
2012/2013	80837	29761	3533	1465	2270	1186	247282	117252	333,922	149,664
2013/2014	65961	27111	3572	1526	2393	1162	213408	110736	285,334	140,535
2014/2015	55542	24427	3414	1537	1839	1051	199517	114884	260,312	141,899
2015/2016	51661	22684	2604	1290	1737	979	187142	108895	243,144	133,848

*** Reflects active claim records, not versions of or historic records*

7. Volume of Claims Activity by Region for the Pharmacy, Dental and MSE benefits (FY2015-2016)

REGION	PAID	PAID REVERSED	REJECTED	REVERSED	Total	Prior Approvals**		Predeterminations**		Total Paid Claims*
						Total Number	Total Lines	Total Number	Total Lines	
Alberta	3,087,623	210,741	641,137	226,770	4,166,271	24,868	36,586	31,134	59,075	$132,504,856.31
Atlantic	1,138,588	73,309	174,317	76,727	1,462,941	13,165	17,464	6,441	10,171	$39,425,179.16
Manitoba	3,471,455	232,197	354,026	253,237	4,310,915	29,640	40,094	14,792	22,232	$129,584,118.31
Northwest Territories	228,625	14,813	34,083	16,975	294,496	2,801	4,054	3,492	5,040	$13,649,496.59
Nunavut	261,764	14,213	31,934	17,054	324,965	2,243	2,960	3,008	4,937	$18,806,707.27
Ontario	5,386,893	253,327	740,076	281,148	6,661,444	28,840	38,739	28,098	48,959	$133,608,876.33
Pacific	3,061,460	222,459	485,316	239,873	4,009,108	28,911	41,590	26,285	51,803	$123,380,758.51
Québec	2,232,240	141,682	282,050	149,806	2,805,778	13,535	16,739	6,165	17,626	$59,616,398.04
Saskatchewan	2,615,749	158,940	336,388	176,322	3,287,399	30,173	43,727	13,376	21,451	$118,854,889.51

Yukon	101,233	8,382	15,913	9,142	134,670	1,263	1,820	1,057	1,850	$7,504,244.93
Unspecified	7,529	39	14,632	96	22,296					$521,139.93
Grand Total	**21,593,159**	**1,330,102**	**3,109,872**	**1,447,150**	**27,480,283**	**175,439**	**243,773**	**133,848**	**243,144**	**$777,456,664.89**

**Sum of paid claims through HICPS system, not indicative of total program expenditures*

*** Reflects active claim records, not versions of or historic records*

8. Claim Lines Submitted by Provider Type and Submission Method for Fiscal year 2015-2016

Provider Type	Number of EDI Claims	% of EDI Claims to Total Claims	Number of Paper Claims - Provider	Number of Paper Claims - Client	Total Number of Paper Claims	% of Manual Claims to Total Claims	Total Claims
Pharmacy	23,691,475	99.6%	80,364	11,224	91,588	0.4%	23,783,063
MSE	224,287	56.8%	168,842	1,445	170,287	43.2%	394,574
Dental	2,050,399	62.1%	1,216,759	33,373	1,250,132	37.9%	3,300,531
Vision Care	0	n/a*	147,569**		147,569	100%	147,569
Mental Health	0	n/a*	132,093**		132,093	100%	132,093
Total - All Providers	25,966,161	94.5%	1,465,965	46,042	1,512,007	5.5%	27,478,168

**All Vision Care and Mental Health Providers do not use EDI. Claims are submitted manually to Health Canada.*

***Currently, all Vision Care and Mental Health Counseling Claims are paper based Claims and are not differentiated by Provider or Client.*

9. Percentage of Active Providers Paid Through EFT for Fiscal Year 2015-2016

Provider Type	*Number of Active Providers*	*% of Providers Paid through EFT*
Drug	9,435	97%
MSE	2116	45%
Dental	15,647	83%
Vision Care	4337	100%*
Mental Health Counseling	975	100%*

**Vision Care and Mental Health Providers are not currently processed via HICPS and all providers were paid via direct deposit by the Government of Canada.*

10. Volumes of NIHB Program Providers by Region and Language Preference

As of April 2016, there were 33,188 Providers were enrolled in the NIHB Program, of which 27,899 or about 85% were active. To be considered active, a Provider needs to have participated in the NIHB Program at least once over the previous 24-month period

a) Active and Total Enrolled NIHB Program Dental Providers April 2016

Region	Active Dental Providers - English	Active Dental Providers - French	Enrolled Dental Providers - English	Enrolled Dental Providers - French
ALBERTA	2367		2714	
ATLANTIC	953	44	1101	49
MANITOBA	737		905	2
NUNAVUT	81		87	
NWT	53		50	
ONTARIO	5618	12	7287	15
PACIFIC	2539		2970	
QUEBEC	265	2579	409	3681
SASKATCHEWAN	505		546	
YUKON	47		47	
Total	**13165**	**2635**	**16116**	**3747**
Grand Total		**15800**		**19863**

b) Active and Total Enrolled NIHB Program Drug Providers as of April 2016

Region	Active Drug Providers - English	Active Drug Providers - French	Enrolled Drug Providers - English	Enrolled Drug Providers - French
ALBERTA	1267		1240	
ATLANTIC	784	11	779	10
MANITOBA	431		390	
NUNAVUT	6		8	
NWT	10		12	
ONTARIO	3895	6	4179	6
PACIFIC	1369		1329	
QUEBEC	21	1893	23	2032
SASKATCHEWAN	417		377	
YUKON	9		9	
Total	**8209**	**1910**	**8346**	**2048**
Grand Total		**10119**		**10394**

c) Active and Total Enrolled NIHB Program MSE Providers as of April 2016

Region	Active MSE Providers - English	Active MSE Providers - French	Enrolled MSE Providers - English	Enrolled MSE Providers - French
ALBERTA	258		308	
ATLANTIC	206	15	275	18
MANITOBA	84		104	
NUNAVUT	2		2	
NWT	7		8	

ONTARIO	693	1	1204	3
PACIFIC	436		625	
QUEBEC	10	185	16	263
SASKATCHEWAN	75		94	
YUKON	8		11	
Total	**1779**	**201**	**2647**	**284**
Grand Total		**1980**		**2931**

d) Summary of Total Number of Providers by Region and by Language Preference** for Vision Care and Mental Health Benefits*

Region	Number of Providers (Vision Care)	Number of Providers (Mental Health)
ALBERTA	1,209	202
ATLANTIC	460	122
MANITOBA	126	83
NORTH	3	40
ONTARIO	1489	291
QUEBEC	727	161
SASKATCHEWAN	383	76
Total	4397	975

**Values reported are for 2016 (Visions) and 2015 (Mental Health), and are approximate only.*

***Provider Language Preference can be attributed to the commonly used official language by region e.g. Ontario region 78.95% use English, Quebec 79.95% use French, etc.*

e) Summary of Provider Enrolment Requests in fiscal year 2015-16

Type of Request	Dental	Pharmacy/MSE	Total
New enrolment requests	2575	1100	3675
Reactivated	5	29	34
De-enrolled	282	21	303
End Dated	2303	594	2897
Total	5165	1744	6909

f) Average Provider Enrolment Per Month (FY2014/15 - FY2015/16)

Dental	234 new providers/month
Pharmacy	84 new providers month

MSE	17 new providers /month

11. Volumes of Provider Communication Services

a) Call Volumes

a. HICPS Provider Call Volumes

Region	Dental	Pharmacy	MSE
Alberta	34604	4966	835
Atlantic	2101	1361	250
British Columbia	22594	3686	707
Manitoba	22533	2972	543
Northwest Territories	1659	103	9
Nunavut	4627	88	13
Ontario	25037	8253	1525
Quebec	8839	1467	270
Saskatchewan	20787	1522	214
Yukon	1014	52	6
Total for 2015	**143795**	**24470**	**4372**
Total for 2014	**210617**	**33013**	**11011**
Total for 2013	**245733**	**48398**	**12891**

The numbers reported are annual numbers for 2015. For comparison purposes, values for 2014 and 2013 were also provided.

b) NIHB Regional Mental Health and Vision Care Provider Call Volumes

Region	Vision Care	Mental Health
Alberta	10,000	2,000
Atlantic	1200	651
British Columbia	1.600	300
Manitoba	13,000	4,000
Northwest Territories	2,200	450
Nunavut	2,900	600
Ontario	57,200	2,600
Quebec	17,171	1,500
Saskatchewan	10,000	2,500
Yukon	650	130
Total for 2015	115,921	14,731

12. Other Provider Communication Material

Quarterly, approximately 16,000 dentists, 9,000 pharmacists, 2,400 MSE Benefit Providers are mailed, emailed and/or faxed newsletters updating them on NIHB Program changes and claims processing enhancements.

In 2016 the Contractor printed and mailed out approximately 87,343 MSE prior approval Confirmation Letters, 133,848 Dental predetermination letters, and 88,095 Drug Exception prior approval Confirmation Letters.

Between January 2015 and December 2015, upon the request of Providers, the Contractor responded to approximately 708 Dental, 68 MSE and 133 Pharmacy requests for the Provider Kit.

13. Client Volumes

Refer to the NIHB Annual Report on the HC NIHB Program website
http://www.hc-sc.gc.ca/fniah-spnia/pubs/nihb-ssna/2014_rpt/index-eng.php

14. HC Users

There are 892 HC system accounts on the HICPS System from HC and all regions, 318 accounts were accessed in 2016. For a list of regions and their addresses, please see the Provider Information Kit for each benefit area on the HC NIHB Program website.

15. Volumes of Records on the HICPS System

a) Client Records as of April, 2016

i. 1,381,833 total client records, of which 1,133,931 were non-infants and 247,902 were infants

b) Claims History

i. Drug and MSE Claims History from December 1, 1998 to March 31, 2016: 264,326,802

ii. Dental History Records from August 8, 1987 to March 31, 2016: 45,612,708

c) Items - as of April 2016

i. Drug Benefit: Eligible NIHB Drug Item Records

AB	BC	MB	NB	NF	NS	NT	NU	ON	PE	PQ	SK	YT
11,347	11,324	11,350	11,343	11,352	11,348	11,325	11,322	11,376	11,336	11,284	11,344	11,324

ii. Dental Benefit - Eligible NIHB Dental Procedure Records*

AB	BC	MB	NB	NF	NS	NT	NU	ON	PE	PQ	SK	YT
898	858	872	981	909	913	808	843	957	821	1,107	931	800

**does not include number of specialty procedure code combination records*

iii. MSE Benefit: Eligible NIHB MSE Item Records

AB	BC	MB	NB	NF	NS	NT	NU	ON	PE	PQ	SK	YT
673	673	673	672	673	673	672	673	673	673	673	673	674

*d) Prior Approvals, Special Authorizations, Predetermination and Pre-verification Records**

i. Number of Special Authorization Records: 560,228

ii. Predetermination and Pre-verification Records: 4,127,955

iii. Prior Approvals Records MSE: 1,212,439

iv. Prior Approvals Records Drug Benefit: 2,546,363

** Reflects active claim records, not versions of or historic records*

e) Missing Tooth Records: 6,115,906

Appendix B. HC Technical Environment

HC and the HC internal network (HCNet) provide all HC Users with access to personal workstations and shared print and file services built upon the Novell network operating system. The HCNet provides for several access points and methods to enable external connectivity. The maximum network speed is 700 Mega Bits Per Second but could markedly be lower in various parts of the country. The current minimum requirement for any workstation at HC, but subject to change, is as follows:

Processor: Intel Core i5

Memory: 8GB of RAM

Hard Drive: 128GB SSD

Operating System: Windows 7 SP1 64-bit

Appendix C. NIHB Program Verification Edits

The Contractor must ensure that all NIHB program benefit limits are accurately applied to HICPS claims during the adjudication process. Refer to the benefit specific guides on HC's website regarding details for certain program benefit limits (http://www.hc-sc.gc.ca/fniah-spnia/pubs/nihb-ssna/index-eng.php#drug-med). The Project Authority will provide full details during the Pre-Implementation Phase.

The following is a non-exhaustive list of verification edits that the Contractor must apply to HICPS claims. Further details on these edits will be provided to the Contractor by the Project Authority during the Pre-Implementation Phase, including cases where multiple edits must be applied to a claim. Edits may be added, edited or removed from this list as required by the Project Authority. The edits are specific to claims but are applied within the request for approval (PA, SA and PD) workflows including updates or modifications as required by the Project Authority.

Appendix C 1 GENERAL VERIFICATION EDITS

Appendix C 1.1 Edits for real-time claims

Appendix C 1.1.1 Contractor must automatically identify and reject real-time claims with insufficient or invalid data by:

a) Applying appropriate edits to ensure that real-time claims comply with basic mandatory data and data validity requirements for real-time claims processing according to standard professional software, including but not limited to current or future versions of the CPhA, CDAnet, DACnet, CDHAnet, and Réseau ACDQ standards or any standards in place at the time the claims is submitted. See SOW Article 3.3.10.1 *Capture and Retain Records for NIHB Claims and Claim Reversals* for a complete list of standards.

b) Rejecting for immediate correction and re-submission claims which do not meet these mandatory data and data validity requirements using the error codes from the applicable standard (as opposed to NIHB error codes).

Appendix C 1.1.2 The Contractor must send the Provider a message instructing them to contact the HICPS Call Centre when the Provider has attempted to submit the same Claim request five times.

1.2 Mandatory data edits for hard copy claims

1.2.1 Contractor must automatically identify and reject hard copy claims with insufficient Client and benefit data for NIHB claim adjudication.

a) The mandatory client data elements are:

i. An acceptable Client ID number, i.e. INAC registration number, band number and family number, FNIHB number or GNWT or Nunavut health care number;
ii. At least two of surname, given name and date of birth (date of birth must be in valid date format and must not be after the date of service);
iii. Client address.

b) The mandatory benefit data elements are:

i. Valid date of service;
ii. Valid item code or procedure code, and item cost or professional fee;
iii. Quantity, prescriber ID and prescription number are mandatory for the pharmacy and medical supplies and equipment benefits and;
iv. Days supply is mandatory for drug claims.

1.3 Data validity edits for dental claims

1.3.1 Contractor must automatically identify and reject dental claims which do not meet NIHB data validity edit for procedure codes, tooth and surface codes, pay to codes, and lab fees.

a) The Contractor must automatically apply data validity edits to dental claims including, but not limited to:

   i. The submitted procedure code is industry-recognized or an NIHB Unique code and is not a lab or expense code;

   ii. Valid tooth codes and surface codes must be submitted along with the procedure code where applicable;

   iii. NIHB policies also specifies where a quadrant, sextant or arch code may be used instead of a tooth code and limit surface codes I and O to anterior and posterior teeth respectively;

   iv. Invalid or incompatible surface code combinations are not accepted, e.g. OOM, OI, BVF;

   v. The claim complies with NIHB policy limiting eligibility for certain dental procedures to permanent or primary teeth or to specific types of teeth, e.g. anterior, cuspid, bicuspid, molar, wisdom;

   vi. Valid 'pay to' codes are submitted for direct payment to a provider, client or Third Party;

   vii. The lab fee field is valued for procedure codes for which lab fees are allowed under NIHB policies (with a valid lab code on real-time claims) and is not valued for other procedure codes.

1.4 Duplicate claim edit

1.4.1 Contractor must automatically identify and reject claims that are duplicates of previously paid claims.

a) The duplicate edit is bypassed for prior approved or predetermined claims.

b) A duplicate is defined as a claim line which matches a previous claim line on date of service, client ID number, item code or procedure code (including applicable tooth codes and surface codes in dental).

c) The duplicate edit for pharmacy and MSE claims must also include the following when evaluating the previous claim line:

   i. Provider ID;
   ii. Prescription number;

d) The duplicate edit for dental claims must also include, but not limited to, the following:

   i. Recognize equivalencies between tooth, quadrant, sextant and arch codes;

      For example, for procedure codes for which NIHB policies require the affected arch to be designated on the claim, a duplicate match on tooth code is achieved if a quadrant code 10 is submitted on the claim and arch code 01 was submitted on the matching claim in history.

   ii. The duplicate edit must also be able to match surfaces submitted in different order;

      For example, MOD is a duplicate of DOM.

   iii. Include a secondary check on claims which are duplicates of a previous claim on date of service and client ID but which have different procedure codes. Where such claims are submitted by different provider types, e.g. GP, specialist or denturist, the secondary check must determine if the claims actually refer to the same procedure but have different procedure codes because of different coding conventions between provider types. If such claims refer to the same procedure, they must also be rejected as duplicates.

1.5 Claim submission period edit

1.5.1 Contractor must automatically identify and reject hard-copy claims which are not received within 1 year of the date of service.

a) This edit is bypassed for prior approved or predetermined claims.

b) NIHB policy requires that providers submit their claims within 1 year of the date of service. Therefore, if the date of service on the claim is more than 1 year prior to the processing date, the Contractor must automatically reject the claim.

1.5.2 Contractor must automatically identify and reject real-time (EDI, POS etc.) claims which are not received within 30 days of the date of service.

a) Real-time claims must also comply with claim submission period requirements in the applicable real-time standard. Real-time pharmacy claims must be submitted within 30 calendar days of the date of service and real-time dental claims must be submitted within 30 calendar days of the date of service. The Contractor must automatically reject real-time claims which do not meet this requirement with a message indicating that the claim must be submitted manually.

Appendix C 2 PROVIDER VERIFICATION EDITS

2.1 Provider Enrolment edit

2.1.1 Contractor must automatically identify and reject claims when the provider is not enrolled, or with insufficient Provider data:

a) The Contractor must automatically enforce that a provider ID number is submitted and that it matches to a provider ID number on the enrolled NIHB Provider number list. The Contractor must automatically reject claims which do not include a Provider ID number or when the provider number is not on the enrolled NIHB Provider list.

b) For dental benefit Providers an equivalent match must be also be obtained between the Provider office ID on the claim and a Provider office ID associated with the matching NIHB Provider ID number.

2.2 Provider effective period edit

2.2.1 Contractor must automatically identify and reject claims for which the date of service is not within the effective period for the enrolled Provider.

a) If the Provider ID number is verified against the NIHB enrolled provider list, the Contractor must automatically check to ensure that the date of service on the claim is within the Provider's eligibility effective period, as defined by Provider’s start and end dates for NIHB eligibility.

2.3 Qualified Provider edit

2.3.1 Contractor must automatically identify and reject claims for which the Provider is not qualified to provide the item claimed.

a) The Contractor must automatically enforce if the Provider is qualified to provide the item claimed. In some cases, the Provider may be an eligible NIHB Provider for a given benefit area but not for the item claimed.

As examples, pharmacy providers are eligible to provide drugs and MSE items but MSE providers are only eligible to provide MSE items. An Orthodontist is eligible to provide orthodontic procedures while a Denturist or Dental Hygienist is not.

b) The Contractor must automatically enforce if the Provider is qualified to provide the item based on the specialty or sub-specialty for which they are enrolled.

Appendix C 3 CLIENT VERIFICATION EDITS

3.1 Client Enrolment edit

Basic Rule

3.1.1 Contractor must automatically identify and reject claims for which the client is not on the NIHB Client list.

a) A claimant is verified as an NIHB Client if there is a match between the claim and the NIHB Client file on the following identifiers:

   i. One primary identifier including the Client's INAC number, NIHB number, band number and family number, or GNWT or Nunavut health care number for Inuit clients;
   ii. Any two secondary identifiers including surname, given name and birth date.

b) If the required match cannot be made using band number and family number, Client verification may match on:

   i. The band number and all three secondary identifiers surname, given name, and birth date; or
   ii. The family number and all three secondary identifiers surname, given name, and birth date.

Definition of an Acceptable Match

3.1.2 Contractor must provide automated matching logic that must account for the following details which define an acceptable match:

a) The match must be unique meaning submitted identifiers must provide an acceptable match to only one record on the NIHB Client list.

b) Numeric identifiers on the claim must exactly match the numeric identifiers on the NIHB client file. This applies to the INAC number, NIHB number, band number and family number, and means that the Contractor cannot accept minor errors in these numbers.

c) A birth date match must be based on an exact match on day, month and year. A match on only month and year is not acceptable. Logic must be applied so that birth dates submitted with reversed digits, e.g. DD-MM-YYYY, MM-DD-YYYY, and YYYY-MM-DD, are considered a match.

d) Surnames and given names on the claim must exactly match the first 6 characters of names on the NIHB Client file. Furthermore, a match on only the first 3 characters will be acceptable if the primary identifier is an INAC or NIHB number.

e) A surname match may be made against the surname or any alias surname on the Client record.

f) A given name match may be made against any given name on the Client record. The match may be against the given name(s) or alias given name(s).

   For example, if Mary is submitted on the claim, and Mary Ellen is on the Client list record, the match on the given name Mary is acceptable.

g) First initials are not acceptable as a given name or as a given name match, unless first initials are entered as an approved given name on the Client record.

h) If a match is made using the Client ID number (primary identifier), surname and given name, the date of birth on the claim must be within 5 years of the date of birth on the matching NIHB Client file.

i) If client verification is unsuccessful using a submitted INAC number, client verification must be attempted using the band and family numbers embedded in the INAC number. The first 3 digits of the INAC number give the band number and digits 4 through 8 give the family number, digits 9 through 10 is a unique identifier.

j) If the client verification on the Client ID number is unsuccessful, verification must be attempted using the band and family number if submitted on the claim.

Special Provisions for Non-enrolled Infants Under an Age specified by the Project Authority

3.1.3 Contractor must successfully verify non-enrolled infants up to an age specified by the Project Authority.

a) Contractor must verify claims provided that:

i. The child's surname, given name(s), and birth date are provided on the claim;
ii. One of the child's parents can be verified as an NIHB Client according to the Client verification edits included in Appendix C, Article 3.1, *Client Enrolment Edit,* requiring the parent to be eligible for the benefit on the claim's date of service.

b) For pharmacy claims, the Contractor must provide explanatory message to the Provider indicating that claims for unverified infants will be paid under the parent's identifiers only until the infant's first birth date.

3.2 Client effective period edit

3.2.1 Contractor must automatically identify and reject claims for which the date of service is not within the effective period for the enrolled Client.

a) If the claimant is verified against the NIHB client list, the Contractor must automatically check to ensure that the date of service on the claim is within the client's eligibility effective period, as defined by the Client's start and end dates for NIHB eligibility. These dates may vary by benefit group. For example, start and end dates may be different for the benefit areas.

3.3 Client transfer edit

3.3.1 Contractor must automatically identify and reject claims for which responsibility for the claim has been transferred from NIHB to an alternative program.

a) HC will provide an end date for NIHB eligibility for Clients that have been transferred to a First Nations or Inuit organization for one or more benefit areas.

b) For claims with dates of service after the Client's eligibility end date, the Contractor must automatically check the transfer indicator on the Client record and if transfer of responsibility is indicated, reject the claim for alternate processing with a special message.

Appendix C 4 BENEFIT VERIFICATION EDITS

4.1 Common verification edits

4.1.1 Edits bypassed with valid PA, PD or SA

4.1.1.1 Contractor must automatically bypass the benefit verification edits listed within Appendix C 4.1 for claims which have a valid PA or PD. The claim must instead be adjudicated against the terms of the PA or PD.

4.1.1.2 Contractor must automatically bypass the benefit verification edits except Appendix C 4.1.5 Frequency Limitation edit for claims approved on a valid SA. The Frequency Limit must be enforced for claims with a valid SA, unless specified by an HC User (see SOW Article 3.3.7.16.1 (j) *Special Authorization Specifics*.

4.1.2 Eligible benefit edit

4.1.2.1 Contractor must automatically identify and reject claims for items that are not on the NIHB eligible benefit list on the date of service, unless the claim is supported with a PD.

a) Contractor must automatically enforce that the benefit item code on the claim matches to an item ID, jurisdiction, procedure code, etc. on the NIHB benefit list that has NIHB-eligible status on the date of service.

4.1.3 Age eligibility edit

4.1.3.1 Contractor must automatically identify and reject claims for items with age eligibility requirements that are not met by the Client.

a) Contractor must automatically calculate the verified client's age on the date of service and then ensure compliance with any age limitations defined by the Project Authority during the pre-implementation phase for the claimed benefit.

   For example, topical fluorides are only a benefit for dental clients less than 17 years of age and infant vitamins are only eligible for clients under 2 years of age.

b) Contractor must account for Clients born on a February 29th when verifying the age eligibility requirements.

4.1.4 Gender eligibility edit

4.1.4.1 Contractor must automatically identify and reject claims for items with gender requirements that are not met by the Client.

a) The Contractor must automatically enforce that the verified Client's gender complies with any gender limitations defined by the Project Authority during the pre-implementation phase for the claimed benefit.

   For example, only females between the age of 12 years and 50 years are eligible for prenatal vitamins.

4.1.5 Frequency Limitation edit (See Sow Article 3.3.7.7 *Managing a Frequency Limit*)

4.1.5.1 Contractor must automatically identify and reject or reduce claims which exceed applicable Frequency Limits:

a) The Contractor must automatically enforce compliance with any Frequency Limits defined by NIHB policies specified for the claimed benefit:

   For example, in the NIHB dental benefit, a maximum of 10 intraoral radiographs are allowed every 12 months. Or for a pharmacy, overall Morphine equivalence per day.

b) The Contractor must automatically reject claims that fully exceed the limit;

c) The Contractor must automatically reduce the payment for claims that partially exceed the limit so that only the eligible quantity is paid. The eligible quantity must be calculated as part of the Frequency Limitation edit so that this quantity can be used in determining the allowed dollar amount during cost verification;

d) The Contractor must include logical mechanisms for fully enforcing Frequency Limitations including mechanisms for dealing with claims submitted out-of-sequence.

4.1.6 Provider Management edit (See Sow Article 3.3.1.8 *Provider Management*)

4.2 Dental benefit eligibility edits

4.2.1 Tooth eligibility edit

4.2.1.1 The Contractor must automatically identify and reject dental claims for procedures which are ineligible based on NIHB policies for the claimed tooth.

For example, a crown is only eligible on permanent teeth.

4.2.2 Tooth condition edit

4.2.2.1 The Contractor must automatically identify and reject dental claims for procedures which are incompatible with the tooth condition, as per NIHB policies, defined on a previous claim including but not limited to:

a) The Contractor must automatically reject dental claims involving procedures that are incompatible with procedures paid for the same tooth with an earlier date of service.

For example, a filling must not be allowed on a tooth that has been extracted on an earlier date of service according to NIHB claim history records.

b) Similarly, the Contractor must automatically reject dental claims involving procedures that are incompatible with procedures paid for the same tooth with a later date of service.

For example, an extraction must not be allowed on a tooth that has been filled on a later date of service according to NIHB claim history records. This situation can arise because claims may not always be submitted in date of service sequence, e.g. a filling claim with a date of service in May 2015 may be submitted before an extraction claim with a date of service in April 2015.

4.2.3 Procedure code conflict edit

4.2.3.1 The Contractor must automatically identify and reject dental claims for procedures which conflict with a verified procedure code, as per NIHB policies, on the same date of service for the same client.

For example, general anesthesia codes cannot be claimed for the same date of service as an inhalation anesthesia code.

4.2.4 Maximum number of restored surfaces edit

4.2.4.1 The Contractor must automatically identify and reject dental claims for procedures for which the claimed number of surfaces exceeds the maximum allowed (5 surfaces).

a) This edit only applies to procedures for which surface codes are mandatory.

4.2.5 Associated procedure edit

4.2.5.1 The Contractor must automatically identify and reject dental claims, which are not claimed in association with another procedure code where required under NIHB policy, e.g. anesthesia codes.

4.3 Pharmacy benefit eligibility edits

4.3.1 Prescriber Reference Type

4.3.1.1 The Contractor must automatically identify and reject claims if the prescriber type identified by their prescriber reference ID is not eligible for reimbursement under the NIHB Program.

4.3.2 Dose Equivalents edit

4.3.2.1 The Contractor must automatically identify and reject or reduce Claims which exceed the item’s dose equivalent (quantity) limit for the Claim quantity.

a) The amount of an individual item (DIN/PIN/NPN) in terms of the dose equivalents limit defined as the dose of one item is assumed to be functionally equivalent to the baseline item used for a similar purpose.

For example, opioids are given a morphine equivalent value as an equivalent to a 30 mg oral dose of morphine. The dose equivalent value is assigned to each item as needed and the value multiplied by the quantity requested to determine the total dose requested.

The number of dose equivalents for two or more such items can be added together. It is also possible to add together the dose equivalents of all the DINs in the same broad therapeutic class or of all the DINs given to one or more patients.

See the Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain for more information.

4.3.3 Elapsed Period edit

4.3.3.1 The Contractor must automatically identify and reject claims that exceed the quantity limit for a lock-out period (see SOW Article 3.3.7.7.1(l) *Managing a Frequency Limit*).

4.3.4 Severe drug utilization problem edits

Only applicable to drug claim lines which pass all of the NIHB eligibility edits.

4.3.4.1 The Contractor must automatically identify and reject drug claim lines which indicate severe drug utilization problems.

a) At a minimum, the Contractor must provide logic to execute the following edits to identify potential severe drug utilization problems based on a review of at least 6 months of claims history:

   i. Drug-to-drug interactions potential edit: The Contractor must automatically reject the drug claim line if the claimed drug may interact with a previously claimed drug causing a potential clinical problem for the patient. This edit must be bypassed if the pharmacist re-submits the claim with an acceptable override code;

   ii. Duplicate drug edit: The Contractor must automatically reject the drug claim line if the Client has previously received the exact same chemical entity (from the same pharmacy or another pharmacy) and has used less than 2/3 of the days' supply specified on the previous claim. This edit must be bypassed if the pharmacist re-submits the claim with an acceptable override code.

Note: DUR edits are designed for real-time claims but are also applied to hard copy claims except that DUR rejects are not enforced (the hard copy claim line is paid with a warning message).

4.3.5 Drug utilization edits

Only applicable to drug claim lines which pass all of the NIHB eligibility edits.

4.3.5.1 The Contractor must automatically identify and apply a rejection with overriding capabilities to drug claim lines that indicate significant drug utilization problems based on a review of at least 6 months of claim history.

a) The Contractor must automatically identify and reject claims where the Client has previously received an excessive amount of narcotics, benzodiazepines or other drug. Providers can override the rejection with the appropriate intervention code(s). For example:

   i. Use of three (3) or more distinct opioid drug entities;
   ii. Use of three (3) or more distinct benzodiazepine drug entities;
   iii. Use of three (3) or more opioid drug entities, and three (3) or more drug entities and three (3) or more benzodiazepine drug entities;

4.3.6 Duplicate therapy edit

Only applicable to drug claim lines which pass all of the NIHB eligibility edits.

4.3.6.1 The Contractor must automatically identify if the Client has previously received a drug from the same therapeutic class, from the same pharmacy or another pharmacy. Such claim lines may be paid but must be accompanied by a warning message.

4.3.7 Methadone limit for OAT

4.3.7.1 The Contractor must automatically evaluate a claim for methadone with, but not limited to, the following:

a) The Client is 16 years of age or older as defined in the coverage details.

b) There is a seven (7) day supply limit for methadone. This limit is the maximum number of doses that can be dispensed to a Client in one day.

c) The date of service submitted on the current methadone claim cannot overlap with the date of service on a previously paid methadone claim.

d) Dispensing fees submitted on methadone claims must be based on the number of doses allowed for the Client, and must not exceed the pricing guidelines for the Provider's province/ territory.

e) A different Provider cannot submit methadone claims for the same Client on the same date of service.

4.3.7.2 The Contractor must determine a solution where a Client has to split a 1 day dose into morning and night.

4.3.8 Day supply limit for drugs of concern edit

The Contractor must automatically evaluate a claim for any one of the drugs of concern and reject if the day's supply exceeds 30 days, with the ability to override this edit in instances determined by the Project Authority.

4.3.9 Auto Adjudication Edit for Pharmacy Item Claims

The Contractor must automatically identify and process claims according to the criteria within the auto adjudication query when an auto adjudication query has been associated to the claimed item.

4.3.10 Short-Term Dispense Policy Edit

The Short Term Dispense (STD) edit is applied to all current claims for chronic use drugs flagged by NIHB as either under a 28-day supply policy or a 7 day supply policy. The Contractor must enforce NIHB pricing rules covered by the Short-Term Dispensing (STD) policy limit, by jurisdiction, on claims that exceeds the dispensing fee amount allowed by the limit. For example, the edit includes, but is not limited to, the following rules:

a) For items flagged under the 28-day supply STD policy, HC only pays one dispense fee per 28-day's supply for subsequent claims of the item. Where the day supplies paid for claims submitted for subsequent claims of the item is less than 28 days, the dispense fee will be calculated according to the following formula: (dispense fee/ 28) x paid days supply.

b) For items flagged under the 7-day supply STD, HC only pays one dispense fee per 7-day's supply for subsequent claims of the item. The same formula as a) is applied but for 7 days: (dispense fee/7) x paid days supply.

c) Providers need the capability to override the edit for the exceptions to the STD policy, as determined by HC.

4.3.11 Special Dispense Fee Edit

The Contractor must enforce NIHB pricing rules, by jurisdiction, related to dispensing fees based on a defined paid days supply. For example, in Quebec the pricing verification is based on the following formula ((fee/30) x paid days supply).

4.3.12 Adjudication of Extemporaneous Mixtures

a) The Contractor must develop a solution, using the claims submission standard, for submitting extemporaneous mixtures for adjudication. The current standard makes use of the "unlisted compound" codes, which provides an indicator to the system as to what type of mixture the pharmacy is compounding using the main ingredient, and the type of mixture indicates the maximum compounding fee allowed, as well as other pricing parameters that may apply for regular claims during cost verification of the claim.

b) The Contractor must ensure that Providers can send a DIN of the main ingredient along with the applicable unlisted compound code. As the claim standard evolves, the Contractor must be able to adjust the system, so that the provider can use the available process in the new or updated pharmacy claim standard, for example the industry is seeking an update to the standard to allow the provider to list and send all items included in the mixture, in one claim submission.

c) The Contractor must ensure that the system can send back messages to provider based on NIHB eligibility of the main item in the mixture, as the system does for non-extemporaneous mixtures claims submission. For example, items with the benefit status of exclusion not be allowed and limited use and exception items require prior approval.

d) The Contractor must develop similar logic that can be applied during Prior Approval Entry, Special Authorization Entry, Case Record Entry, and associated processes.

e) The Contractor must ensure that when the system uses a miscellaneous code from the database, the system allows the capturing of the actual name of the item being dispensed. The actual name needs to appear on all records associated to the approval request, including but not limited to the BEQ.

Appendix C 5 HC APPROVED CLAIM VERIFICATION EDITS

5.1 PA and PD claim edits

5.1.1 Missing PA or PD number edit

5.1.1.1 The Contractor must automatically identify and reject claims for benefit items, which require prior approval or predetermination but HC approval has not been obtained.

a) The Contractor must automatically enforce that claim lines for benefit items or procedures which are identified as requiring prior approval or predetermination are:

i. Submitted with a PA or PD number;

ii. Approved on a special authorization (see Appendix C, Article 5.2 *Special Authorization Edits*)

iii. Approved through an auto adjudication query

5.1.2 PA or PD verification edit

5.1.2.1 The Contractor must automatically identify and reject claims that have an invalid PA or PD number.

a) If a PA or PD number is submitted for a claim line, the Contractor must automatically verify that it is a valid PA/PD number by confirming that it matches to a PA or PD number on a PA or PD record with settled or amended status.

5.1.2.2 The Contractor must automatically identify and reject claims which do not match the terms of the applicable PA or PD record excluding approved costs.

a) If the PA or PD number on the claim line is valid, the Contractor must automatically verify that the claim line complies with the terms of approval by obtaining a match between the claim line and an approved line on the associated PA/PD record on the following identifiers:

i. Client ID number;

ii. Provider ID number including office number for Dental Benefit Providers;

iii. Item ID number where item ID number means item code for non-dental claims or procedure code, tooth code, and tooth surface code as applicable, on dental claims.

b) The Contractor must automatically reject a pharmacy item claim if the quantity within the claim is less than the total quantity approved divided by the number of refills plus 1.

5.1.3 PA or PD effective period edit

5.1.3.1 The Contractor must automatically identify and reject claims for which the date of service is not within the effective period of the applicable PA or PD record.

a) PA and PD records are effective for one year from the start of the authorized period.

b) PA and PD records are effective within the start and end dates of the authorized period when an end date is set.

5.1.4 Used up PA or PD edit

5.1.4.1 The Contractor must automatically identify and reject claims for which the associated PA or PD record has been used up by a previous claim or claims.

a) A line on a PA or PD record is considered used up if a claim line has been previously claimed against it;

b) Standing order prior approvals are structured to allow repeat claims against the same PA or PD line and which are not considered used up until either the total quantity or dollar amount approved have been exhausted by previous claims.

5.2 Special Authorization Edits

5.2.1 SA verification edit

5.2.1.1 Contractor must only apply the SA edit to claims without a verified PA#.

5.2.1.2 Contractor must automatically verify that the claim is a valid SA by confirming that it matches a SA record with settled or amended status. If multiple matches are found, then the Contractor must use most recent SA in accordance with the SA start date.

5.2.1.3 Contractor must automatically verify that the claim line complies with the terms of approval by obtaining a match between the claim line and an approved line on the associated SA record on the following identifiers:

a) Client ID number;

b) Item ID number or item ID number within item group when set.

5.2.1.4 Contractor must automatically verify the Client's eligibility for the item:

a) If Client is eligible for item then verify the claim against the remaining terms (Appendix C, Article 5.2.2 *Compliance with the terms of the SA edit*); or

b) If Client is not eligible for item, reject the claim.

5.2.1.5 Contractor must automatically bypass the SA verification edit if claim does not meet the requirements of the edit.

5.2.2 Compliance with terms of the SA edit

5.2.2.1 Contractor must automatically obtain a match between the claim line and an approved line on the associated SA record for, but not limited to, the following elements set within the SA record:

a) Prescriber ID or prescriber ID within prescriber group when set;

b) Provider ID number when set;

c) Maximum dose equivalent limit;

d) Minimum, maximum or total day's supply;

e) Minimum, maximum or total quantity.

5.2.3 SA effective period edit

5.2.3.1 Contractor must automatically identify and reject claims for which the date of service is not within the effective period of the applicable SA record.

Appendix C 6 COST VERIFICATION EDITS

6.1 Cost verification edits for claims submitted without prior approval or predetermination

6.1.1 Common verification edits

6.1.1.1 Contractor must automatically enforce that all cost parameters are paid at the lower of the amount claimed or the amount allowed under the NIHB pricing rules, as per the benefit pricing schedule.

a) The Contractor must automatically enforce that NIHB claims are paid according to all applicable NIHB pricing rules in effect on the date of service in the jurisdiction in which the Provider provided the item or service.

6.1.2 MSE claims

6.1.2.1 Contractor must automatically apply separate edits to enforce NIHB pricing rules for the following cost parameters for MSE items: item cost, mark-up, and professional fee (normally professional fees are not allowed for MSE items).

a) This includes enforcing pricing rules on allowed mark-up percentages and must accommodate up-charge and/or tolerance margins set by HC.

6.1.3 Dental claims

6.1.3.1 Contractor must automatically apply separate edits to enforce NIHB pricing rules for professional fees and lab fees for dental procedures. This includes, but not limited to, the enforcement of pricing rules which:

a) Limit lab fees to a percentage of the associated professional fee;

b) Limit payment for multiple services (e.g. extractions) in the same quadrant, where applicable;

c) Relate payments for fillings on the same day on the same tooth to the number of unique surfaces restored on the current claim and any previous claim;

d) Enforce alternate pricing arrangements for certain procedures, e.g. bonded amalgams are paid at the rate of non-bonded amalgams.

6.1.4 Pharmacy claims

6.1.4.1 Contractor must automatically enforce separate edits to enforce NIHB pricing rules for the cost parameters for pharmacy items related to the pricing rules defined by HC. See SOW Article 3.3.7.2, *Setting the Pricing for an Item* for details.

a) This includes enforcing pricing rules which include:

i. Lowest cost equivalent drug costs where HC uses lowest cost-equivalent drug pricing when applicable;
ii. Variable values for allowed costs defined in SOW Article 3.3.7.2, *Setting the Pricing for an Item* where the allowed dollar amount depends on the allowed product cost.

6.1.4.2 Maximum claim dollar amount

Contractor must automatically enforce NIHB pricing rules for the maximum claim dollar amount set by HC.

6.1.4.3 Alternate Pricing Category Eligibility Edit

Contractor must enforce NIHB pricing rules when an alternate pricing category has been set for an item. For example, over the counter items are allowed to be paid at the pricing rules for a controlled access drug.

6.1.4.4 Dossette Fee Eligibility Edit

Contractor must enforce NIHB pricing rules related to a Dossette fee.

a) Pharmacy claims submitted as Dossette claims are not entitled to the regular dispensing fee; a specific fee applies. The days' supply must equal a multiple of 7 and verify that the item is eligible for submission as a Dossette.

6.1.4.5 Trial prescription program edit

The Contractor must enforce NIHB pricing rules related to the trial prescription program.

a) Pharmacy items qualifying for the Trial Prescription Program are to be identified in their coverage detail information.

b) Under the Trial Prescription Program, a patient receives a 7-day supply of a new medication in order to determine if the drug is tolerated.

   Claims are submitted with an intervention code to identify that the drug is part of the Trial Prescription Program and with another intervention code to identify that the claim is for a Trial prescription balance.

c) Detailed business requirements to be determined and approved by the Project Authority, during the Pre-implementation Phase, including but not limited to reporting and vendor communication.

6.2 Cost verification edits for claims submitted with a valid prior approval or predetermination

6.2.1 Contractor must automatically enforce that claims for prior approved or predetermined items are paid at the lower of the amount claimed or the amount allowed on the applicable PA or PD.

a) MSE claims include quantity, item cost, markup and professional fee.

b) Dental claims include professional fee and lab fee where applicable.

c) Pharmacy Claims:

   i. Include but not limited to quantity, markup, professional fee and compound fee.
   ii. Contractor must use the item cost values (such as item cost, mark-up, professional fee and compound fee) for the date of service in calculating the amount allowed when the prior approval request indicates that standard pricing is to be used.

Appendix C 7 THIRD PARTY VERIFICATION EDITS

7.1 Provincial / Territorial plan coordination edits

7.1.1 Contractor must automatically identify and reject claims for submission to the appropriate plan under the following conditions:

a) For items which are covered (fully or partially) under such plans, and identified.

b) The claim can only be accepted after it has first been submitted to the appropriate plan and the applicable Third Party share determined. The Third Party share is required so that the NIHB payment can be limited to the NIHB share during cost verification.

7.1.2 Contractor must automatically:

a) Bypass the provincial/territorial coordination edits for predetermined and prior approved claims.

b) Apply the NIHB DUR edits to all pharmacy item claims that have been first submitted to provincial or territorial plans.

c) Apply edits on the assumption that all Clients are eligible for provincial/territorial programs applicable at the point of service. HC cannot provide the Contractor with up-to-date residency information for all Clients.

7.2 Private plan coordination edits

7.2.1 Contractor must automatically identify and reject claims for Clients that have private insurance coverage as indicated in their Client details and for which the coverage is not reported on the claim.

a) The claim can only be accepted after it has first been submitted to the appropriate plan and the applicable third party share determined. The third party share is required so that the NIHB payment can be limited (where determined by the Project Authority) to the NIHB share during cost verification.

b) The private coordination edit is bypassed for prior approved claims.

c) NIHB DUR edits shall be applied to all pharmacy item claims that have been first submitted to private plans.

7.3 Third party coordination cost verification edits

7.3.1 Contractor must automatically enforce that claims which report third party shares previously paid by a public or private plan, excluding the Ontario Drug Benefit, are adjudicated so that the total amount paid is limited to the NIHB share.

a) Pharmacy and MSE Claims: The Contractor must pay the lessor of the amount allowed using each pricing parameter recorded within the claim line and the third party share reported on the claim.

b) Dental Claims – The Contractor must automatically calculate the allowed professional fee as the greater of the provincial fee for the claimed procedure or the NIHB allowed fee. The total amount allowed for each claim line is then calculated as the sum of the total allowed fee minus the reported third party share.

7.3.2 Contractor must automatically enforce that claims for prior approved or predetermined items, which report third party shares previously paid by a public or private plan, excluding the Ontario Drug Benefit, are adjudicated so that the total amount paid is limited to the NIHB share.

a) Pharmacy and MSE Claims: The Contractor must pay the lessor of the amount allowed using each pricing parameter for the claim and the third party share reported on the claim.

b) Dental Claims: The Contractor must automatically calculate the allowed professional fee as the greater of the provincial fee for the claimed procedure or the NIHB allowed fee. The total amount allowed for each claim line is then calculated as the sum of the total allowed fee minus the reported third party share.

Appendix D. Current SVS Interface (File Layout)

The purpose of the SVS interface is to enable HC to provide updates on Client eligibility. The Contractor must provide an interface that consists of access to a secure FTP server managed by the Contractor at the Contractor's location where HC can upload the SVS updates file for the Contractor to update the HICPS data. The Contractor must use the SFTP transfer protocol. Refer to the SVS file layout available below. The Contractor must provide the following electronic interface:

1- The Contractor must accept regular weekly updates of Client information from SVS and more frequently on an as needed basis determined by the Project Authority.
2- The Contractor must deliver weekly transaction reports to the Project Authority and more frequently on an as needed basis determined by the Project Authority.
3- The Contractor must deliver to the Project Authority a weekly summary of transaction results by region, including counts of transactions processed.
4- The Contractor must deliver to the Project Authority process weekly failure reports, listing all failed Claims Processing transactions with the reason for failure.
5- The Contractor must deliver to the Project Authority weekly transfer reports listing all Clients with a transfer status and more frequently on an as needed basis determined by the Project Authority.
6- The Contract must participate in annual reconciliations, led by the Project Authority, to ensure the Client eligibility information in the HICPS solution is consistent with that in SVS. The Contractor must deliver to the Project Authority two separate files on an annual basis containing active and inactive Clients by them uploading to the secure FTP server and must provide assistance to the Project Authority in making any corrections, if required.
7- The Contractor must maintain audit trail for all modifications, additions, or deletions to HICPS data by this interface.

SVS Interface Record Layout

Note: This file layout must be validated with HC prior to implementation as it may not be current anymore.

FIELD NAME	**LENGTH**	**FIELD POSITION**	**TRANSACTION CODE***						
			A	**C**	**D**	**X**	**Y**	**T**	**B**
TRANSACTION CODE	1	1	X	X	X	X	X	X	X
CLIENT TYPE	1	2	X	X	X	X	X	X	X
CLIENT ID	9	3	X	X	X	X	X	X	X
CLIENT TYPE TRANSFERRED **	1	12						X	X
CLIENT ID TRANSFERRED	9	13						X	X

FIELD NAME	LENGTH	FIELD POSITION	TRANSACTION CODE*						
			A	C	D	X	Y	T	B
**									
SURNAME	30	22	X	X					
GIVEN NAME	30	52	X	X					
ALIAS SURNAME **	30	82	X	X					
ALIAS GIVEN NAME **	30	112	X	X					
DATE OF BIRTH CCYYMMDD	8	142	X	X					
SEX	1	150	X	X					
REGION CODE	2	151	X	X					
API**	1	153	X	X					
RESERVE INDICATOR **	1	154	X	X					
TRANSFER INDICATOR **	1	155	X	X					
INAC NUMBER **	10	156	X	X		X			
BAND **	3	166	X	X		X			
FAMILY **	5	169	X	X		X			
DENTAL START CCYYMMDD	8	174	X	X					
DENTAL END ** CCYYMMDD	8	182	X	X					
PH START CCYYMMDD	8	190	X	X					
PH END ** CCYYMMDD	8	198	X	X					

FIELD NAME	LENGTH	FIELD POSITION	TRANSACTION CODE*						
			A	C	D	X	Y	T	B
HEALTH PLAN NUMBER **	21	206	X	X					
ALTERNATE ID **	10	227					X		
INSERT DATE CCYYMMDDHHMISS	14	237	X	X	X	X	X	X	X
CON DATE SENT CCYYMMDDHHMISS	14	251	X	X	X	X	X	X	X
CONSENT INDICATOR	1	265	X	X					

* The Transaction Codes are as follow: A = Add, C = Change, T = Transfer, X = Add Alternate Id, Y = Remove Alternate Id, D = Delete, B is not used anymore and can be ignored.

**Although indicated to be sent for each transaction type, these fields may have null values for a given transaction.

Appendix E. HC's Financial Management System Interface

The SAP interface is a manual process. A Health Canada authorized user will download a file from a drop folder which is then processed by SAP. A series of manual checks will be performed to ensure the payment amount is accurate and that no errors have occurred with the SAP import. The frequency of data exchange is bi-weekly. The record layout consists of a header record, detail record and a trailer record. Each record is 80 characters in length.

FIELD #	FIELD NAME	FORMAT	DESCRIPTION
1	Record Code	X(2)	Record Identifier "10"
2	Account Code	X(11)	'9000SF06020'
3	Benefit Code	X(2)	01 - Dental 02- Prescription Drugs 03- OTCs 04- Proprietary Medicines 05- Medical Supplies 06- Medical Equipment Codes for Mental Health Counselling and Vision TBD
4	Date	X(8)	Date of last day in period containing transactions in 'CCYYMMDD' format
5	Id Reference	X(12)	File identifier (date – time stamp) in 'CCYYMMDDHHMM' format
6	Filler	X(49)	Filler

Detail Record Specs

FIELD #	FIELD NAME	FORMAT	DESCRIPTION
1	Record Code	X(2)	Record Identifier “21”
2	Sign for total	X(1)	Sign for amount total of claims paid: Space for positive ‘-‘ for negative
3	Amount total	X(14)	Amount total of claims paid. No decimals or commas. Claims with status of paid (claims and reversals) with settled dates between the 1st of the month and the end of the month with a paid amount > 0.00.
4	Filler	X(1)	Filler
5	Band	X(3)	Band Number. Where band number is invalid on the claim, a pseudo-band number in accordance with on Provider region is assigned.
6	Code	X(2)	‘XX’
7	Filler	X(57)	Filler

Trailer Record Specs

FIELD #	FIELD NAME	FORMAT	DESCRIPTION
1	Record Code	X(2)	Record Identifier “90”
2	Sign for total	X(1)	Sign for amount total of claims paid: Space for positive ‘-‘ for negative
3	Amount total	X(14)	Amount total of claims paid. No decimals or commas.
4	Filler	X(1)	Filler

FIELD #	FIELD NAME	FORMAT	DESCRIPTION
5	Record Count	X(6)	Count of data records (including header and trailer records)
6	Filler	X(56)	Filler

Appendix F. Task Authorization Labour Categories

For educational requirements for a particular degree, designation, or certificate, Canada will only consider educational programmes that were successfully completed by the resource by the date of TA issuance. If the degree, designation or certification was issued by an educational institution outside of Canada, the Contractor must provide a copy of the results of the academic credential assessment and qualification recognition service issued by an agency or organization recognized by the Canadian Information Centre for International Credentials (CICIC).

Also, it should be understood that all health professionals must be members in good standing with the regulatory body of the province or territory in which they practice; even if not always stated below.

Training or professional development of Contractor personnel will be performed at the Contractor's expense.

The following is a list of qualifications for labour resources for Task Authorizations:

1. Provider Claim Verification Personnel

1A. Pharmacy Claim Verification Representative

Qualifications:

- Must have a diploma from an accredited post-secondary educational program in the Pharmacy Technician program, or equivalent; and
- Have at least 2 years full-time or equivalent of demonstrated experience, within the last 5 years, in the retail pharmacy environment;
- Experience in data analysis, financial analysis and statistics;
- Experience in report writing;
- Must have current knowledge of the professional legislation for each province or territory, as applicable.

1B. Dental Claim Verification Representative
Qualifications:

- Must have a diploma from a recognized post-secondary educational program in the dental services field either as a dental assistant or dental hygienist with a valid license; and
- At least 2 years full-time or equivalent of demonstrated experience within the last 5 years in a dental office environment;
- Experience in data analysis, financial analysis and statistics;
- Experience in report writing; and
- Must have current knowledge of the professional legislation for each province or territory, if available.

1C. General Claim Verification Representative (for MSE, Vision Care and Mental Health claims verification)

Qualifications:

- Must have a diploma from a recognized post-secondary educational program in the health

services field; and
- At least 2 years of full-time or equivalent demonstrated experience within the last 5 years in health services;
- Experience in data analysis, financial analysis and statistics;
- Experience in report writing;
- Must have current knowledge of the professional legislation for each province or territory, if available.

1D. Pharmacist

Qualifications:
- Must have a valid license to practice pharmacy in Canada
- At least five years of experience practicing as a pharmacist

Tasks:
- Conduct reviews of On-site and Desk Claim Verification Reports during all review stages to ensure they are accurate and adhere to provincial/ federal regulations, and legislative requirements ensuring timely submission to HC for approval
- Resource to ensure regulatory and legislative issues are identified and communicated accordingly
- Participate in Provider Review Committee (PRC) reviews as on-site expert/ resource

Other Claim Verification Programs:
- For consultation, as required

1E. Dentist

Qualifications:
- Must have a valid license to practice dentistry in at least one province or territory in Canada
- At least five years of experience practicing as a Dentist

Tasks include but not limited to:
- Participate in on-site and desk processes including but not limited to: on site visits, report development, participation in PRC claim verifications
- Review pre and post radiographs for evidence of service
- Review, document and copy relevant records/ documents
- Introduction to dental provider and explanation of claim verification process
- Deliver Exit Interview to dental provider (high level view of results)

Other Claim Verification Programs:
- For consultation, as required

2. IT Personnel:

2A. Business Analyst

Must have minimum of 3 years of demonstrated experience in the IM/IT industry within the last 7 years; and this experience must include:

- Experience in leading business requirements definition, including the discovery, analysis and documentation of business requirements, process flows, use cases, test

and training plans.

2B. Configuration and Change Control Management Specialist

Must have 2 years of demonstrated experience in establishing and maintaining a configuration and change management process in the IM/IT industry within the last 5 years; and this experience must include:

- Experience in authorizing and managing Configuration Management policies and procedures including, but not limited to Version Control, Release Management, Documentation Control, Error/Defect Tracking, Change Management, and Audit Control; and
- Experience in evaluating and implementing automated tools in support of Configuration and Change Management.

2C. Data Analyst

Must have at least 2 years of demonstrated experience in data or metadata management support within a Corporate or Enterprise architecture in the IM/IT industry within the last 5 years; and this experience must include:

- Experience in analyzing data to identify anomalies; perform cyclical reviews to ensure that it is complete, accurate, timely, and consistent with established standards and procedure;
- Experience in identifying and developing IT security requirements for all systems and services as they apply to data;
- Experience in maintaining the Data Dictionary to ensure consistent authoritative data definitions, including access control and maintenance; and
- Experience in data and conversion mapping from legacy / partner data to destination system Data Model.

2D. Database Administrator

Must have 2 years of demonstrated experience with a minimum of one relational database system such as Sybase, Oracle or MS SQL Server in the IM/IT industry within the last 5 years; and this experience must include:

- Experience in providing specialized expertise and practical assistance in use of database management systems and the manipulation of data for information systems, including work at any stage of the database life cycle (feasibility, design, development and service delivery);
- Experience in defining security requirements for all data elements;
- Experience in defining and customizing data conversion strategies, specifications and routines; and
- Experience in managing and organizing electronic databases in order to ensure share ability, coherence, availability, accuracy, completeness and integrity to meet informatics needs.

2E. Programmer

Must have 1 year of demonstrated experience using structured methodologies for program coding and testing in the IM/IT industry within the last 3 years; and this experience must include:

- Experience in conducting systems tests and evaluating systems test results, according to test

scripts.

2F. Programmer Analyst

Must have 2 years of demonstrated experience using structured methodologies for program coding and testing in the IM/IT industry within the last 5 years; and this experience must include:

- Experience in gathering and analyzing data for the conduct of studies to establish the technical and economic feasibility of proposed information systems, and for the development of functional and system design specifications; and
- Experience in analyzing security requirements for all systems and services.

2G. Quality Assurance Specialist

Minimum of 2 years of demonstrated experience working as a Quality Assurance Specialist in the IM/IT industry within the last 5 years; and this experience must include:

- Experience in developing, reviewing and assessing appropriateness and effectiveness of quality assurance policies, procedures, metrics, forms and tools;
- Experience in developing and evaluating performance measurement for the acceptance of systems and software; and
- Experience in validating QA and performance meets security requirements for all systems and services.

2H. IT Application Tester

Minimum of 1 year of demonstrated experience working as an application Tester in the IM/IT industry within the last 3 years; and this experience must include:

- Experience in the management and monitoring of test plans for all levels of testing;
- Experience in the development of test scenarios and test scripts, including security-related testing requirements;
- Experience in executing the test cases/scenarios and documenting the actual test results against the expected results; and
- Experience in establishing software testing procedures for unit test, integration testing and regression testing with emphasis on automating the testing procedures.

2I. IT Security Specialist

Must have at least 3 years of demonstrated experience providing IT security advice and guidance for integrated application design and development in the IM/IT industry within the last 5 years; and this experience must include:

- Experience in conducting compliance audits of IT operations, application systems and infrastructure;
- Experience in conducting security threat and risk assessments of IT facilities, application systems and communications;
- Experience in conducting vulnerability assessments of IT facilities, application systems and communications; and
- Experience in investigating security incidents and reporting causes and related

weaknesses and recommending remedies.

3. Other Professional personnel

3A. Lawyer

Qualifications:

- Must have a valid license to practice law in at least one province or territory in Canada; and
- Have at least 2 years of demonstrated experience in the practice of law within the last 5 years.

3B. Financial Operations Specialist

Qualifications:

- Must have a professional accounting designation (CA, CMA or CGA) valid to practice in Canada and
- Have at least 2 years demonstrated experience in managing complex financial operations within the last 5 years.

3C. Privacy Specialist

Qualifications:

- Must have 2 years demonstrated experience in managing secure information systems containing personal information within the last 5 years.

4. Technical Personnel

4A. Call Centre Operator:

Qualifications:

- At least 1 year experience in customer service, preferably in a call centre environment; and
- Good working knowledge of call centre technology and software.

4B. Editor/Writer

Qualifications:

- At least 2 years of experience in writing or editing materials for a health benefits program or for a similar specialized program.

4C. Technical Writer

Qualifications:

- At least 2 years of experience in writing or editing technical IT documentation.

5. Administrative Personnel

5A. Senior Administrator

Qualifications:

- Must have a degree from a recognized post-secondary educational program or an acceptable combination of training and job experience;
- At least 5 years of experience with managing complex financial, administrative or human resources issues; and
- Experience preparing business analyses and reports for management.

5B. Intermediate Administrator

Qualifications:

- Must have a degree from a recognized post-secondary educational program or an acceptable combination of training and job experience;
- At least 2 years of experience in handling financial, administration or human resources issues; and
- Experience in preparing business analysis and reports.

5C. Junior Administrator

Qualifications:

- Knowledge of general office management practices and administrative practices and procedures.

Appendix G. Partial List of NIHB Claims Services HICPS Website Content

The following is non-exhaustive list of Posted Documents, Forms and Links

Benefit	Forms/Documentation	Description
Dental	Dental Provider Enrolment Form	Form used by all dental specialists (i.e. Dentists and Denturists) to enroll to the dental benefit under the NIHB Program
	NIHB Dental Claim Form	One of the claim forms used for submission of Dental claims, Predetermination/Post-determination, Client Reimbursement submissions
	NIHB Completion of Active Orthodontic Treatment Form	Form used for claiming the payment for orthodontic treatment.
	NIHB Referral for Orthodontic Examination and Diagnostic Records	Form used when referring a client to an orthodontist.
	NIHB Dental Claims Submission Kit	Document outlining the terms and conditions for the submission of claims, and the administration of the dental benefit under the NIHB Program.
	Dental Hygienist Provider Enrolment Form	Form used by Dental Hygienists to enroll to the dental benefit under the NIHB Program
	Modification to Dental Provider Information Form	Form used by providers to inform of any modifications in their contact information, additional offices, etc.
	Dental Benefit Grids, organized by year and by province or territory and by dental specialty	NIHB Regional Dental Benefit Grids for general Practitioners, Specialists (i.e. Oral Surgeons), Denturists, and Dental Hygienists.
	Newsletters for Dental benefit, Organized by year and by province or territory	Newsletters folder with drill down capability and search function
	Policy and Program Information	Link to HC Website, to the Dental benefits
	Broadcast Messages	HC communications published as required, which clarifies benefit definitions, and communicates changes in benefits.
Pharmacy	Pharmacy Provider Agreement	Agreement between Pharmacy Provider and NIHB
	NIHB Pharmacy Claim Form	Form used by Pharmacy Providers to submit claim
	NIHB Pharmacy Claims Submission Kit	Document outlining the terms and conditions for the submission of claims, and the administration of the pharmacy benefit under the NIHB Program.
	Modification to Pharmacy Provider Information Form	Form used by Providers to inform of any modifications in their contact information, additional offices, etc.
	Newsletters for Pharmacy benefit, organized by year and by province or	Newsletters folder with drill down capability

Benefit	Forms/Documentation	Description
	territory	
	Broadcast Messages	HC communications published as required, which clarify benefit definitions, and communicates changes in benefits.
	Drug Benefit List	Searchable listing of drugs provided as a benefit by NIHB
	Policy and Program Information	Link to HC Website, provide guide to Pharmacy benefits
MSE	Medical Supplies and Equipment Provider Agreement	Agreement between MSE Provider and NIHB
	NIHB Medical Supplies and Equipment (MSE) Claim Form	Form used by MSE Providers to submit claims
	NIHB Hearing Aid and Hearing Aid Repair Prior Approval Form	
	NIHB General Medical Supplies and Equipment Prior Approval Form	
	NIHB Orthotics - Custom Footwear - Prosthetics - Pressure Garments Prior Approval Form	
	NIHB Oxygen and Respiratory Medical Supplies and Equipment Prior Approval Form	
	NIHB Medical Supplies and Equipment Claims Submission Kit	Document outlining the terms and conditions for the submission of claims, and the administration of the MSE benefit under the NIHB Program.
	Modification to Medical Supplies and Equipment Provider Information Form	Form used by Providers to inform of any modifications in their contact information, additional offices, etc.
	Newsletters for MSE benefit, organized by year and by province or territory	Newsletters folder with drill down capability
	Broadcast Messages	HC communications published as required, which clarify benefit definitions, and communicates changes in benefits.
	Policy and Program Information	Link to HC Website, provide guide to Medical Supplies and Equipment (MSE) benefits
	Modification to MSE Provider Information Form	Form used by Providers to inform of any modifications in their contact information, additional offices, etc.
	NIHB General MSE Prior Approval Form	
	MSE Blood Pressure Monitor Questionnaire	A document for prescribers with specific questions that assist reviewers with determining eligibility for a

Benefit	Forms/Documentation	Description
		blood pressure monitor
	MSE Incontinence Questionnaire	A document for prescribers with specific questions that assist reviewers with determining eligibility for incontinence products.
	MSE Wound Assessment Table Form	A document for health care providers that describes the client's wounds and their treatment.
Vision Care	Vision Care Provider Agreement Health Canada Non-Insured Health Benefits (NIHB) Program	Agreement between Vision Care provider and NIHB
	Newsletters	Newsletters folder with drill down capability and search function
	Claims Submission Kit	Document outlining the terms and conditions for the submission of claims, and the administration of the Vision Care benefit under the NIHB Program.
	Policy and Program Information	Link to HC Website, provide guide to Vision Care benefits
	Modification to Pharmacy Provider Information Form	Form used by Providers to inform of any modifications in their contact information, additional offices, etc.
	NIHB Eye and Visions Products and Services Prior Approval and Claims Form	Form used by Vision Care Providers to submit claims
Mental Health Counselling	Mental Health Counselling Provider Agreement	Agreement between Mental Health Provider and NIHB
	Newsletters	Newsletters folder with drill down capability and search function
	Claims Submission Kit	Document outlining the terms and conditions for the submission of claims, and the administration of the Mental Health Counselling benefit under the NIHB Program.
	Policy and Program Information	Link to HC Website, provide guide to Mental Health Counselling benefits
	Modification to Mental Health Provider Information Form	Form used by Providers to inform of any modifications in their contact information, additional offices, etc.
	Mental Health Counselling Prior Approval Form	Form used by Mental Health Providers to submit a PA request
	Mental Health Counselling Appointment Confirmation Sheet	
	Mental Health Counselling Claim Form	One of the claim forms used for submission of Mental Health Counselling benefit claims
General	Other general information	• Telephone and fax numbers of HC's Call

Benefit	Forms/Documentation	Description
		Centers for the NIHB Regions, Drug Exception Centre (DEC) and Dental Predetermination Centre (DPC) • Late-breaking news with content appropriate to the Provider and Clients • Alerts • Frequently Asked Questions (FAQ) based appropriate content • User Documentation • Direct links to the NIHB Program sections of the HC Website

Non-exhaustive list of Special Communication Letters

Welcome Letters
Operational Letters (for example, Standard Claim Return Letters due to insufficient information),
Provider Delisted Letters
Letters to vendors, providers, clients and associations

Other

Client Reimbursement Form Client Secure Access Enrolment Form

Appendix H. Summary of Static HICPS Operational Reports

The following is a summary of static reports with report title, details, and frequency.

Report Title	SOW References	Pre- Implementation Report Details	Frequency
Annual Operations Plan status report	2.9	Detail the status of activities, recurring problems, corrective actions taken and recommendations for improvements in the Pre-Implementation Phase.	Monthly within five business days after month end
Pre-Implementation Status Report	2.1	During the Pre-Implementation Phase, progress against the Pre-Implementation Plan	Twice per month
Transition Plan status report	2.7	The status of the plan activities during pre-implementation for which the Contractor is responsible - as well as issues or obstacles affecting the schedule timelines and corrective actions taken	Twice per month
Office simulation report	2.2.3	Pre-implementation testing of model office simulation report	Within 4 business days of completion of simulation
Phase Out activities and progress report	4.2.3	Summary report of queries received during phase out activities	As determined by HC
Report Title	SOW References	Post-Implementation Report Details	Frequency
Quality Assurance Report	3.2	Report detailing the Contractor's performance against the established quality metrics	Monthly within five business days after month end
TA Report	3.1.3.2	Reporting on a status of all TAs as detailed in SOW Article 3.1.3.2	Monthly within five business days after month end
Post-mortem disaster/incident report	3.1.4.8	Post mortem report detailing causes, remedial action and preventative measures taken	No later than 30 business days following end of disaster/ incident
DRP test report	3.1.4.9	A reporting detailing the results of the DRP test.	Annually, no later than 20 business days following end of test

BCP test report	3.1.4.9	A reporting detailing the results of the BCP test.	Annually, no later than 20 business days following end of test
Privacy Incident/Report	3.2.2.3	Quarterly report on all privacy/personal information protection matters or whenever a breach of privacy event has occurred.	Quarterly within 5 business days of quarter's end, or whenever a breach of privacy event has occurred within 1 business day of the breach.
HICPS Call Centre service standard report	3.3.2.9	HICPS Call Centre performance reports on, but not limited to, the matrix illustrated in Appendix I.	Monthly within five business days of month-end.
Provider Enrolment Reports	3.3.1.7.1	Quarterly reports Provider Enrolment statistics outlined in SOW Article 3.3.1.7.1	Quarterly within five business days of quarter end.
Statistical reports detailing all claims submitted under the NIHB Program from Ineligible providers	3.3.1.7.2	Twice a year the Contractor must prepare and post Statistical Reports detailing all claims submitted under the NIHB Program from ineligible providers.	Twice annually within 5 business days of the end of the semi-annual period (May 31 and November 30)
Provider and Client Communication Reports	3.3.3.10	The Contractor must provide Provider and Client Communication Reports as detailed in SOW Article 3.3.3.10.	Quarterly within 5 business days of quarter end
SVS Interface Report	Appendix D & 3.3.9.13	Summarizes activities of processed data and provides details of the rejected transactions. Enable FNIHB NHQ to correct and re-submit the transactions via subsequent weekly updates.	Weekly, whenever interface is run
SVS Transfer Details Report	Appendix D	Details all transfer activity. Enable FNIHB NHQ to maintain a list for verification and record keeping.	Weekly, whenever interface is run
SVS Infant Exception Report	Appendix D	Details transactions that are deemed as Infant records. Enable FNIHB NHQ to verify/correct the errors and action appropriately.	Weekly, whenever interface is run
Annual Reconciliation Summary Report	Appendix D	Summarizes by region the number of Clients on the database	Annual, whenever reconciliation is run

Benefit information import validation report	3.3.10.4	The report on service provided to Clients that will be registered in HICPS and not to be adjudicated and the payment must be suppressed.	As required within five business days of receipt of data
Claim Funding Request report	3.3.12.1	The report of all manual adjustments shall include a list of recoveries, sorted by Provider number and office ID, to be offset against claims settled in the payment period	Three business days prior to the payment date
Un-cashed cheques resolution report	3.3.12.3	Cheques issued but not enchased	Monthly within 10 business days of month-end
Report on stale-dated cheques	3.3.12.3	Stale-dated cheques not cashed within 12 months of the cheque issue date	Monthly within 10 business days of month-end
Report on stopped/cancelled payments	3.3.12.3	Stopped or cancelled payment details	Monthly within 10 business days of month-end
HICPS Claims Expenditure Data File Report	3.3.12.4	HICPS claims expenditure data file, content and layout to be provided by the Project Authority	Bi-weekly 26 times per year
Outstanding Recovery Report (Financial)	3.3.12.3	Outstanding recovery details from providers	Monthly, within 5 business days of month end
Monthly Recovery Report	3.3.12.3	Money recovered, owed by the providers during current month	Monthly, within 5 business days of month end
Annual Recovery Report	3.3.12.3	Money recovered, owed by the providers during current year	Annually, 10 business days following the end of the fiscal year

Recovery of Funds related to the Provider Claim Verification Program Report	3.3.13.14	Track separately by Provider, name, benefit, region, claim verification type (on-site or desk), and by Provider claim verification showing monies collected and monies outstanding:	Reports must be submitted to the Project Authority monthly, within 10 business days of month end. An annual summary report must be submitted to the Project Authority within 10 business days following the end of the fiscal year.
The availability and performance service standard report for the DRR	2.6 and 3.4.1	Availability Service Standards and statics of the DRR	Monthly, within 5 business days of month end
Detailed disaster/incident report	3.1.4.8	The disaster/incident report include a report on the integrity and completeness of any data that had to be restored	10 business days following disaster/incident
Operational Support Problem and Incidence Management Reports	3.5.1.4	Problems, incidences and their resolution, technical support to HC HICPS Users through the Contractor provided help desk.	Monthly, within 5 business days of month end
Third Party software testing report	3.5.1.7	HICPS EDI interface, the Contractor must report to HC on the results of the testing against third party software.	Within 5 business days following the testing of third party software
Provider Claim Verification Reports	3.3.13.17	The Contractor must produce static reports for the PVCP components for all five benefits areas, on a monthly, quarterly, or annual basis as required by the Project Authority.	Within 10 business days from the required period (monthly, quarterly, or annual)
Acceptance Testing Report	2.2.3	For all UAT runs the Contractor must include a report on outcomes and corrective action plans that must be posted to the DRR	within 3 business days of a user acceptance testing run

Back-up/restore report	3.4.6.25	Random data back-up/restore tests for HC review	Quarterly, within 5 business days of quarter end
Release Post-Mortem	3.5.1	The release and configuration management processes and reports	Maximum 15 business days after each release
Change management report	3.5.1	Log of all changes and for providing a change management report posted to the DRR.	Within 5 business days of month end.
Vulnerability Assessment	3.4.6.14	Report on the results of vulnerability assessments and propose solutions and timeframes for resolving identified limitations	Annually, within 20 business days of the completion of the assessment
Claims Processing Service Standard Report	3.3.10	Compliance of service standards for paper and electronic claim processing measured through monthly HICPS Operational Reports	Monthly, within 5 business days of month end
The availability and performance service Report for the HICPS Website	3.3.3.1	HICPS Website performance and statistics, matrix to be provided by the Project Authority	Monthly, within 5 business days of month end
The availability and performance service standard Report for the network infrastructure	3.4	Contractor provided network infrastructure availability and performance service standard report	Monthly, within 5 business days of month end

The availability and performance service standard Report for the applications and applications infrastructure	3.4	Overall applications and applications infrastructure provided by the Contractor	Monthly, within 5 business days of month end
Testing results report	3.5.1.7	Testing results report to the DRR	Within 1 business day of testing completion
Active and inactive user account report	3.4.6.19	Lists all active and inactive user accounts and the various roles assigned to them.	Monthly, within 5 business days of month end
Change Management status report	3.5.1.1	Reporting on a status of all outstanding Task Authorizations(TAs)	Monthly within five business days of month end

Appendix I. HICPS Call Centre Service Standards

Service Level Standard	Frequency (Report submission to Health Canada
a) Calls answered: 80% of monthly calls in each official language, measured separately, must be answered within 20 seconds by a live person after automatic call distributor (ACD)/ Interactive Voice Response (IVR) call transfer. b) All calls (100 percent) on hold in each official language must be answered within 5 minutes by a live person after automatic call distributor (ACD)/Interactive Voice Response (IVR) call transfer. c) Calls, in both official languages, must be answered by a live person after automatic call distributor (ACD)/Interactive Voice Response (IVR) call transfer in the order that calls are received (“first in; first out”); d) Calls resolved: 95 percent of monthly calls to be resolved (e.g. question was answered, call was appropriately redirected, or escalated) at initial contact or within the same day. The performance must be measured monthly from the call management reporting system; e) Calls abandoned: no more than 2.5% of monthly calls are to be abandoned - measured via the call management reporting system; f) Voice messages: voice messages must be returned within 1 business day of receiving an initial call. g) Hours of operation for the Pharmacy call centre are Monday to Friday from 6:30 a.m. to 12:00 a.m. (Eastern Standard Time – EST) and from 8:00 a.m. to 12:00 a.m. on Saturday, Sunday and statutory holidays; h) Hours of operation for the Dental, MSE, Vision Care, and Mental Health Counselling call centre(s) are Monday to Friday 6:30 a.m. to 8:30 p.m. EST (excluding Statutory Holidays).	Monthly posted to DRR within five business days of month end.